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ABSTRACT

This book was written to help educators to deal more effectively with pregnant and parenting students by working with both the students and their kinship networks to assure the well-being of teenage parents and their infants and by developing ideas, policies, and procedures to reduce the incidence of unwanted student pregnancies. The six chapters in Part One of the book focus on the student and the school. Chapter 1 examines the scope of the teenage pregnancy problem and looks at its long-term consequences. Chapter 2 explores the expanding role of the school and recommends helpful school responses to pregnant and parenting adolescents. Chapter 3 focuses on how educators can help, offering specific suggestions for school boards, superintendents, principals, teachers, counselors, and other school employees. Chapter 4 looks at classroom interactions and discusses advice-giving, supportiveness, and communication. Chapter 5 stresses the importance of parental involvement and describes ways to get parents involved. Chapter 6 presents a comprehensive approach to prevention. The five chapters in Part Two, "The Student, the School and Society," deal with: (1) determinants of teenage pregnancy; (2) teenage pregnancy and the larger social issues; (3) pregnant and parenting adolescents and their families; (4) pregnant teenagers' decision making; and (5) organizational responses to teenage pregnancy. An appendix contains a sample of networking services for pregnant adolescents, a policy statement on school age parents, and excerpts from various published sources on the problem. (NB)

How Schools Can Help Combat

Student Pregnancy

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How Schools Can Help Combat

Student Pregnancy

by Nancy Compton
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NEA Policy on Family Planning

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The National Education Association supports family planning, including the right to reproductive freedom.

The Association urges the government to give high priority to making available all methods of family planning to women and men unable to take advantage of private facilities.

The Association further urges the implementation of community-operated, school-based family planning clinics that will provide intensive counseling by trained personnel. (85, 86)

Note

The opinions expressed in this publication should not be construed as representing the policy or position of the National Education Association. Materials published as part of the NEA Combat Series are intended to be discussion documents for teachers who are concerned with specialized interests of the profession.

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Preface

This book has been written to help educators deal more effectively with pregnant and parenting students. The approach throughout is compassionate and holistic. It features information and case studies to help conceptualize the problem, and includes practical ideas for use by educators and school staff members.

Between 1971 and 1979 there has been a two-thirds increase in teenage sexual intercourse, which of course, in various ways, corresponds to teenage pregnancy.[1*] *We neither condone nor condemn this phenomenon, but we do view the act of sexual intercourse, its concurrent relationship issues and potential negative consequences, as serious and complex, and think the experience is best postponed until after the central identity development issues of adolescence have been resolved. We believe, however, that the ethical issues involved are value judgments that individual educators must rightly make for themselves.* Our concern here is an educational one. We believe that the role of educators is to aid in the development of the students entrusted to them. Consequently the purpose of this book is twofold: (1) to help educators work with both the pregnant and parenting adolescents and their kinship networks to assure the well-being of the infant and its parents; and (2) to help educators develop ideas, policies, and procedures that will reduce the incidence of unwanted student pregnancies.

We offer this book with a profound respect for educators and the role they are being

*Superior numbers appearing in the text refer to the References beginning on page 176.

asked to play in the growth and development of our children. We believe that the fate of pregnant and parenting adolescents and their infants is intricately intertwined with cultural norms, legislation, family networks, and economics. Nevertheless, when preteens and teenagers begin puberty they are in school, and the most significant adults in their lives—in many cases including their parents—are educators. Therefore it is difficult to overestimate the potential of schools, as institutions, and educators, as individuals, for helping these young people in their struggle to make sense out of their lives.

PART ONE

The Student and the School

CHAPTER 1

The Scope of the Problem: Teenage Pregnancy and Its Long-Term Consequences

The teen birth rate of the United States is higher than that of any other developed country. It cuts across all races and classes. Although it is greatest among the Black population and low income youth, statistics have shown that omitting Blacks from the figures altogether, the U.S. teenage pregnancy rate is still significantly greater than that of England, France, Canada, Sweden, and the Netherlands.[1] Each year over 300,000 babies will be born to teenage mothers who have not completed high school. Thirty-six thousand of these mothers have not completed ninth grade. Of the more than 500,000 babies born to teens each year, one-third have mothers under the age of 18.[2]

> If there is no change in current rates, four out of 10 girls who are now 14 will get pregnant in their teens, two in 10 will give birth and three in 20 will have abortions.[3]

Three out of four of the one million teenage pregnancies that occur each year are unintended.[4] Most of the teen parents who decide to raise their children remain unmarried, leave school because of psychological, financial, and logistical reasons, and are destined for a life of poverty and reliance on welfare.

While the overall number of births to teenagers has declined since 1970, births to those under 15 have risen: "Nearly 10,000 babies were born to girls 14 and under in 1982 and two-thirds of them are white."[5] These mothers experience the most complications because of their immature bodies, their lack of knowledge about caring for themselves and their unborn babies, and—in many cases—their absolute lack of prenatal care. Mothers and fathers in this group are also those least able emotionally to nurture and parent a newborn baby. As a result, literally thousands of children each year enter life unhealthy, undernourished, and unwanted. They are born to parents who lack self-assurance, parenting skills, maturity, emotional support systems, and the financial means to adequately cope with and provide for a child. These factors do not lend themselves to the healthy development of young egos and the sense of basic trust that parents and children need. Instead, there are alarmingly high rates of child abuse, poverty, learning disorders, malnutrition, and behavioral problems.[6]

Moreover, the younger the mother at the time of her first pregnancy, the greater the number of children she will bear. Concomitantly, despite her best efforts and intentions, child care will limit her opportunities for education and the number of hours she can work. It will also limit the kind of position she will be able to obtain. In addition, the children who are raised in female-headed households, as is typically the case, are often unable to break out of a life of poverty. Unfortunately, this is a factor in the continuing cycle of generations reproducing themselves at an early age with few benefits.[7]

In short, the consequences of teenage pregnancy are both *far-reaching* and *cyclical*. They are far-reaching in the sense that teenage parenthood circumscribes the lives of young people and has severe implications for the education, health, and well-being of both parents and offspring; and also in the sense that both parents and offspring may never recover sufficiently to become productive members

of society. They are cyclical in the sense that the children of teenage parents frequently become teenage parents themselves and thus become subject to the same consequences that their parents faced.[8]

The lists that follow contain indicators that illustrate these consequences in detail. The lists are arranged by category: high-risk factors; health risks; psychological, emotional, and developmental consequences; educational consequences; and financial consequences.[9]

High-Risk Factors for Children of Teenage Parents

- The risk of infant death is twice as high for teenage mothers as for women in their twenties.
- Mothers 15 and younger are twice as likely to have low birth-weight babies.
- Low birth weight is associated with
  - —serious birth defects.
  - —both a high risk of retardation and brain injuries.
  - —high morbidity rate—three times as likely to develop childhood illnesses.
  - —high mortality rate.
- Children are subject to a higher incidence of abuse and neglect due to the multiple stressors of early parenting.
- There is a greater probability that the child will have low self-esteem due to the parent's lack of ability to conceptualize the child's needs and then fulfill them.
- The child's cognitive development is likely to be impaired unless there is interaction with several caregivers.
- There is a greater probability that the child will be less successful in adapting to and achieving in school.
- Social and emotional problems are more prevalent,

especially with boys.

- Children have lower achievement scores and are more likely to repeat grades.

Health Risks for the Teenage Mother and Her Baby

- Most young teens receive no prenatal care in the first trimester. In general, they are half as likely as older women to receive prenatal care.
- Teens under 15 receive the least prenatal care.
- Teens' births are associated with higher rates of birth complications—toxemia, anemia, difficult and prolonged deliveries.
- Young adolescent mothers are twice as likely to die from causes related to childbearing than are mature women because of their immature bodies, lack of proper nutrition, and inadequate health care.
- The table on page 17 compares the health indicators of Hispanic and non-Hispanic mothers and their children.

Psychological, Emotional, and Developmental Consequences

- The suicide rate for teen mothers is higher than that for other teens.
- The number of teenage mothers who attempt suicide is seven times the rate for young teenage women without children.
- Teen mothers are more likely to abuse their children because of their restricted social networks.
- Teen mothers are faced with multiple stressors, which include bearing the brunt of child rearing, living in poverty, being isolated from a support network, often having a poorly developed self-identity, and raising children who are less likely to be healthy.

Hispanic Maternal and Child Health Indicators, U.S., 1982†

	Origin of Mother					
	Hispanic*			Non-Hispanic		
	Total	Mexican-American	Puerto Rican	Total	White	Black
% of babies born at low birthweight	6.2	5.7	9.1	6.9	5.6	12.4
% of babies born prematurely	10.7	10.6	12.6	9.5	7.6	17.0
% of babies born to mothers who began prenatal care early	61.0	60.7	54.5	76.9	81.2	60.1
% of babies born to mothers who began prenatal care late or not at all	12.1	12.0	17.2	5.2	3.8	10.5
% of babies born to mothers younger than 15 years	0.4	0.4	0.5	0.3	0.1	0.9
% of babies born to mothers younger than 20 years	18.3	19.1	23.0	13.7	11.3	24.9
% of births out of wedlock	25.6	21.9	49.0	19.4	10.2	58.0

*Based on data from the twenty-three states recording Hispanic or ethnic origin on birth certificates. These states account for 95 percent of the total national estimate for Hispanic-origin births. In 1982, 95.0 percent of births to mothers of Hispanic origin were white, 3.3 percent were black, and 1.7 percent were other races.

†Reprinted with permission from the *Maternal and Child Health Data Book: The Health of America's Children*, Children's Defense Fund, 122 C St., NW, Washington, D.C., 1986, p. 37.

- Teen marriages are more likely to end in separation or divorce than are older marriages. Three out of five teen marriages break up when the teenage mother becomes pregnant before marriage.
- Young teenage mothers have 50 percent more births than later childbearers; close to 20 percent become pregnant again while still in their teens.
- Teen fathers are burdened with finding a job, quitting school, and supporting the child.
- Teen parents have few resources available to them to talk about their feelings and gain support.

Educational Consequences

- Less than half of teenage mothers who become pregnant between the ages of 13 and 15 graduate from high school.
- Approximately 80 percent of teenage mothers drop out of school.
- Teenage fathers are less likely to finish high school.
- It is unlikely that either the teenage mother or father will obtain a higher education.

Financial Consequences

- The income of young teen mothers is half that of those who give birth in their twenties.
- Once separated, young mothers are far less likely to receive child support payments than are older mothers. Only one in ten mothers ages 14 to 24 receives child support payments compared with more than one in four older mothers. For the small number who do receive financial assistance from the father, payments average under $1,500 per year.
- Only 42 percent of teen males hold jobs; among high school dropouts only one in five is employed.
- Families headed by young mothers are seven times as likely to be poor as are other families; 66 percent of all households headed by women ages 14 to 24 with young children live below the poverty line.
- Black children in female-headed families are the poorest in the nation. Eighty-eight percent of young Black female-headed families were poor in 1983, as opposed to 72 percent of young white female-headed families.
- Black female-headed families are more likely to remain poor. Statistics suggest that only one Black single mother in four will escape poverty. Among

young white single mothers, the rate is closer to one in two.

- Over half of the mothers on welfare bore their first child in adolescence.
- The following table shows the high rate of poverty in female-headed families. Black children fare the least well.

Percentage of Families with Children under Age 18 with Incomes Below the Poverty Level, 1983[10]

Family Type and Age of Head	Black	White	Total
Two-parent families	17.2%	9.0%	9.8%
Head under 25	25.8	18.9	19.5
Head 25–44	13.6	8.5	9.0
Female-headed families	63.7	39.3	47.8
Head under 25	85.2	72.1	77.7
Head 25–44	62.6	38.1	46.1

Reprinted with permission from *Preventing Children Having Children*, Children's Defense Fund, 122 C St., NW, Washington, D.C., 1985, p. 12.

CHAPTER 2

Helpful School Responses to Pregnant and Parenting Adolescents

Throughout this book we stress the interrelationship of the culture and teenage pregnancy. In short, *we believe there are multiple and complex causes for the teenage pregnancy phenomenon, which would suggest that the responses needed to address the issue also be numerous, varied, and complex.* Here and in Chapters 3, 4, and 5 we recommend several responses that educators—teachers, administrators, support staff—can make to help both in preventing pregnancy and enabling parenting adolescents to complete their education. However, we strongly feel that *teenage pregnancy has such potentially dire consequences for so many people that, in addition to individual responses, schoolwide responses in the form of policies, programs, and activities are also needed.*

This chapter addresses the specific needs of pregnant and parenting adolescents to fully participate in the educational program of the school. We are not advocating that all schools respond to all the recommendations that follow, but that each school respond appropriately and comprehensively to its particular needs and circumstances. The one exception is our first recommendation, sexuality education. We believe that all schools should build sexuality education into the curriculum regardless of the number of pregnant and parenting adolescents, or even if a school has no record of pregnancy. Our position is based on the following: (a) research

documents that sexuality education works as a deterrent to adolescent pregnancy,[1] (b) a comprehensive school curriculum would not be complete if it did not include instruction in one of life's most critical areas, and (c) teenagers have a right to be educated so that they can make informed decisions about their bodies, their lives, and sexual activity.[2]

It is important to add here, and for schools to take into account, that adolescent pregnancy frequently goes officially unrecognized when students drop out of school without giving reasons. Consequently, there may be more need to address the problem than appears at first glance. Local variables such as school size, location, and available resources must be considered.

The Expanding Role of the School

As we write this chapter, we are all too aware that we are asking schools, already overwhelmed with societal expectations, to assume yet another responsibility. For the past several decades schools have come to play a greatly expanded role in our children's lives. This is reflected in the extension of schooling in both directions. At one end are kindergarten and prekindergarten programs. At the other end, 75 percent of all students are now completing high school, compared with 6 percent in 1900 and 50 percent in 1940.[3] In addition to the extended amount of time spent in school, there has also been a geometric increase in expectations. We now look to the schools to teach and be responsible for not only academic subjects, but also such areas as career education, ethics education, health education, driver education, and vocational education. It is irrefutable that the expectations for teachers have increased beyond normal limits.

This change from the family to the school as the primary educational and socializing institution has repercussions for youngsters and edu-

cators alike. In recent years a crescendo of voices has pointed to the stress levels of both children and teachers. Certainly, teachers need increased support. Educating children whose basic physical and emotional needs have not been met is an almost impossible task. Early sexual behavior and resultant pregnancies can be related to these unmet needs. Generally, early pregnancy brings extended schooling patterns to a halt.

Clearly there is a problem and there are no simple solutions. We are encouraged, however, by recent indications that parents, educators, social service workers, health care personnel, and some legislators are joining forces in an effort to assist schools in their work with young people. By a linking of community organizations and resources, student needs can be met through the formation of services in both the school and the community. For example, the Adolescent Health Services and Pregnancy Care Act passed in 1978 provides for comprehensive services (health, educational, and emotional) to teenagers (to prevent unwanted pregnancies) and to parents. The legislation also makes grants available to coordinate services between community agencies.

Each community will have to come up with its solutions to reflect its particular needs. The development of a local Adolescent Needs Service Committee made up of school personnel, service providers, parents, teens, and interested citizens can offer guidance and direction in both the formulation and the coordination of a comprehensive service system. A Sampling of Community Networking Services Specifically for Adolescent Pregnancy appears in the Appendix.

Most of the recommendations that follow focus on schools, but several go beyond schools to include other community agencies, and Chapter 5 deals exclusively with parental involvement. *Clearly, the problems now facing the schools are more than educational problems, and the need for a unified approach is indeed paramount.*

Recommended School Responses

This section discusses 12 recommendations that we offer to alleviate the problem of adolescent pregnancy. We recommend that school responses to the issue include provisions for sexuality education, a range of options, staff development, dropout prevention, advocacy personnel, flexible attendance, day care, prenatal care, parenting skills, support groups, recordkeeping, and school policies.

1. *Sexuality Education.*

> "I never used birth control. I didn't know nothing about it. I thought birth control would hurt me. They didn't mention birth control in school. They talked about the uterus, ovaries, vaginas, but not no birth control. It would have been better not to get pregnant. My friend says she takes her friend's pills. Another says she takes her grandmother's pills. . . .What would a grandmother need with birth control pills? You can't believe nobody.
>
> "My girlfriend says she's had twelve abortions. But I know you can only have two. This is going to be my first and last. I don't believe in it. They say abortions mess up your insides. I'm going to get me a big medical book if I can read it.
>
> "I didn't even know I was pregnant. My sister looked at me and said, 'You're pregnant.' 'No, I ain't,' I said."[4]

We recommend sexuality education programs that go well beyond basic reproductive anatomy and measures of birth control to include the teaching of communication skills, relationship building, self-awareness, values clarification, and, most importantly, programs and activities that are geared toward increasing self-esteem. The Planned Parenthood Federation of America defines sexuality education as

> a learning process which includes the discussions of responsibility and ethical behavior, stressing the impor-

tance of understanding sexuality in all its aspects—human growth, sexual development, social relationships and decision-making, as well as information on the biology of reproduction.[5]

Sexuality education programs may include objectives such as these:

- to provide accurate information about sexuality
- to facilitate insights into personal sexual behavior
- to reduce fear and anxieties about personal sexual developments and feelings
- to encourage more informed, responsible, and successful decision making
- to encourage students to question, explore, and assess their sexual attitudes
- to develop more tolerant attitudes toward the sexual behavior of others
- to facilitate communication about sexuality with parents and others
- to develop skills for the management of sexual problems
- to facilitate rewarding sexual expression
- to integrate sex into a balanced and purposeful pattern of living
- to create satisfying interpersonal relationships
- to reduce sex-related problems such as venereal disease and unwanted pregnancies.[6]

Regardless of any other activities they may initiate in responding to this issue, we firmly believe that all schools should include such a program as a regular part of the curriculum.

2. *A Range of Options.* Historically schools have responded to teenage pregnancy in the following ways. First, and most commonly, they have ignored it on the assumption that pregnant stu-

dents would drop out; beyond ignoring it, there has been subtle and not-so-subtle pressure or encouragement to leave school. Others have denied the problem or claimed it does not exist in their districts. Second, schools have developed special alternative programs for pregnant and parenting teenagers. While we certainly favor the availability of such alternatives because many pregnant and parenting adolescents may prefer to continue their schooling in such a program, we also believe it is frequently better for them to remain in the regular school program. For students who prefer the latter, a supportive atmosphere that includes special services is a necessity. Still other students, for any variety of economic and/or family reasons, may need home tutoring, GED availability, or classes that meet at irregular times to accommodate child care needs.

3. *Staff Development.* Many adults who work in schools have never been involved with pregnant and parenting adolescents. Their lack of knowledge as well as certain ethical perspectives may make it difficult for them to work effectively with these students. In-service workshops on adolescent development, sexuality, early child rearing, and ways to be helpful to and supportive of these students can do much to foster a positive school environment.
4. *Dropout Prevention.* The tendency for pregnant females, and oftentimes for stressed males, is to drop out of school.[7] Unless schools become sensitive to this possibility and take proactive measures to prevent it, dropouts can easily occur without formal recognition. Therefore, *we urge each school to develop a sensitivity process to identify such potential dropouts, contact them, and respond in ways that encourage them to remain in or return to school.* The process is indeed a delicate, but critical, one, involving the adolescents' tendency to avoid school and their right to privacy.

5. *Advocacy Personnel.* Local, state, and federal services may be available for pregnant and parenting adolescents. However, these young people may not have access to them because of their own intimidation or lack of knowledge. The school can remedy this problem by assigning a staff member the responsibility for connecting and coordinating students with services.
6. *Flexible Attendance.* School attendance and tardiness policies have been set with students in mind who are childless, not pregnant, and who usually live at home. In general, these students have little more to do than walk, drive, or take a bus to school. In such cases rather firm policies are understandable. This is simply not the case with pregnant and parenting adolescents. School policies that are supportive of these students need to be flexible to accommodate their prenatal, postpartum, pediatric, child-care, and other needs.
7. *Day Care.* No deterrent to continued schooling may be as difficult for teenage parents to responsibly overcome as the unavailability of affordable quality day care. A creative school can not only provide such a service, but also enrich its career exploration and child-care programs by connecting these students with the day care.
8. *Prenatal Care.* Pregnant young women have much to learn about nutrition, drug abuse, exercise, and other ways of caring for themselves and their unborn children. Schools can develop credit courses, free period classes, or even afterschool prenatal care programs. We also advocate involving the young fathers in such courses to support the health of both the mothers and their unborn children.
9. *Parenting Skills.* Probably little research is as solid and compelling as that which documents the importance of early childhood. Yet there is no reason to believe that teenage parents have the necessary knowledge, skills, or attitudes to give their offspring a healthy start. Schools

would be serving these parents, the infants, and society at large by establishing effective parenting skills classes.

10. *Support Groups.* Many lives are affected by a teenager's pregnancy. Many of the people affected experience such feelings as isolation, guilt, anger, fear, helplessness, and bewilderment. When people in a like situation are formed into a support group, led by a knowledgeable and sensitive group leader, much good can result. Participants can see they are not alone, they can share their feelings, and they can plan the future with others who have similar concerns. Support groups, sponsored by the school, might be initiated for (a) the pregnant adolescents, (b) the male counterparts, or (c) the parents of pregnant adolescents.
11. *Recordkeeping.* One of the difficulties of gathering data on pregnant and parenting adolescents is the dearth of reliable information, especially on the number of school dropouts. Many school districts keep no records on this point. We recommend that schools take a proactive stance with regard to school dropouts. This would include validating the reasons for dropout by routine personal outreach contacts after any student leaves.
12. *School Policies.* Given that many educators have little experience in working with pregnant and parenting adolescents, and may be uncertain about the school's expectations, *the formulation of guidelines is imperative to both protect and offer clarity to the entire faculty and staff.* The school's stance with regard to pregnant and parenting students should be clearly spelled out. As an example, we have included in the Appendix the Policy Statement on School-Age Parents by the Boston School Committee for use in the Boston Public Schools.

CHAPTER 3

How Educators Can Help

Adolescent pregnancy raises no new issues for educators in the sense that schools have a long history of continuous adjustment to meet particular student needs. Clearly, pregnant adolescents, like the gifted, the handicapped, the non-English-speaking, and the talented athlete, have needs particular to themselves. Interestingly, however, their needs are not overwhelming; they call for no herculean efforts, no massive financial outlays, no rare human resources. Rather, *the need is for all school personnel to acknowledge that pregnant adolescents have become a factor in our schools,* and to make subtle, but vitally important, adjustments to accommodate this development.

This chapter suggests ways in which various education personnel can effectively help the school better serve its pregnant adolescents. Even though individual suggestions are relatively minor, we believe that collectively they make the school a more sensitive, more involved, more effective, and much more humane institution.

School Boards

School boards can play a paramount role in helping pregnant and parenting adolescents in two ways. First, they can set policy. Presently most school districts, as far as we can tell, have no policy that addresses these students. The absence of policy creates uncertainty for teachers, administrators, counselors, and support staff when responding to pregnant and parenting adolescents. It has been our experience that these conditions promote much restraint and caution on the part of school employees.

Therefore, we urge school boards to develop policy that documents their district's commitment to *all* its students, as well as their overt encouragement of administrators and teachers to meet the special needs of these students.

Second, school boards can help by simply being open and honest about the issue of pregnancy in the schools. Research shows that teenage pregnancy is a nationwide phenomenon that cuts across all races, classes, and geographical areas.[1] It is doubtful that there is a school district in the United States that does not have sexually active teenagers. While there are those who would like not to believe this and who would prefer that school boards ignore the matter, we search in vain for any evidence that ignoring the situation results in anything but negative consequences. Therefore, we strongly encourage school boards to set policy that clarifies their district's intention to remain open and responsive to *all* students. We also encourage them to openly acknowledge the reality—or at least the immediate potential reality—of teenage pregnancy and their readiness to do what is necessary to help those students maximize their education. Of course, in some areas of the country frankness and sensitivity about teenage pregnancy will be unpopular and school boards may find their courage tested.

Superintendents

Issues such as teenage pregnancy call for the very best from superintendents. These administrators will need to call upon their finer qualities of leadership, including sensitivity, articulation, wisdom, courage, and vision. As the school spokesperson to the community as well as the person in charge of school policy, the superintendent can influence both educators and parents. If the superintendent ignores the issue, it is likely that others will do the same. If the superintendent addresses the issue—includes it as an everyday fact of life to be dealt with—it is likely that others will also do the same.

Superintendents can—

- Develop policy and urge school boards to provide support.
- Raise the issue in administrators' meetings and encourage building principals to do the same in their buildings.
- Speak to the issue at various community functions in order to sensitize the community to the reality and to confirm the schools' resolve to work with all students.
- Provide central administration support for special programs.

Principals

It is difficult to overestimate the importance of building principals. Most adults can get a feel for that reality by simply conjuring up their own schooldays, and reflecting on how the character and personality of the principal set the tone for the entire school. Clearly, school climate—including morale, values, interactions, and attitudes—is heavily influenced by what the building principal says, does, ignores, and attends to. The fate and treatment of pregnant and parenting adolescents in a particular school are perhaps more subject to the thoughts and decisions of the principal than to those of anyone in the school district.

Principals can—

- Encourage the school board to set districtwide policy on pregnant and parenting adolescents.
- Develop such policy for their own buildings.
- Establish programs as needed.
- Speak out openly and frankly about the issue, articulating and confirming the school's resolve to meet the needs of all its students.
- Hold in-service workshops that address teenage pregnancy and parenting.

- Speak personally to pregnant and parenting teenagers reassuring them that the school will try to be sensitive to their special needs, and even *invite* suggestions on how the school might better serve them.
- Keep accurate records of pregnancy in the school. All too often the issue of pregnancy never surfaces in a school because pregnant teenagers drop out. Only the administration is in a position to keep such records so that the extent of teenage pregnancy can actually be known.

Teachers

In addition to being sensitive and responsive in their classrooms, teachers can—

- Make phone calls to pregnant students who have dropped out of school inviting them to return. (It is difficult to overestimate the positive impact of such personal contacts.)
- Urge administrators to develop policy articulating the school's commitment to all students, including pregnant and parenting teenagers.
- Request in-service workshops or speakers who can share information and/or perspectives on the issue.
- Inform counselors of suspected pregnancies.

Counselors

"I thought I was pregnant because I missed my period, but I tried not to think about it. I didn't want to talk to anybody because I was too scared. My mother would have never let me forget it, so I didn't want to tell her, and I didn't want to tell any of my friends because I was afraid word would get around school. But finally I told my boyfriend. He found out where I could get a test done, but I was scared. I'd make an appointment at the clinic and then I wouldn't go. Weeks were going by and finally I talked to my counselor at school who I really like. She

was great. She explained everything to me. I went and got the test and it wasn't so bad. But what came out was that I was already five months pregnant, so now I have to have the baby. I can't have an abortion because I'm too far along."[2]

It is difficult to imagine anyone more in need of support and counsel than pregnant adolescents, yet ironically this is a time when they are least likely to receive such help. We strongly recommend that counselors be especially sensitive to pregnancy and proactive in responding to it.

Counselors can—

- Keep in close touch with pregnant and parenting teenagers, anticipating their tendency to drop out of school, withdraw, and feel isolated.
- Inform teachers of cases of pregnancy, with students' permission, so that teachers can be sensitive and responsive.
- Encourage the establishment of school policy and programs for pregnant and parenting teenagers. Counselors may be in a particularly good position to take a leadership role in determining the nature of the policies and programs needed.
- Advise librarians of books and materials that may be particularly appropriate for pregnant and parenting teenagers.
- Contact the parents of pregnant adolescents, with their permission, confirming the school's resolve to be responsive to these students.

Librarians and Resource Staff

The predominant attitude in schools across the country, when faced with pregnant and parenting teenagers, is to ignore the situation. It is difficult to know whether this attitude is based simply on not knowing how to respond to a personal and sensitive issue, or on a conscious repression in

the belief that to openly address the issue would be to encourage more pregnancy (there is no evidence to support such a belief).[3] In any event, for whatever reason, in most schools information on sexuality, pregnancy, and parenting is not readily accessible. We encourage librarians and resource staff members to be proactive in making such materials available.

Librarians and resource staff members can—

- Stock materials providing basic information on sexuality, pregnancy, and parenting.
- Inform teachers and counselors that such materials are available.
- Encourage administrators to develop policies articulating the school's resolve to be responsive to teenage pregnancy and parenting.
- Display and make available pamphlets from hospitals, and such groups as La Leche League, Childbirth Education Association, Planned Parenthood, Family Planning Council.

Social Workers

These professionals, trained in human relations, can offer a wide range of support services to the pregnant teenager, the father, and both families. The social worker's job should be to ensure that the teenage student receives all the services he or she may require. Coordinating all the needed services—prenatal care, financial assistance, child care, food stamps, counseling, childbirth education classes—can be a complicated task. Nonetheless, these are some of the most crucial resources for a teenager dealing with a pregnancy.

Social workers should be called upon to assist in the following areas:

- Coordinating the support services needed.
- Encouraging and supporting the father in his

involvement with and reaction to the pregnancy and performing in the parenting role.

- Counseling pregnant teens on speaking with parents.
- Consulting with parents of pregnant teens to offer support and to assist in working out feelings and overall planning.
- Exploring options before and after the pregnancy with all persons involved in and affected by the decision.
- Keeping track of students and providing outreach if they should drop out of school. This may include phone calls, home visits, contact with group homes, hospital visits, contact with other service providers.
- Helping teenagers make the transition back into the school and remaining available both to help the young parents process their many feelings and to serve as a support system.
- Aiding the young woman in processing her post-abortion feelings and remaining available to the father to counsel him about his reactions.

School Nurses

Because of their unique position in the school—with no responsibility for grading or evaluating students—nurses can play a more neutral role offering the support and understanding every pregnant teenager seeks. Many pregnant teens frequent the nurse's office presenting a number of different symptoms before mustering up the courage to admit to their real fears. It is important that nurses be aware of this pattern, questioning the teen if they think pregnancy may be the real problem, and offering services for nutrition counseling, helping to

set up medical appointments, and making referrals for prenatal care and abortion (if requested). Other helpful functions nurses can provide include—

- Having pamphlets on hand that describe community resources such as birthing classes, sensitive pediatricians, Lamaze classes, childbirth education, family planning, peer support groups (if they exist), counseling services, names of abortion clinics, copies of nutritionally sound diets, drug abuse information, and literature describing fetus development throughout the course of the pregnancy.
- Coordinating prenatal visits, including contacting the student and the medical facility to ensure that followup visits have been made.
- Continuing discussions and providing information on the physical and emotional changes of pregnancy and how the teenager can best care for herself.
- Being flexible about the time pregnant students spend in the nurse's office because of symptoms they may be experiencing (such as nausea or fatigue) or simply allowing for their need for short respites from the classroom.
- Acting as a liaison between teachers and the pregnant student to help her feel that she has an advocate and to ensure that activities are appropriate or better suited to her individual needs (for example, Lamaze classes could be substituted for physical education classes).
- Following delivery, contacting the mother to check on the health of both mother and child. Such inquiries give the young mother a sense of being cared about and may serve as a screening measure to ensure that both mother and child are well.
- Following up the student who opts for an abortion to assess her emotional and physical recovery. This is an important task, all too often not performed.

Physical Education Teachers

Physical education teachers should be open to alternative ways for pregnant teenagers to obtain credit. For example, they can either develop a prenatal exercise class or refer students to community courses for credit. It is also important that they are aware of the pregnant teen's self-consciousness and sensitivity about her body. Early in the pregnancy, the teenager may feel humiliated changing alongside her peers in the locker room or overly critical of herself when she finds that she can no longer perform as she did only months previously. In encouraging physical activity and presenting the facts about its benefits during childbirth, the physical education teacher should remain flexible about the student's needs and desires. In exploring the best options, the teacher can present models of women who have continued vigorously exercising as well as models of those who have opted for more private or gentler methods.

Support Staff

While teachers are often busy interacting with many students at a time, support staff members may be the first ones in the school system to recognize signals alerting them to the possibility of a pregnant student or a young father. Depending on their relationship with the student, and their own feelings about the situation, these staff members could either try gently to explore their intuitive feeling or convey their suspicion to a counselor. Whether they choose to speak with the student themselves or refer the question to another school staff member, they should be aware of the resources available to pregnant teens. Support staff members should also remember that their attitudes are important and they can readily transfer them to the already anxious teen.

All Education Employees

It is incumbent upon all school system employees to accommodate pregnant and parenting students, particularly considering their high dropout rate. Special allowance should be made for their unique circumstances. This should include sensitivity to the following aspects of their condition:

- During the first four months in particular, pregnant teens may experience nausea, fatigue, dizziness, back pain, shortness of breath, and the need to eat something every hour to keep up their strength.
- Extreme fatigue may result in the pregnant student's attending school only half days or being excused for naps.
- Frequent urination, sometimes every 10 to 15 minutes, is quite common.
- Small desks do not accommodate pregnant bodies.
- Long walks across campus can be tiring and take a long time for pregnant students.
- Climbing several flights of steps can be precarious, especially toward the end of the pregnancy.
- Doctor's appointments, welfare visits, prenatal classes, childhood illnesses, and child-care availability often make for absences or half-day schedules.
- The ability to concentrate in class, both at the beginning and the end of the pregnancy, will likely be disrupted because of many personal concerns.
- Crowds on campus will feel stifling to the pregnant student.
- Most importantly, keep in mind the pregnant student's probable feelings of isolation, alienation, and embarrassment in relation to peers.

CHAPTER 4

Classroom Interactions

The theme throughout this book is that pregnant adolescents are not simply a responsibility of individual teachers, but also of schools and school districts. These institutions need to develop policies and programs to deal effectively, perhaps creatively, with the phenomenon of pregnant adolescents. In the final analysis, however, school programs and policies are only as effective as the individual teachers working with students in classrooms. There is no escaping the fact that the support pregnant adolescents need to continue in school will ultimately have to come from these teachers. Yet, as we say this, we are all too aware that teachers are already stretched with exhausting work loads and stressful working conditions (as has been well documented by the recent barrage of commissioned reports on the public schools).[1] We are not suggesting an additional role for teachers. We believe that the roles they now play—as facilitators, parents, guides, friends, counselors—are sufficient to provide for the needs of pregnant adolescents. Rather, we believe that the subtle nuances teachers use in carrying out these roles are of critical importance.

Teachers are important and powerful adults in the lives of students. Who does not know of a person who chose a career, who stayed in school, who went to college, who pursued a talent, who kept faith in her/himself because of a teacher—*or* even as the result of one casual comment from a teacher? And as much as this is true for students in general, it is even more true for pregnant adolescents, who are especially vulnerable and in need.

We therefore have a profound respect for the roles teachers play and we encourage

them to work consciously to make those roles effective. What we are suggesting is that when teaching under the scrutinizing eye of a pregnant adolescent, small things may make a critical difference. A word of disapproval, a skyward glance, an averted look, a pat on the shoulder, a supportive comment, a shared smile, an understanding of homework—these reactions may be far more significant than expected. We are not attempting to add to the burden of classroom teachers. In fact, the opposite is true. We believe that by being sensitive and paying attention to certain details, with no additional energy output, teachers can have a tremendous positive influence on a category of students much in need of their support. And further, when working with pregnant and parenting adolescents, teachers can experience a deep sense of making a difference—an immediate difference—that is frequently elusive in teaching.

We are assuming that dealing effectively with pregnant and parenting adolescents is not qualitatively different from dealing with other students. That is, we believe that the ability to work effectively with these adolescents requires the same set of skills that have always characterized effective classroom interaction. We also know, however, that effective teachers apply their instructional skills differently with different audiences, taking into account such variables as motivation, age, readiness, ability, and so forth. Consequently, we make no pretense that teaching pregnant adolescents is in any way mysterious or requires any special instructional skills. Rather, *what we suggest is that pregnant adolescents, like any distinguishable group of students, have particular vulnerabilities and sensitivities to which effective teachers might want to pay special attention.* That special attention will generally require a more deliberate and careful use of certain teaching skills.

The remainder of this chapter contains a brief overview of the kind of supportiveness we think is desperately needed. It also highlights several critical teaching skills. But, first, a word about advice.

Advice Does Not Help!

While it is clear that pregnant teenagers face decisions with far-reaching implications, we have no reason to believe that advice, no matter how well intended, is in and of itself helpful. In many cases these students are more likely than not already receiving advice from a number of quarters—family, relatives, peers—and it is equally likely that the advice is confusing, value-laden, and contradictory. More advice may simply add to their prevailing feelings of bewilderment. A second reason for withholding advice is that *the options facing pregnant teenagers are many, and those options are rightfully influenced by individual characteristics related to family, values, religion, economics, self-concept, community attitudes, and personal experiences with other pregnant teenagers.* Seldom do teachers have the background information necessary to safely predict the most appropriate course of action for any given pregnant student. In addition, *individual teachers' ideas about the wisest course of action are based on their own upbringing, experiences, and values, and seldom will these factors correlate very highly with those of any given pregnant teenager.* Therefore, the receiver of even well-meaning advice can easily perceive it as racist, sexist, classist, degrading, and/or insulting.

While we are quite steadfast in our belief that educators ought to refrain from giving specific advice as to the course of action pregnant teenagers should take, we believe there *is* much that they *can do* to help these young people at this critical time. Several specific suggestions follow.

Supportiveness

The theme throughout this book is one of *support*. We believe that pregnant teenagers typically feel isolated, overwhelmed, paralyzed, out of control. They need all the help they can get to enable them to use their own internal resources for

making decisions that are in their best interests. In other words, they need an environment that is sensitive to their situation—especially to the turmoil they are experiencing. They also need an environment that is stable, firm, and dependable to give them something to hold onto when they feel swept away by forces outside their control. Providing this sensitivity, availability, dependability, and stability is what we mean by support. *Supportiveness does not mean approving of teenage pregnancy, or even approving of the decisions that the pregnant teenager has made up to the present. Supportiveness does not mean approval of the values or behaviors that are being manifested.* Supportiveness does mean providing an environment for pregnant teenagers that will give them the best chance to call upon and use their own internal resources at a time when that availability is most likely hindered. From this perspective, *being supportive is almost synonymous with being an effective educator in that its purpose is to maximize the ability of individuals to use their full human potential.*

Communication

An important element of supportiveness is effective communication, which is also a great part of quality teaching. This section highlights several communication skills, common to any instruction, that take on special significance when the interaction may have serious consequences. "Communication" of course means more than words. It includes tone of voice, facial expression, posture, gestures, and eye contact or lack thereof. But the words themselves are vitally important. If the words are specific, descriptive of the sender's feelings and observations, and also match the tone of voice and other nonverbal expressions, then the message communicated is clear, congruent, and more likely to be understood by the receiver. A discussion of questioning, perception checking, and praising follows. These three communication skills assume special signifi-

cance for those working with pregnant adolescents. While it is understood that teachers already possess and use these skills in varying degrees, this brief review will help those who will be working with this extremely sensitive and vulnerable population.

Questioning

Central to support is finding out what is going on with the person who is to be helped. In other words, it is difficult to be sensitive to people unless we know what they are thinking and feeling. Therefore, supportive people tend to ask questions. The questions serve two purposes. First, they can help elicit the information—the thoughts, fears, anxieties, dreams, memories, anticipations of the responder—that the supportive person needs. Second, the questions may provide the responder with an opportunity to talk about what is going on inside, which in itself is frequently a freeing and helpful experience.

Yet, not all questions are helpful, especially for a person under stress who may be feeling extremely vulnerable. Depending on their wording, questions can imply any number of values, opinions, and attitudes. A carelessly worded question, then, can easily have the opposite effect from what was intended. For instance, a question meant to demonstrate concern and caring can be interpreted as implying indifference or even hostility. To avoid such misunderstanding, *a general rule to follow is to ask questions that are open-ended, nonjudgmental, and nonleading.* Such questions are supportive and encourage communication.

Open-ended questions do not restrict the possible responses, and thus allow responders to answer as they genuinely feel. For example, "Has your morning sickness started yet?" is much more confining than the open-ended "How are you feeling these days?"

Nonjudgmental questions do not imply a value judgment on the part of the questioner.

For example, "How did you get yourself into this mess?" is judgmental and is likely to put the responder on the defensive, whereas the nonjudgmental "Do you want to talk about it?" is more apt to encourage an open dialogue.

Nonleading questions, like open-ended questions, do not suggest an answer. They are worded to encourage responders to answer as honestly and as freely as they choose. For example, "You must be wondering about whether to stay in school, aren't you?" leads toward an answer, while the more nonleading "How is school going for you these days?" is much less suggestive of any particular answer. Additional examples follow of nonsupportive and supportive questions.

Nonsupportive Questions

The following questions are judgmental, leading, and not open-ended:

- "Can you tell me how you ever got yourself into this kind of predicament?"
- "Are your parents even talking to you?"
- "You must be feeling terribly embarrassed!"
- "Are you thinking of quitting school?"
- "How did you let this happen?"
- "Do you really think you can manage a baby?"
- "Have you thought about what this is going to do to your future?"

Each of these questions is likely to add to the burden of an already overwhelming situation. Such questions tend to make people feel defensive, hostile, judged, and isolated.

Supportive Questions

The following questions are open-ended, nonjudgmental, and nonleading:

- "How are you doing these days?"

- "It's nice to see you coming to school each day. How are you feeling?"
- "You must have a lot on your mind these days. How can I help?"

These questions encourage honest communication.

Perception Checking

A second communication skill that is especially useful when working with pregnant and parenting adolescents is perception checking. Supportive teachers work to correctly identify the feelings of students; and it can be assumed that adolescents in this situation have a wide range of feelings, frequently volatile and often in conflict with one another. Consequently, pregnant teenagers and young fathers may be sending signals that hide their true feelings, that mask the intensity of those feelings, or that suggest the exact opposite of what they are experiencing. Therefore it is very hazardous to assume that the feelings of pregnant teenagers and young fathers are congruent with their outward mannerisms. Perception checking is a way for teachers to find out if what they are perceiving is true.

To check their perception of the feelings of a student, teachers should state their perception. A good check conveys this message: "I want to understand your feelings. Is this (statement of the other's feelings) the way you feel about it?"

Examples are as follows:

- "I get a sense that you are feeling out of touch with what we are doing today. Am I correct?"
- "Lately I sense your being overwhelmed by all this. Is that accurate?"
- "You seem more relaxed and sure of yourself this week. I sense you have come to some resolution. Is that right?"
- "I get the impression that you are angry with me. Are you?"

- "I'm not sure whether your expression means that my comment hurt your feelings or confused you."
- "I sense tears behind your eyes. Are you feeling especially blue this morning?"

Note that a perception check first identifies the other person's feelings in some way—"out of touch," "overwhelmed," "angry," "blue." Second, it does not express disapproval. It merely conveys the message "This is how I understand your feelings. Am I accurate?"

Perception checking performs two functions in communication. First, simply checking a perception in a supportive, nonjudgmental way can have a freeing, legitimizing impact on the student. In effect, the teacher is saying, "I sense this feeling coming from you," and his/her manner says, "and it is okay to feel that way; I can understand it."

Second, perception checking gives teachers critical information that will help them to be more effective. It tells them whether the assumptions they are making about students are accurate—and that knowledge is essential for creating and maintaining a productive learning environment.

Praising

Of all the research findings on teaching and learning, none is more solid and consistent than that relating to the effectiveness of positive feedback. Students, like all of us, tend to respond more openly and energetically when their behavior is encouraged and supported. However, based on our experience—working with teachers and other professionals who have worked with pregnant and parenting adolescents—we believe that these students are less likely to receive positive feedback than are other adolescents. Of course, this is quite understandable since nobody is likely to be truly supportive of their recent behavior. However, the cumulative effect of a collective withdrawal of positive regard can quickly

worsen the situation. Such lack of support can predictably lead to an inability to use whatever internal resources—intelligence, wisdom, intuition, and spunk—they can muster.

Fortunately, there is much to praise. Adults who have worked closely with adolescents in stressful situations are commonly taken aback by the depth of character they can demonstrate at these times. In fact, given the rather limited role adolescents play in our society—primarily as students—unusual circumstances may be required to enable them to manifest such character traits as integrity, responsibility, tenderness, love, courage, and vision. Surely pregnancy as a teenager is one of those unusual circumstances, and many adolescents rise to the challenge. Just when their world seems to be falling in on them, they are able to deal with their expanding body, family turmoil, financial insecurity, loss of some peer relationships, and other accoutrements of their condition. There is much reason to believe that any one of the following statements could be a major factor in helping these students stay in school, not give up on themselves, maintain physical and/or mental health, and make the best of the situation.

- "I am so impressed that you are continuing to come to school. I should think it takes some spunk to do that."
- "You are looking especially pleased with yourself these days; it appears that you are managing quite well. Good for you."
- "I so admire the way you participate in things here. It demonstrates a lot of courage."
- "I realize that you have a lot on your mind right now. I don't want you to feel additionally burdened by worrying about school work. Let me know if the assignments feel like too much and we will work something out."
- "I have had some other pregnant and parenting students in my classroom. Unfortunately, many of them were unable to stay and dropped out. Let me know if there is anyting I can do to help you decide to keep coming. It matters to me that you finish school."
- "It can be a tough situation parenting a child and attending school. Let me know if you need some help sorting it all out."

- "I heard you were the father of _____'s baby. You both have some big decisions ahead of you. If you would like to talk to someone I am available."
- "I have noticed that you have been rather quiet lately, and not spending much time with your classmates. That is unusual for you. Are you worried about something? I would like to help if I can. I don't like to see you looking so unhappy."
- "You have been absent a lot lately. I've been worried because I've noticed you haven't looked particularly well. Are you feeling okay? Have you been checked out by a medical person? Are you getting enough to eat or feeling understandably exhausted by the whole situation?"
- "You look great. I like the way you are taking care of yourself."
- "I can see that you have thought a lot about what you are going to do. I'm impressed; it's not easy to keep your wits about you at a time like this."
- "Your homework assignment was well done. Good for you. I know it's not easy to be a full-time student. I want you to know how much I admire you."
- "I hear that you are having a tough time at home. That must surely take a toll on you. Yet you keep coming to school and hanging in. That takes a lot of courage. My heart goes out to you."

CHAPTER 5

Networking: The Importance of Parental Involvement

Research shows that parental* involvement is one of the keys to successful planning and execution of sexuality education programs.[1] Not only is the issue of sexuality a sensitive one—not always believed to be appropriately taught by teachers—but funds may not be available for starting new programs. In many cases, teachers currently instructing in related subject areas are unable to take on an additional program and cover it comprehensively. Many positive outcomes can result from involving parents in teaching and learning about sexuality. Among these outcomes are further educating and updating them on sexuality issues, knowledge of and input into the process and information to be covered, and, most importantly, *increased communication between parents, their children, and teachers.*

Organizing: The First Step

A number of different individuals could take responsibility for (a) contacting parents and (b) organizing the first meeting of parents. The approach will depend on the individual or individuals

*Because some children live in situations without either parent, the familial term "parent" (or "parental") as used in this publication is extended to include other caretakers.

functioning in the outreach capacity. Following are three different letters exemplifying various approaches that can be effective in recruiting concerned parents to work on formulating and executing a sexuality education program.

Individual Parents

No individual can influence others more powerfully than one who has been personally affected by an issue. It may be difficult to locate and then recruit parents who are willing to share their experience but, if they can be convinced that their experience and insight would be helpful to others, oftentimes they will be willing to step forward. A letter from such parents might read something like the one on page 50.

Professional Parents

Another parent might speak from both a personal and a professional perspective. It is important to bear in mind that a number of valuable resources exist within the parent group of the student body. The tendency is to look outside the school when the best (and most practical) resources are often within. Not only can parents who are professionals talk personally to other parents, but they have a stake in the outcome and usually volunteer their services.

A letter from such a professional parent might read like the one on pages 51–52.

Volunteers and Professionals

Other volunteers and professionals who live or work in the area but who are outside the school can also be effective in recruiting parents and teachers to a first meeting. An example of a letter from one of these individuals appears on page 53.

To the Parents of Current Eighth Graders:

We are the parents of one of your child's former classmates. Last March our son informed us that he was responsible for the pregnancy of a girl in his class. We, of course, were utterly shocked, dismayed, and disappointed and certainly did not respond the way we now wish we had.

Our son came to us confused because, as it turned out, he had had sexual intercourse only once and could not believe that such a brief encounter could culminate in such a critical event as a pregnancy with all its related decision making. To make a long story short, our son and the girl decided that it would be best to raise the baby. This option has caused critical changes in both lives. All their previous plans and goals have been temporarily put on hold or fallen by the wayside. They discovered that they could not continue with school and financially support and care for the infant. At this time no alternative programming is available in this area that would allow them to continue with their school work.

Both have come to regret their experience. As their parents, we can speak firsthand that we have suffered right along with them. We have wondered, more times than we can possibly count, what could we have done to prevent this? If only we had given them more information, if only we had spoken to them about the many components involved in a relationship, the facts about birth control, the responsibilities involved in raising a child, the importance of education in procuring a job—and the list goes on. It is too late for our eldest son, but we are certainly not going to make that mistake again with our other children.

If you are interested in discussing the formation of a sexuality education program that would be conducted at the school, please attend a meeting on Thursday, May 25th, at 8 P.M., in the auditorium.

Sincerely,

Cynthia & Gerald Johnson

Dear Parents and Teachers:

I am a fellow parent and a medical practitioner. The reason for this letter is twofold. First and foremost, I want to share my real concern for my child's future which, I realize, is related to her sexual decision making and has grown out of my contact with numerous pregnant teenagers. Second, I'd like to appeal to you as responsible parents to get together, share the facts, face them, and plan a responsible way of disseminating the crucially needed information to our young.

Most of us find it difficult to talk to our kids about such sensitive subjects as sexuality. Some of us have tried and been put off by moody, independent, rebellious teens. Others deny that our children have sexual feelings and, if they do, certainly can't envision them acting them out (even though many of us can recall early sexual experiences ourselves). Many of us do not want to know if our children have experimented, and particularly if they have gone all the way and engaged in sexual intercourse. Some of us have had indirect comments or even more direct ones come our way. We may have written them off as just another test when actually we were being asked for some guidance and direction.

One thing we all share in common is that we have trouble talking to our kids about things that really matter, and we worry about it as if that will improve the situation. We have difficulty talking to our daughters about its being okay to say no if a situation arises that feels uncomfortable or not right. Or to convey that it's really okay, even when pressured, to take a stand.

We have difficulty talking to our sons about the other issues involved in a relationship beyond the sexual, and informing them of the tremendous responsibilities and potential consequences involved.

Even though we may not have been able to verbalize our concerns, this does not mean that we do not stay up nights fearing for our children, especially our daughters, and hope they will use good judgment, contraceptives, or be lucky. *Unfortunately, the bottom line is that our kids do get pregnant and our sincerest and most loving hopes are not going to protect them from a real crisis in their young lives.*

The Alan Guttmacher Institute in New York is an organization that collects and publishes statistics on teenage sexuality and pregnancy. I wanted to share these statistics that I found rather startling:

If there is no change in current rates, 4 out of

10 girls who are now 14 will get pregnant in their teens, 2 in 10 will give birth and 3 in 20 will have abortions.[2]

Now that you know the reality, so that you can make informed decisions and also help your children do the same, I ask you to attend a meeting on Monday, May 13th, at 7:00 P.M., in the school auditorium. Realize that many other parents and teachers who will be attending will be sharing your same feelings—hesitancy, uncomfortableness, uncertainty, or whatever. I urge you to call parents you may know and encourage them to attend also.

I look forward to meeting you on the 13th.

Sincerely,

Carol Hogan, M.D.

Dear Parents of Thursten Middle Schoolers:

I am a volunteer outreach worker with the Children's Aid Society, an agency that provides services for pregnant and parenting adolescents of this county. My functions include visiting schools, organizing meetings around the topic of sexuality education and pregnancy, and advocating for needed services for this group. I am also involved with planning and coordinating workshops and seminars geared toward individual participants' needs and, most importantly, organizing concerned community members to discuss the issues.

I am writing to inform you of a fact that you may not be aware of. Currently there are no sexuality education programs at your child's school. Not only does this concern us, but we feel that you as parents may wish to become involved and assist in organizing such a program. In this way you would be able to voice your feelings about appropriate and important topics to be covered in your child's curriculum.

You may be saying to yourself, as so many parents do, my child will not get him/herself into a situation sexually that will be destructive to him or her. Or you may be concerned that in providing the information you will in some way be encouraging your child to use it. I am writing to tell you that study after study shows that teens are sexually active and that sexuality education cuts down on the risk of an unwanted pregnancy by increasing teens' responsibility by allowing them to make informed choices about their future.

Getting involved in a sexuality education program can be an opportunity for you to open up the communication channels between you and your teen, by sharing in the process and reactions to the information discussed.

I sincerely hope that you and your teen will be able to attend a meeting on Thursday, May 10th, at 7:30 P.M., at the school. A movie will be shown and refreshments will be served. If you should have any questions in the meantime, please do not hesitate to call me. I can be reached between the hours of 9 and 4 Monday through Friday.

See you on the 10th.

Sincerely,

Jim Williams

Other Approaches

In addition to sending letters to the homes of students, volunteer parents can encourage the participation of other parents, particularly those they may know personally, by making followup phone calls. Teenagers too can get involved in designing posters and displaying them around the school. It is important to publicize the issue; therefore the meeting announcements should be as visible as possible. A letter should be sent to those parents who are unable to attend the first meeting, explaining briefly what was covered, as well as future plans, and encouraging their participation.

Choosing a Meeting Place

A room at the school that is both informal and comfortable would best serve everyone's need for an environment conducive to sharing and developing support. Chairs should be movable in order to form small discussion groups. It is a good idea to begin with all the chairs arranged in a large circle so that all participants are visible and feel a part of the group. The teenagers and teachers usually prefer to meet in a space other than one they use all day. An auditorium, a cafeteria, or a gymnasium might provide an appreciated change of scenery.

Leadership

The first meeting should be structured with one person or a core group of people in charge. This leadership will depend upon who called the meeting initially—a parent or professional. Over time, the goal is to let control shift to the group with all members becoming equal contributors. Such an arrangement provides participants with a sense of ownership in the group.

One of the outcomes of the initial meeting could be the formation of an advisory group whose members are willing to spend extra time on the project and make a commitment to organizational and developmental needs. This group should include members of diverse backgrounds and representatives of all participating groups—parents, administrators, teachers, other professionals, and, of course, the teenagers themselves.

The First Meeting

During the first meeting it is important to have participants make contact with one another and to receive information on the current situation in the school, as well as an update on the scope of the problem. All participants should also have a chance to speak if only briefly. And they should leave the meeting with an understanding of the probable positive benefits of membership in such a group.

A good way to begin after a general introduction and welcome is to go around the circle asking each person to introduce him/herself, briefly mentioning his/her interest in attending and reaction to the letter. Participants could also speak about any ideas they would like to see developed. This exercise could take a good deal of time as people respond to each other and state their feelings. These interactions, however, are important and the time should be made available.

The middle part of the evening could follow with a presentation, an elaboration of a common theme present in participants' initial statements, or a panel of speakers. Before the meeting closes, all participants should have an opportunity to speak again. They might be asked to respond to such questions as—Will you come to other meetings? How do you see yourself getting involved? What did you learn from this meeting, if anything? What would you like to see these meetings address or develop

into? Finally, refreshments should be served both to foster further socializing and to accommodate participants who may not have had a break before the meeting began.

Followup Meetings

A wide range of possibilities exists for productive followup meetings. Informational sessions on a number of topics can lead to discussions and other activities that promote participants' involvement. Several specific suggestions follow.

Speakers

An effective way to talk about an issue is to invite a number of different speakers with varying perspectives. These can include professionals from many fields, as well as parents who have witnessed firsthand their children's decisions and are willing to speak out. Of most importance are the young people themselves. Teenagers listen to their peers and have a tendency to trust them more readily than they do professionals (despite their desire for direction and guidance). The teens should be invited to talk about their personal experiences raising a child, leaving school, attending school during pregnancy, attending an alternative program, marrying, having an abortion, or surrendering a child for adoption. How have these decisions affected their lives—in relation to their physical, emotional, and spiritual development, and their sense of well-being?

Situational Exercises and Discussions

Small group activities can be a very effective way to increase contact between group members and have them look more personally at the issues to be considered.

A large group presentation can be a springboard into smaller group discussions. How did participants feel about the information presented? What was their emotional reaction? Were they surprised by their response? Did they learn something new? Were they startled? Did they feel more informed, or confused? Did the material make them feel angry, empathetic, or scared?

Small groups can include either a heterogeneous or a homogeneous mix. For some discussions a group of parents, teachers, and teenagers is best. For others, homogeneous subgroupings of participants can foster stimulating and helpful discussions.

If participants respond personally rather than intellectually to the material presented, they may develop further insight and compassion. After they receive the facts, their exploration of the feelings involved within the scope of the issue presented makes the evening complete.

Role Playing

Role playing can help participants delve into an issue and become involved with one another. Reversing roles is an effective way to see a situation first from one's own perspective and then from that of the other person. For example, the teacher can become the teen deciding to quit school and the teen the teacher. Or the parent can become the adolescent who wants more freedom and the teen the parent who is concerned about protecting the child from dangerous situations.

Volunteers can read suggestions for case scenarios from cards that have come from anonymous participants. For example:

- Mother, I think I'm pregnant. What should I do?
- I've been dating John for over a month. I really care about him a lot, but he says it doesn't make any sense to keep delaying sex even though I want to wait. I don't know what to do. I don't want to lose him.

- Susan called me last week and told me that she is pregnant. She wants to have the baby and says I have to support them. I just want to run away. What should I do?
- Rumor has it that Michael has some kind of VD. I'm so worried because he made love with me. I don't know how to ask him and I don't know how I would ever explain it to the school nurse. What should I do?
- I'm tired of coming up with excuses and making false promises I don't feel right about keeping. I feel so pressured by my friend and he's getting more and more persistent. What should I do? How can I help him understand where I'm coming from?
- Dad, what would you say if I told you I was pregnant?
- I don't like feeling that I have to tell all my teachers at school that I'm pregnant, but so many times I feel so ill I just have to leave. I think it would really blow some of them away. What would I say? How would they respond?
- Last week when I went out with Bob we saw a movie at a drive-in. We kissed, which was okay, and I liked snuggling up next to him. After the movie, however, when all the other cars left, he really forced himself on me. I just kept telling him over and over again that I didn't want to. Afterwards I was so upset and angry. He drove me home and told me that he knew I had really wanted to go all the way—why else would I be wearing such a revealing leotard? But I was just scared. I'm absolutely clear that I didn't want it. I'm so confused and yet feel responsible because I should have known, I guess. I wish I could talk to my mom about these things, but I don't know what to say to her.

The Outer and Inner Group Model

Four chairs facing one another placed in the center of a large group can facilitate small group discussions that others can watch and rotate into. Four volunteers begin by agreeing to discuss a topic. They are informed that they are free to move into the outer circle any time they wish, making room for other participants to replace them. If the process seems to get stuck because of flow or conflict, the leader can suggest more structure. For example, "Why don't we have four mothers move

into the inner circle and continue discussing this issue?" This structure can be very effective in aligning subgroups and building support or resolving conflict. Other combinations may include mother/daughter or father/son pairs. Such groupings serve to open up communication channels. Mixed combinations may include a number of different blends of teachers, parents, teens, and professionals. This structure can help diverse members speak to one another on equal ground when communication is difficult.

Any activity that helps individuals think more concretely about their position on an issue, or that drives home the fact that these problems do occur in reality and they could be faced with such problems, will be positive. Such an activity can also help participants see the benefits of these practices, possibly affecting their current behaviors so that they can predict outcomes and probable consequences.

Small groups may want to explore some of the following questions:

- Do you think your peers consider the risks of pregnancy when engaging in sexual intercourse, or is it more of an unplanned, spontaneous thing?
- What do you think the positive and negative factors would be in having a child right now? Which side weighs more heavily?
- Do you consider plans for the future, such as a career, when you think about sexual decision making?
- What advice would you give to your daughter if you knew she was seeing boys? Would you say anything? Do you think you should keep trying even if you are put off by anger during the first attempt?
- At what age do you think it's okay to engage in sexual intercourse, or do you see other criteria as more important?
- How would you make the decision about which option to choose if you got pregnant? Is it clear to you?
- Who do you think should be more responsible for birth control?
- Do you see leaving school as decreasing your opportunities for the future?

- What do you see yourself doing in five years? How does having a child impact on these plans?
- What would you expect from your boyfriend if you got pregnant? Does it depend on your relationship with him?
- What do you see as your responsibilities, having been informed that you have gotten a girl pregnant?

After the small group discussions, time should be available for members of the outer group and other participants to voice their reactions to the experience, including the feelings expressed, the communication styles, and the content.

Helpful Tips for Working with Groups

1. There is likely to be disagreement about attitudes and values among group members. There will be resistance to changing perspectives; this should be predicted and addressed early on.
2. *Each participant should be entitled to the space to define his/her own position and yet be tolerant of others.*
3. Remember that conflict filters down. Group organizers should meet with school officials beforehand to discuss the situation and learn about any possible areas of conflict.
4. Pushing toward collectiveness or togetherness may increase conflict. Try to find a middle ground all members can tolerate and live with.
5. Be aware of the tendency to blame others (for example, "The reason we have this problem with young girls getting pregnant is because some parents are just too permissive."). *Focus on what the group can do specifically about the problem.*
6. Remember the reason for meeting—a common concern for the teens, their sexual decision making, and their futures. Avoid focusing on obstacles and assigning blame.

7. Discuss commonalities instead of differences (for example, "We are all here because of a shared concern for the same kids. We want opportunities to be available to them so that they have other choices besides parenthood."). Come back to this purpose in times of conflict.
8. Anticipate responses and openly predict resistance. Typical examples of resistance that will be encountered include the following:
   - Parents will state that their children are not sexually active and therefore attending meetings or discussing issues is meaningless and a waste of time for them.
   - Sexuality issues should be talked about in the family and are not appropriate for public discussion or scrutiny.
   - Parents will say they do not want to be involved and will not let their teen attend because they do not want to encourage the use of the information presented.
   - People are tired in the evening after a long day at work and just cannot attend another meeting.
   - Busy teachers may not have time for regularly scheduled meetings after hours.

Advisory Group Projects

Advisory group members may be willing to work on special projects and should be encouraged to do so. For example, they might—

- Purchase library books.
- Screen and order films.
- Design a questionnaire for distribution to different student age groups to find out what they already know about sexuality issues, and evaluate the degree to which kids are sexually active.
- Begin a file (to be centrally located) containing information on services available for sexually ac-

tive, pregnant, and parenting teens.

- Obtain quality speakers.
- Review school policies related to pregnant and parenting students.
- Make contacts with appropriate groups and agencies.
- Keep an up-to-date bulletin board of various opportunities such as job listings, youth groups, clubs, special classes, vocational programs, outdoor and sports activities.
- Send all parents a questionnaire emphasizing the importance of jobs and vocational training for teenagers and requesting appropriate positions. Begin a file to match students' interests with job possibilities or internships.
- Request that parents volunteer their time to become involved with teens through a number of different activities—fishing trips, hiking, canoeing, teaching sewing, automobile maintenance, printmaking, photography, dance, music, tennis, yoga, ornithology, sailing, bike trips. The options are limitless and extremely valuable.

Final Note

In *High School: A Report on Secondary Education in America*, Ernest L. Boyer echoes a theme that has a long history in public education in America: "The high schools of the nation are only as strong as the communities of which they are a part. The renewal of the school must, quite literally, begin at home."[3] Yet as most practitioners who have tried to generate parental involvement know, this is not an easy task. We believe that the issue of pregnancy, perhaps more than any other, has the potential to serve as a catalyst for that involvement. The benefits that might accrue from such a result—to students, teachers, parents, and the school itself—cannot be overestimated.

CHAPTER 6

Prevention: A Comprehensive Approach

There was a knock on the door. Jimmy, 18, opened it. A man introduced himself, explaining that he was from the Department of Social Services. He had come to investigate a child abuse complaint. Jimmy wanted to hit him. Carol, 17, who was standing in the background, turned toward the bedroom where their 18-month-old daughter, Stephie, was sobbing and whimpering.

Jimmy angrily explained, "I had to hit her. I've had it. She's got to learn. She keeps getting into everything . . . she ruined my record. She's spoiled rotten. All she does is whine and cry all the time!" He was thinking, "Who are you to come to my door? What do you know about what it's like to have no money, no job . . . and no one to help."

Carol said nothing. She sat down, lowered her head, and reached for a cigarette. The social worker thought he saw tears dripping from her cheek. Carol was thinking, "I can't stand it . . . I can't go on like this. I wish she was dead . . . I wish I were dead."

In presenting what we hope is a comprehensive approach to prevention, we recognize that it may not meet the specific needs of all schools. For example, in a community where only two teenage pregnancies occur every few years, some program elements described here will not be possible. In such cases we hope this chapter will be useful in conceptualizing the needs of pregnant and parenting teens. We also recognize that many or most schools are deeply concerned about the issue and are already working to implement some of the prevention strategies discussed here. We encourage those schools that have impressive and thought-provoking success sto-

ries to share them both in their individual teachers' lounges and throughout their local, state, and federal governmental agencies and organizations. Further, while we believe schools can and do have a significant impact on both primary and secondary prevention, we recognize that neither teachers nor programs work in a vacuum. Funding, program design, and service models need to be developed, and communitywide support is essential to success.

As a final note, before discussing early pregnancy prevention strategies and our reasons for believing that they should be in the school, we recognize an interconnection with other social problems such as drug and alcohol abuse, juvenile delinquency, child neglect and abuse, the feminization of poverty, and even suicide. But it is beyond the scope of this book to explore these interconnections in great detail. However, we are certain that a prevention program that significantly lowers teenage pregnancy will help significantly in reducing these other social problems as well. In other words, *an effective comprehensive appproach could result in students with enough competencies, confidence, and self-esteem so that they would not need to turn to drugs, alcohol, delinquency, suicide, or sex.* Furthermore, teaching adolescent parents to be responsible, nurturing caretakers offers a unique opportunity to intervene in ways that will meaningfully change the course of these young people's lives.

In articulating this same total prevention approach, the Children's Defense Fund sets forth these needs for all children:

1. A Healthy Start and a Sound Beginning

Children need to be ensured the things that will give them the basic ability—physical, emotional, intellectual, social—to succeed. They need to be born healthy; this means that their mothers need early and continuous prenatal care. They need to come home to an environment that will protect and stimulate them and will provide them with caring, consistent caretakers. They need to be watched carefully as they develop so that problems can be diagnosed and treated early.

2. *A Good and Broad Education*

   Children need to learn. They need to master the three R's, but they need to do this in a way that fuels rather than dampens their desire to use them once mastered. Children need to be exposed to ideas, people, options. They need to learn to ask good questions and to expect that they can find and understand the answers. They need to learn about careers. They need to get firsthand work experience.

3. *A Sense of Their Place in the World*

   Children need self-esteem. They need to feel valued and valuable. They need to feel that they will be successful at whatever they try. They need a sense of responsibility. They need to feel in control of their lives. They need to feel that they have opportunities and options.[1]

Levels of Prevention

In helping to reduce early pregnancies among young people, and trying to eliminate the negative life patterns accompanying the pregnancies that occur, we believe it is useful to conceptualize two levels of prevention—primary and secondary. *Primary prevention* strategies attempt to keep potentially problematic situations from occurring (for example, sexuality education). *Secondary prevention* strategies focus on early identification of problematic situations that have already occurred (for example, early prenatal care), followed by interventions designed to improve the outcome. It is of paramount importance to work on both levels simultaneously. Primary prevention reduces the need for secondary; secondary prevention with young parents becomes primary prevention for their children. Thus, working at both levels at the same time means a greater chance of breaking long-term destructive life cycles.

In short, *an effective primary prevention program would result in fewer pregnant teenagers;* and *an effective secondary prevention program would result in healthier infants, fewer school dropouts, and more teenage parents having jobs that enable them to support their new families.*

This approach, quite clearly, requires the establishment of an environment in which children can grow to their maximum human potential. It has, of course, serious implications for the family and all cultural institutions—educational, political, religious, economic. Yet in several ways the schools receive the heaviest burden. As we stated earlier, while we recognize that schools are stretched beyond their capacity, we nonetheless look to them as the *only* logical catalyst for generating a prevention approach. There are several reasons for this.

Why in the Schools?

By accepting and supporting teenage parents, the school serves multiple purposes:

1. No other social institution has sufficient access to teenagers to have the necessary impact. Schools are potentially capable of setting up critical outside networks, as well as diffusing the intensity of family situations, while at the same time meeting students' educational needs. Many students have vital relationships with their teachers and various members of the school staff, which greatly increases the program's potential impact. Comprehensive health care services in the school, including family planning, provide the best chance of reducing fertility rates. Positive aspects of providing in-school services include easy access, more consistent followup, and, ideally, accommodation of drop-in services—alleviating the need for transportation and special hours.

2. It is clear that the majority of parents are not providing the sexuality education their children need. According to various public polls, parents favor sex education in the schools. These polls show that from 79 to 93 percent of parents support instituting or expanding sex education programs in secondary schools.[2]

3. The school can create a safe and acceptable climate where young people can explore questions of sexuality in a responsible manner. They can learn to understand the consequences of their choices rather than acting on the spur of the moment in ways they perceive are expected by the messages from the media and peers. In this way, their susceptibility to exploitation can be reduced.

4. A school program can decrease the pressure on teenagers to leave their peer group prematurely and discontinue their education. Currently, teenage pregnancy is one of the most common factors in dropping out of school: "Forty-one percent of all female students who leave before completing high school do so because of pregnancy and/or marriage, according to the National Center for Education Statistics."[3] Keeping pregnant and parenting teenagers in school also helps to demystify childbearing and any romantic notions about the parent-child relationship other students may have. In addition, peers who see a teenage parent with the responsibility of a child might lose the sense of immunity many of them have—that pregnancy can't happen to them.

5. By providing child care, schools can potentially meet the needs of 804,000 children of teenagers in need of service.[4] Also, such programs present the opportunity to teach parenting skills, train students in early childhood education, and, it is hoped, develop a sense of community responsibility for children. Moreover, by reducing stress on young parents these programs decrease the chances of teenage suicide and child abuse, and permit early identification of any developmental problems in the children.

6. School programs that encourage and develop nurturing skills are an acknowledgment and validation of what is probably the most critical work of a society—the rearing of its young.

Primary Prevention

Young people need to have choices and options—a real future. To exercise these choices they need information to make decisions. We recommend that the primary prevention level of a comprehensive approach focus on the following elements for all adolescents:

- *Family-Life Programs* that include sexuality education offering contraceptive information and access to methods of birth control.* Adolescents need the opportunity to discuss their beliefs, values, and fears about contraception. They also need realistic information on what their lives may be like if they choose to parent early and they need decision-making skills to help them make their choices. Experts suggest sexuality education should begin as early as kindergarten and continue through secondary education.[5]
- *Health Education* and *Human Development Courses* that cover both physical and emotional well-being, and stress the importance of nutrition, exercise, and education about substance abuse.
- *Parenting Classes* that teach child development, stressing the concepts behind bonding, prenatal care, and parenting skills. These classes should also emphasize the parent's role as a model for the child's development, and the nature of parenthood in terms of responsibilities, to help students understand that love means providing adequate care (including food, shelter, clothing, opportunities). Many young people, for example, do not understand the potential effects on their child's future (both financial and psychological) of acknowledging or not acknowledging paternity.

*If not provided directly in the school, then by a community health center or family planning center that is closely linked to the school's sexuality education program, and that has developed specific services designed to meet the unique needs of adolescents. See "Characteristics of Successful Programs" at the end of this chapter.

- *Developing Self-Esteem*, or a positive self-image, that comes from perceiving oneself as lovable, important, competent, and in control of one's future. This may require deemphasizing competition over grades and focusing on the individual's personal progress and developmental pattern when evaluating performance. It may also require provisions for various learning styles in curriculum design. In addition, classes and programs can address issues of sexism, racism, and economic disparity.
- *Vocational Programs* with strengthened assessment and guidance services and a status similar to that of college preparatory programs. These programs should also be expanded to reflect both the interests and talents of their students and the needs of the community at large. Generally, this involves close contact with business people as well as local and state agencies. Programs can include work in the arts through apprenticeship training—photography, music, pottery, for example.

Some or all of these elements of primary prevention are already being implemented in varying degrees by certain schools. These suggestions are intended as a guide for individual teachers and schools to help them set up new programs or strengthen areas of existing programs.

Secondary Prevention

Obviously, pregnant and parenting adolescents have the same needs as their peers in terms of education and personal support, but they have many additional needs. Although at times it may be tempting to take a punitive attitude and write off these young people, it is important to remember that *the support or lack of support adults provide in response to their situation will, in the majority of cases, determine the direction of their lives.* Further, these adult reactions will determine the quality of life their children experience. Consequent-

ly, we think that the following support services are particularly crucial to successful outcomes of young parent programs:

- *Active Assertive Outreach* is needed because generally the young people most in need of services are the ones who are most difficult to contact and engage. Many can be contacted at the bowling alleys, laundromats, and restaurants where teenagers congregate. It is also important to involve members of the young person's network. Parental involvement (see Chapter 5) can be crucial to success, especially for young teens, the majority of whom continue to live at home. Any efforts that help to minimize conflict within and between the families of young parents increase the chances of a positive outcome of the pregnancy, the childbearing process, and the development of adequate parenting skills. Common areas of conflict arise between mothers and daughters over child-rearing issues, and between partners and parents over blame and responsibility for the situation.
- *Advocacy* is necessary, particularly concerning vocational pursuits, housing, AFDC benefits, food stamps, and medical care for young parents and their children. This can include helping the parents develop the necessary skills to communicate their needs to families, friends, agencies, and employers.
- *Transportation* can involve buying or renting a vehicle and driver, coordinating volunteer and staff transportation, and funding or using public transportation. In general, programs that pick up their members directly rather than relying on their finding their own rides have greater participation. Transporting the children of teen parents requires special attention.
- *Day-Care* programs ideally will offer both part-time and full-time services based on the needs of the family. It is also helpful if parents spend time at the day-care program learning to be astute observ-

ers of their children, as well as noting alternative approaches to children modeled by the staff.

- *Prenatal Classes* should include education about nutrition, exercise, health care, and childbirth preparation.
- *Parenting Classes* are needed to teach both the physical aspects and the emotional development concerns of child rearing. These include bathing, feeding, playing, toilet training, and bed-time rituals. These classes also can teach skills to build self-esteem in children. Young people need to learn the effects of neglect and abuse on their children's future. In addition, classes can include exercises to help young parents decide what they want for their children's future and discussions about concrete ways to plan for that future.
- *Counseling* services are necessary for young parents and their families. The combined pressure of learning the role of parent at the same time these young people are continuing their adolescent development and consolidating their identity will probably require the assistance of a trained counselor to help them sort out their many feelings. Services could be provided on an individual, family, or group basis by paid staff, volunteers, or trained peers.
- *Family Planning* is needed to prevent unwanted subsequent pregnancies. Followup is important to encourage consistent contraception use.

To reflect for a moment on the young family presented at the beginning of the chapter—if Jimmy and Carol lived in a community where services for pregnant and parenting teenagers were already in place, their outlook could be much brighter. A possible scenario might go like this.

Jimmy runs into an outreach worker, Paul, while hanging around at the local basketball court. Paul is a counselor with a new teenage parent program, HELPS, that has been established to provide services for several local junior and senior high schools. After running into each

other several times, Jimmy opens up to Paul and shares the details of his situation and the anger and helplessness he feels. After several months of working with Jimmy, Carol, Stephie, and their families, Paul is able to hook them up to appropriate resources and programs.

Stephie is in a day-care program located in the high school that houses the HELPS program. She has slowly adjusted to the program and is beginning to play with other children. The teachers report that she seems less fearful and is smiling much more. Carol drops her off at 8 in the morning on her way to class and picks her up at 3:30. She also stops in to lunch with Stephie twice a week. And, for one hour a day, she is a participant observer in the day-care center as part of her parenting skills program.

Carol is now in her junior year of high school and while she is not finding it easy, she thinks she may be able to stick it out.

Jimmy is enrolled in a two-year work training program that pays him a low salary while he acquires the skills to become a machinist. He likes being with the guys at work and talks about having his own shop some day. Both Jimmy and Carol participate in the HELPS program. They are involved in a parenting class that meets three times a week. Because of tightly coordinated services, they have been able to work this into their schedules. They also attend family counseling sessions bimonthly and participate in a peer support group once a week.

Jimmy, Carol, and Stephie's families—Jimmy's mom and Carol's parents—are more willing to help now. They believe their kids have a real future.

It is unclear whether Carol and Jimmy and Stephie will continue to live together as a family or whether the parents will finish their current programs. What is clear is that their future looks a lot brighter than it did a year earlier.

Characteristics of Successful Programs

Lastly, we would like to share some characteristics that seem important to the success of several programs. We have reviewed the literature and/or talked with the staff of these programs:

Teen Father Collaboration, Bank Street College of Education, 610 West 112th Street, New York, NY 10025

Project Redirection, Manpower Demonstration Research Corporation, Three Park Avenue, New York, NY 10016

New Future Schools, Perinatal Program, Young Parents Center, 2120 Louisiana, NE, Albuquerque, NM 87110

Adolescent Health Services, St. Paul Maternal and Infant Care Project, St. Paul-Ramsey Medical Center, 640 Jackson Street, St. Paul, MN 55101

Sojourn's GED-DAYCARE Program, 42 Main Street, Northampton, MA 01060

Community Adolescent Resource and Education Center, Holyoke Hospital, 575 Beech Street, Holyoke, MA 01040

Adolescent Health Programs/Teen Clinic, Inc., Holyoke High School, 500 Beech Street, Holyoke, MA 01040

Page Program (Alternative Program), Springfield Public Schools, Springfield, MA 01101

Additional suggestions have come from staff members whom we questioned about elements they thought were important.

Staff

A paramount requirement is that those working with adolescents sincerely like them and enjoy their company. Staff members need—

- Flexibility, patience, and understanding. For example, young parents may become quite depen-

dent on staff and services at first. They need a great deal of acceptance and nurturance to resolve personal identity issues at the same time they are adjusting to the role of parent. Later they need support and encouragement to establish their independence. Staff members need the ability to maintain a positive outlook for the teen parents and their children. This involves helping the parents develop a long-term perspective on their lives and a positive perception of the experience. It also requires staff recognition and praise of all small gains the young parent makes toward becoming an independent, responsible, and good caretaker. Close, trusting relationships between staff members and teens must be established. In many cases, staff members will have to reparent the teen to help him or her establish positive parenting practices.

- The ability to set clear limits, gently but firmly. This provides the security that young people need, as well as a model for them to emulate when interacting with their children. Realistic expectations and a recognition of developmental patterns and individual needs are also important. For example, young people's complete absorption in their relationships with peers can be frustrating; in terms of their development, however, this stage of intense relating is primary to their ability to separate and individuate and thereby reach the next stage of independence.

- A resolution of their own feelings about teenage sexuality. The same holds true for the issues of racism, sexism, and class differences. It is unlikely that students will be able to address these issues and resolve conflicts unless staff members feel comfortable and safe addressing them. Also, it is helpful if the staff is composed of both males and females, with an equitable representation from disadvantaged groups—the poor, minorities, and handicapped.

Accessibility

Services and programs should meet the specific needs of young people. This means that the majority of services and programs should be provided under one roof. Those that are not should be tightly linked to and coordinated by the main site. The school provides the ideal main site in terms of location, time, transportation, and long-established relationship with the student. Also, all services and programs should not entail an undue financial burden on students or their families.

Comfortable Settings

It is important to create a space where young people feel at ease.

- Confidentiality is critical. Young people fear the disapproval of their parents as well as that of their peers. They need to be listened to and have their individual needs taken seriously; they need a place where they can share their joys and their fears.
- Generally, young people feel more comfortable in spaces that are warm, colorful, and decorated with art—posters, signs—that they can identify with. When appropriate to the situation, snack food and music help reduce their anxiety and make them feel welcome.
- In designing the curriculum and literature for a program, it is important to recognize the limited reading comprehension skills of some students. Films are an excellent way to present material. Theater groups provide another effective means of communicating with adolescents, as well as an outlet for adolescent feelings of conflict over the issues addressed.

Other Considerations

- It is important to work with fathers on the same issues that the mothers are focusing on so that both parents can share similar attitudes about their futures and can be knowledgeable and involved in child rearing.
- It is important not to classify either mother or father in a "bad guy" or "victim" role, but instead see each one as an individual who shares equal responsibility for creating and raising a new life.
- Long-term support services will be necessary to ensure a positive outcome. This means supporting the young parents through the pregnancy and possibly for several years thereafter, until they have received sufficient education, job training, and parenting skills to perform successfully in the adult world.

PART TWO

The Student, the School, and Society

CHAPTER 7

Determinants of Teenage Pregnancy

Much is unknown about the reasons teenagers become pregnant. The available research indicates that the vast majority of teenage pregnancies are unintended. They are a result of lack of knowledge, misinformation, and concerns over the safety of birth control methods, including inconvenience and unavailability.[1] We fully recognize that large numbers of teenage pregnancies occur for those reasons. However, we also recognize that the research methodologies available are relatively crude as instruments for making fine distinctions about human motivation. Moreover, it is always the case that teenagers responding to the question of why they became pregnant are responding *after* the pregnancy has occurred when they are subject to their vacillating feelings, pressure from parents or significant others, and the interviewer's influence. There is no way to determine whether the reasons they give after the fact are the same as those that motivated them before the pregnancy occurred.

In addition to the methodological problems of research, there are psychological reasons for the lack of precision in determining the cause of teenage pregnancy. As we all know, much motivation is subconscious or partially subconscious. What does it mean, for example, when a teenager reports, "It just happened. I never even thought about getting pregnant," or "I thought he would pull out in time," or "I simply forgot my diaphragm that night," or "I never worried about getting pregnant—if it was going to happen it was going to happen"?

Each of these cases could easily be categorized as an unintended pregnancy, but we believe that term tells only part of the story. What is not known is the motivation that lies beneath *forgetfulness, risk taking*, and *indifference*. While we do not pretend to know the answers, we do have grave reservations about self-reported data that simply concludes that the vast majority of teenage pregnancies are unintended. We are suggesting that there are multiple ways to think about determinants of teenage pregnancy, and that classifying all of them as merely unintended conceals very significant differences. Moreover, those differences are critical when thinking about prevention. Each of the preceding quoted statements could easily lead to what would be considered an unintended pregnancy, yet the implications for prevention in each case are vastly different. For example, the decision *not* to use birth control can reveal ignorance, intimidation, fear of side effects, misinformation, indifference, or a host of other things—all of which could result in unintended pregnancy. But there are worlds of difference between, say, misinformation and indifference. A prevention strategy designed for a person who believes pregnancy is impossible before menarche or if the boy is under 15 would be dramatically different from one designed for the person whose life was so empty that she or he was indifferent to the possibility of pregnancy. While, in one sense, then, indifference can be considered as leading to unintended pregnancy, there are major implications about *what leads to indifference.*

In short, calculating determinants of teenage pregnancy can be risky business. We believe that the inclusive approach taken by Kristin Moore and Martha Burt in their book *Private Crisis, Public Cost*[2] makes good sense. The table containing their information on those determinants appears in the Appendix.

CHAPTER 8

Teenage Pregnancy and the Larger Social Issues

Teenage pregnancy has emerged as a national concern. It has become the focal point of local, regional, and national conferences; it is being featured on television programs. And leading magazines have had such cover stories as "What Must Be Done About Children Having Children"[1] and "Children with Babies."[2] Although teenage pregnancy rates are high enough to deserve the attention of thoughtful people, we question whether the recent escalation is sufficient, in itself, to cause such public furor. Therefore, even as we are pleased to witness increased attention to a phenomenon resulting in much pain and heartache, we find reason for mild perplexity in the particular timing of the groundswell.

Primary Reasons for Increased Attention

Determining causation in a complex, fast-paced, technological society is hazardous; it is even more so when dealing with sexual issues. Furthermore, it is quite likely that multiple forces are pushing teenage pregnancy to the forefront, and there is much reason to believe that people are alarmed for different reasons, which further complicates the determination of causality. There is no

way, of course, to decipher the messages coming from legislators, educators, nonprofit organizations, or the media to determine the nature of their origins. Consequently, there is no formula for weighing causation. Lacking that, we have identified a rather inclusive list of reasons that we suspect are behind this upsurge of attention given to teenage pregnancy. They are as follows:

1. *Visibility*. Historically, in this country, pregnant and parenting adolescents have dropped out of school. Their lack of visibility plus a lack of precision in school recordkeeping meant that public knowledge of teenage pregnancy was quite limited. However, as a result of changing social norms and recent legislation prohibiting schools from banning pregnant and parenting students, more of these young people may be remaining in school, where they are more visible. (We have found no research data that indicates the number of pregnant students who remain in school, but our experience suggests that the percentage, while still relatively low, has climbed in recent years.)
2. *Out of Wedlock*. Pregnant and parenting teenagers are less likely to marry now than in the past.[3] Given contemporary cultural norms, there is reason to believe that many people who previously could politely ignore premarital sex now have a harder time turning their backs on out-of-wedlock childbirth.
3. *Increased Sexual Activity*. It is also possible that teenage pregnancy is flagging what, to some, is the more fundamental issue of teenage sexual activity. Without the overt signs of pregnancy, the increases in teenage sexual activity are quite hidden and, in fact, could only be surmised—except for those who read the research findings of the past two decades. *Pregnancy, of course, raises the curtain on teenage sexual activity; it may be that making overt what was once covert is the cause of much of the outcry.*

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4. *Younger Teenagers*. While teenage births have actually declined, by some measurements, in the past few years, the number of under-15 white pregnancies has increased.[4] It is quite likely that the specter of 11- to 14-year-old junior high pregnancies raises more concerns than do the pregnancies of older teenagers. Certainly the health risks for mothers and infants are greater, and the potential long-range costs to the taxpayer are substantial. Also, as we indicated in Chapter 1, the linking of early parenting with female-headed households and long-range poverty is considerable.

We are quite certain that other factors are contributing to the spotlight recently placed on teenage pregnancy, but we suspect that these four reasons are primary. At least these are the reasons that we believe *originally* drew public attention. Pictures of 14-year-olds having children were beamed from television screens and magazine covers; 7, 10, or 35 pregnant students in a school generated educational conferences; skyrocketing costs for postnatal care of underweight babies appeared on page three of local newspapers. Suddenly "children having children" became a well-known phrase and student pregnancy a national issue.

Relation to Larger Social Issues

Is it more than that? Is student pregnancy a straightforward problem of trying to curtail unwanted pregnancy? We do not think so. We believe that the controversy over teenage pregnancy has indeed captured public attention. However, under closer scrutiny, fueled by both scholarly research and penetrating analysis, we think that the attention focused on this problem has laid bare far deeper issues. In short, we believe that as the debate intensifies, it becomes more apparent that the root

causes of teenage pregnancy are embedded in the fundamental *ethos*—norms, mores, institutional values—of the country. Therefore, *any serious dialogue about teenage pregnancy can readily escalate into issues of ethics, racism, sexism, income distribution, and the role of young people.* Analysis of the relationships between teenage pregnancy and these broader social issues is, of course, far beyond the scope of this book. We would feel remiss, however, if we failed to acknowledge their potential interconnection. Therefore, painting with a broad brush we have outlined some of the ways that teenage pregnancy is seen as connected to these social issues that continually haunt this country.

1. *Racism.* While teenage pregnancy exists in all neighborhoods, school districts, towns and cities, there is a much larger problem among low income and minority populations. The following table compares the sexual activity of Black and white youth:

Among every 10,000 white unmarried 15- to 17-year-old women there are about 3,200 who are sexually active
600 who become pregnant
200 who give birth
120 who raise their children as a single mother

Among every 10,000 Black unmarried 15- to 17-year-old women there are about 5,400 who are sexually active
1,400 who become pregnant
700 who give birth
660 who raise their children as a single mother
Source: Alan Guttmacher Institute[5]

Certainly factors such as access to abortion and cultural values need to be taken into account, but there is also the issue of opportunity. According to the Children's Defense Fund: "Teens have to believe that they have opportunities in order to fear losing them to an unplanned pregnancy. For many poor and minority youth the opportunities are not there."[6]

A recent *Ebony* magazine article, "What Must Be Done About Children Having

Children,"[7] speaks to the disproportionately high number of Black single teens bearing children with few supports. It touches on the disintegration of the kinship network leading not only to a sense of isolation for these young mothers but also to the real increase in the tolls suffered by the children resulting from the factors involved in the feminization of poverty. The article is a plea for individuals, organizations, and institutions to work together to prevent the continuation of this vicious cycle and to offer young Blacks of this era other opportunities—including valued roles, educational advancement, vocational training, and the real possibility of employment. (See the Appendix for excerpts from this material.)

2. *Sexism.* There is much reason to believe that the determination *not* to get pregnant is correlated with the way pregnancy affects future anticipations.[8] The brighter the individual's future—career and educational opportunities—the more caution exercised around pregnancy. Therefore, to the extent that women see limited career opportunities, less pay than males for the same job, and higher performance expectations, their motivation to delay pregnancy is lessened.

   To the extent that sexual exploitation of females is a norm, males will continue to see contraception as "her problem" and will continue to pressure females into sex.

   To the extent that males have limited options to learn nurturing behavior, they will not learn the difference between intimacy and sex.

   To the extent that the new sexual freedoms continue offering no direction, guidance, or rules to the young, girls will submit to boys' pressures and expectations to engage in sexual intercourse.[9]

   To the extent that a girl retains the ideal of falling in love with a boy who will provide for, love, and take care of her, she will continue to accede to his sexual demands.

Included in the Appendix are excerpts from the article "Schools Must Ease the Impact of Teen-Age Pregnancy and Parenthood," written by Margaret C. Dunkle, Co-director of the Equality Institute, and Susan M. Bailey, Director of the Council of Chief State School Officers Resource Center on Educational Equality.[10] Ms. Dunkle and Ms. Bailey, consistent with other recent authors, connect the lack of opportunities available to minority youth with the high pregnancy rate among these teens. The research they cite shows a correlation between the motivation of women to continue their education and procure employment and deferring pregnancy. The article also speaks to the vulnerability of girls to engaging in intercourse and becoming pregnant as a result of their socialization process, and the likelihood of their leaving the classroom because of subtle and not-so-subtle communications that they should do so.

3. *Poverty*. The interconnectedness of teenage pregnancy and poverty is inescapable. People who have thought seriously about the problem for some time conclude that ultimately the battle will be won or lost on the economic front.[11] The argument holds that as long as large numbers of people live in poverty with no hope of escape, no significant change in their lack of grave concern over pregnancy can be anticipated.

4. *The Role of Young People*. More than two decades ago, Paul Goodman in *Growing Up Absurd*[12] and Edgar Friedenberg in *The Vanishing Adolescent*[13] drew much attention to the cultural phenomenon of the eroding social roles of adolescents. Their blistering analysis of the lifestyle offered the young—lack of identity-providing roles and functions—was followed by numerous reports about the diminishing place for adolescents in our society. More recently, David Elkind in *All Grown Up and No Place to Go*[14] has continued the plea to

rethink this circumscribed role of adolescents, who, in his words, are "displaced."

While the phenomenon has different labels—"youth crisis," "displaced adolescents," "the apathetic generation"—the persistent theme running through those protestations is the notion that schooling is not sufficient in itself to meet the developmental needs of young people. In addition to schooling, they need better integration into the adult world to find economic and social roles that would provide them with an opportunity to gain competencies, approval, and self-esteem—which, in turn, would contribute to their developing identities.

In addition to lacking productive roles, teenagers also have a good deal more unsupervised and unstructured time to fill. Without functional adult interactions, many young people are turning to peers in search of the comfort and caring that is missing in their lives. Longing for close, loving relationships, they often end up confusing sexual intercourse with emotional support. Unfortunately, they enter into these relationships with little foresight, knowledge of consequences, or accessibility to birth control methods—a situation resulting in high rates of adolescent pregnancy. Considering these changes and pressures, it should not be surprising that many young people are indulging in a number of risk-taking activities, living moment to moment, gambling with the odds that pregnancy will happen to them, and some seemingly unalarmed, even at a very early age, when it does happen.

In short, the century-long evolution that has slowly but steadily relegated teenagers almost exclusively to the role of student is being seriously questioned. Beyond a doubt, the limited role for adolescents in our society has much to do with teenage pregnancy.

5. *Sexual Activity*. The extent to which public opinion is aroused by teenage pregnancy as opposed to

the increased levels of teenage sexual activity (a two-thirds increase between 1971 and 1979) is not clear.[15] *If teenage chastity is the central issue, then debate about pregnancy and how to help teenage parents cope will be convoluted.*

6. *Policy Implications.* What has become crystal clear is that it is difficult to frame any law or policy recommendation or suggestion concerning teenage pregnancy without offending someone's deeply held convictions. Since we are writing this book for educators, we are foregoing any discourse on policy analysis. However, a special report of the Children's Defense Fund, "A Children's Survival Bill," illustrates how policy implications are irrevocably intertwined with cherished values and ideals.[16] An excerpt from this report appears in the Appendix.

CHAPTER 9

Pregnant and Parenting Adolescents and Their Families

"I used to rub my stomach and cry and say, 'I'm really sorry this has to happen, baby,' because I felt it was a human being we gave life to. I love my boyfriend and want to marry him someday, but we still want to run around and act like idiots and play tennis. How could I with a stomach out to here? Still it hurts to think about it, so you try to deaden your mind."

—A 16-year-old[1]

This chapter discusses three main topics: developmental differences in pregnant adolescents by age level (11 to 15, 15 to 16, and 17 to 19); the characteristics of adolescent fathers; and parental responses to adolescent pregnancies. Because significant differences exist between early, middle, and late adolescents in relation to their pregnancies, the major part of this chapter is devoted to the cognitive frameworks of the three age groups. These differences are reflected in age-specific world viewpoints, problem-solving strategies, and coping abilities.

This emphasis is not intended to deny the existence of other important variables besides age that correlate with an individual's developmental position and maturity. Such factors as receiving adequate mothering through consistency and the caretaker's genuine love and devotion are too complex and numerous to be sufficiently addressed here. We do want the reader to bear in mind one point, however. When we refer to adolescents of

specific age groups we are speaking about those young people who have not suffered significant physical trauma or emotional deprivation. Individuals who have had such experiences are much more likely to be functioning on a lower level due to arrested or delayed cognitive/emotional development.

Developmental Differences in Pregnant Adolescents

Early, middle, and late adolescents who are pregnant have different abilities to fantasize about the fetus within, to visualize caring for the infant, to participate in the decision-making process, and to think realistically about the options available to them. The degree to which an adolescent has been able to formulate her own identity apart from her parents determines the investment she will be able to make in another relationship: that of the mother and the new infant. A young woman who has not developed a sense of autonomy will have difficulty establishing a relationship with her infant because of her impeded ability to empathize with the child. An egocentric teenager cannot possibly tune into her infant's needs or respond to its cues; she therefore lacks the ability to provide an appropriate nurturing environment.

Research shows that it is the adolescents' cognitive position, which correlates with their psychological maturation, that determines their ability to parent successfully.[2] A clear pattern of the sense of self predicts not only the motivation of these young people for pregnancy or parenting, but also their concept of the choices available to them, their mental representations of the fetus, their choice of alternative, and the degree of support they need. The sense of self also plays a significant role in their later reaction to the alternative chosen, their sense of loss, and their ability to recover from the initial "crisis" period.

The following pages describe the characteristics of pregnant adolescents in greater detail. The information is arranged by developmental levels—for early, middle, and late adolescents—in order to be more helpful to those working with these young women.

Early Adolescents (11- to 15-Year-Olds)

Members of this age group just emerging into young womanhood are more likely than older adolescents to let their pregnancy go on longer before acknowledging it because of the severe threat it presents to their still unstable self-image. These young women often engage in much play acting in an effort to try on new ways of being before establishing a stable sense of identity. They are least educated about body changes, reproductive functioning, and contraception. Upon hearing of her pregnant state, the early adolescent typically blames others—her mother for not giving her the information she needed and protecting her from this crisis, the father, or any other significant person in her life. Her inexperience in decision making contributes to her real sense of helplessness and of being overwhelmed by the pregnancy. If important figures in her life are in opposition and are exerting varying degrees of pressure as to the course of action she should take, she is likely to react with a significant amount of anxiety. Of all the age groups, these youngest women are the most likely to think of making a suicidal gesture.

In the vast majority of situations, the early adolescent's mother is very involved and influential in helping her daughter make the needed choices concerning the pregnancy. If the choice is made to give up the child for adoption, mother and daughter typically go through similar mourning periods following the loss. If the choice is made to keep the baby and the daughter remains at home, the

young teenager's mother often plays a large role in the child rearing.

It is important to keep in mind that these young adolescents have not yet developed a level of thinking that enables them to project into the future. They have great difficulty realistically envisioning themselves in the mothering role and focus little on the actual carrying and delivery of the baby. One easily gets the impression from interviews that they have little idea of what their daily life will be like if they choose to carry to term and raise the baby. Of all the age groups, these pregnant adolescents report the bodily and emotional changes that accompany their pregnancies least well. They have little concept or perception of the fetus within. When asked to draw a picture of it, their drawings are the least babylike of the three groups.

Their lack of ability to fantasize and their depersonalization of the pregnancy experience serve to protect them from a situation beyond their capabilities for coping and resolving. Support and education are crucial to inform them of the various choices and the consequences thereof. They need help to concretely visualize the effect their decision about the fetus within will have on their lives.

Causal factors of pregnancy for the early adolescent include the following:

- Lack of information about the body, birth control, and reproduction
- Earlier onset of puberty and menstruation causing a lack of preparedness or awareness of the ability to become pregnant
- Experimentation
- Sexual abuse (incest or rape).

In general, the pregnancy is an accident.

Be sensitive to the early adolescent's—

- Extreme vulnerability during this crisis period.
- Need for a supportive environment—that is, she needs to know she is cared about, valued, has possibly made a mistake but is not a "bad per-

son." She also needs to have someone to talk to so she doesn't feel alone or overwhelmed.

- Need for privacy along with a neutral, nonjudgmental environment where she can make her own decision.
- Need for concrete information about the different alternatives available.
- Need for assistance in problem solving and answering questions about the major life decisions she is making.
- Need for room to change her mind about the alternative chosen.
- Need for ongoing support, counseling, contact with others in a similar position or who have already made the decisions and are living out the results.
- Need for education to avoid repetition—that is, communication skills, learning to say no, relationship planning, career goals, birth control.
- Potential suicide risk if she is made to feel guilty about going against family mores; if she feels caught between significant figures in making her decision; if she does not have enough support and acceptance or feels that her decision was wrong, too painful, or impossible to live with.

Middle Adolescents
15- to 16-Year-Olds)

Members of this age group tend to be defined as narcissistically oriented. In other words, they are egocentric and self-absorbed. The hallmark of the middle adolescent's reaction to her pregnancy is ambivalence. She does not want the responsibility, yet she would like something of her own. She sees having the baby as a way of leaving home and possibly school, maturing into a woman, and becoming independent. But she wonders if she will have enough money, support from the father, the ability to procure affordable housing, and so on. She asks herself if these realities will outweigh the anticipated new-found freedom and independence.

It is common for members of this age group to refer to the baby as a possession. At a stage where she is still reliant on her family, the young woman fluctuates between wanting to mother and to be mothered herself. The developmental tasks of this age are at risk if she decides to carry to term and then raise the infant. Her ability to separate and then individuate from her family may be delayed due to financial constraints. In fact, she may become even more dependent on her family.

Unlike the younger adolescents, she is more reality-oriented about her baby even though she, too, when asked to draw a picture, produces a somewhat distorted image. She likely dreams about babies and generally is able to fantasize a good deal more than the younger teenagers because her cognitive abilities allow her to envision the future.

Causal factors of pregnancy for the middle adolescent include the following:

- Desire for independence, maturity, love
- Wish to live on her own, away from parents
- Spontaneous and unplanned intercourse
- Belief that bad things don't happen to her
- Actual or threatened loss of significant person
- Test of boyfriend's love or commitment
- Escape from internal conflict
- Something to live for
- A rebellious act to get back at parents or to help in separating herself from a relationship that feels too close and threatening
- Teenagers' mutual loneliness/need
- Wish to raise child the way she wished she had been raised
- Romanticization of love by not using protection
- Lack of education about the body and birth control
- Sexual abuse (incest or rape)
- Testing of parental values
- Wish for acceptance
- Reinforcement of attractiveness or value.

Be sensitive to the middle adolescent's—

- Fluctuating stance regarding her pregnancy. (In short, do not expect her to be consistent over time as to mood, desires, and choices.)
- Need for stability and support from others.
- Need to make her own decision free from the pressure of others.
- Need for a neutral space—for example, a group home or a relative's home—if the issue is too charged or upsetting to those around her.
- Despair if she feels she has transgressed family mores.
- Need for information about different options and life planning.
- Probable need to change her mind several times before making a final decision.
- Need for peer support and empathy.
- Need for resources including professionally trained counselors to help her through her pregnancy.

Late Adolescents (17- to 19-Year-Olds)

Late adolescents are the most informed of the three age groups about their bodies. They have the most realistic perception of the fetus and knowledge of what will be required of them if they choose to keep the baby and act in the mothering role. They are the most conscious of the mental and physical changes of pregnancy and seek tests sooner than the younger teenagers. Unlike young women of earlier eras, they accept at least some responsibility for the situation instead of blaming others in order to cope with, or defend against, what seems to be an overwhelming situation.

The late adolescent often wishes to mother and care for a child, viewing the [illegible] in a more positive light. Her perceptions of the unborn

baby show that she is developmentally more ready to serve another's needs rather than focusing mainly on self as is the case with the middle adolescent. She may have begun separating herself from her family emotionally, if not physically, and may be ready for and seeking interpersonal commitment. Because she can fantasize and think about the future, she can make a more realistic decision about her ability and willingness to mother.

Causal factors of pregnancy for the late adolescent include the following:

- Attempt to consolidate identity
- Slip-up, conscious or unconscious
- Test of boyfriend's commitment to her and their relationship
- Desire for maturity, to become a woman
- Desire for separation from family
- Sexual abuse
- Aversion to the use of messy, inconvenient, or dangerous contraceptives.

Be sensitive to the late adolescent's—

- Need for a supportive environment.
- Need for information to make her own decision about the pregnancy.
- Need for assistance in planning for the future—career, goals, education.
- Need to discuss the options, the availability of resources, and the future impact of her decision.

Adolescent Fathers

Ralph was a tall, gangly-looking 17-year-old adolescent, who had another semester to go before graduating from school. He appeared extremely frightened, shy, and embarrassed. He was relieved to know that the worker's role was not to pass judgment, nor did he represent an arm of the law. Ralph found it hard to talk with anyone about this and was glad that he could talk to a male social worker. He and Nancy had had sexual intercourse three or four

times at a drive-in theater. He knew about contraceptives but had been careless, he thought. Several months ago he learned that Nancy was pregnant. He was scared and did not know what to do. His grades at school had begun to drop. He said voluntarily that he did not want to get married at this time, although he liked Nancy very much and was going to stand by her.

Ralph's parents did not know about his predicament, and he said he was afraid of what their reaction would be. He was relieved when the worker said that his parents would have to be told, that they had a right to know that he was in trouble, and that perhaps they could be helpful. He accepted the suggestion that he tell them.

Ralph did not keep his next appointment. His parents had advised him to deny paternity and not to keep further appointments. At this point we took the initiative in contacting the parents. We indicated that Ralph was in serious trouble and that it was important that they come in to talk with us.

Ralph's parents, although hurt, bewildered and threatened, wanted to do whatever they could to help their son. . . .

Through his discussions with his social worker, Ralph clarified that while he liked Nancy, he was not thinking of marrying her. He just was not ready for this. How could he support her or the baby? He wanted to finish high school and then go on to college. Getting married was certainly not a part of these plans, and being responsible for a baby was the furthest thing from his mind. He also wanted to discuss this with Nancy. He guessed now that he had a real stake in whatever decision Nancy made. . . .

Ralph had done a lot of heavy petting with girls and some experimenting, but thinks his experience with Nancy was the only time he had had sexual intercourse. It was not a satisfying experience and certainly not worth what he was now going through.[3]

Much attention is given to possible unconscious factors operating in the teenage female who engages in sexual experiences while little emphasis is placed on those factors operating in the male counterpart. Like the young women, males too are grappling with issues beyond normal sexual attraction, pleasurable sensations, and general experimentation. Other forces that may serve to fuel the fires of their already thriving sexual impulses

include pressure from peers or family, feelings of pride, assertion of manhood, fear for masculinity, or defense against homosexual drives. If parents question their son's heterosexuality, he may set out to prove to them, out of his own anxiety, that there is nothing to fear. Sons have also been known to act out their parents' repressed feelings or more clearly communicated messages. These messages are often conscious on the parents' part, but they can also be unconscious and thus not readily understood by the parents. What may begin in the young man's mind as rather harmless experimentation can culminate in a very traumatic situation for all involved. Early sexual experiences can color future relationships for many years.

The young man, upon becoming aware of the fact that he has impregnated a young woman, may find his life, too, becoming quite complicated. His status with peers may be affected and certainly a number of pressures will ensue from members of his own and possibly the young woman's family. He may well harbor fears about having to leave school, financial responsibility, possible court action, pressure to marry and support the woman who carries his child—to name a few of his concerns. All these pressures occur at a time of great tension on the homefront. Moreover, many pregnancy counseling centers view the adolescent father as a bystander, a shadowy figure in the whole situation, at best, and at worst, as "the bad guy" who is expected to operate as a hit-and-run victimizer. Counseling can offer hope at a time when the world looks rather dismal; however, support services are not always available or easy to find for these young men.

At the same time that the young father may be working at accepting responsibility, he also may have little say in the choice the woman makes about her pregnancy. If she bears the child, he may not be allowed much contact or participation in the upbringing. If she decides to get an abortion or to sign the child over for adoption, again, he may have little to say.

The general trend appears to be that social service agencies are currently working toward greater involvement of the male counterparts. The father is an important element to include in the decision-making process—even though we feel that the ultimate decision should be the woman's since it is her body and her life that will be most disrupted. Sometimes, however, the baby can be seen as more separate if the father is involved, a human being in its own right, instead of an extension of a relationship or a connection to a young man the woman may fantasize growing closer to or marrying. The male can bring an aspect of reality into the whole situation, giving all parties a clearer perspective.

Causal factors of pregnancy for adolescent fathers include the following:

- Pressure from peers
- Upholding a macho image or status
- Experimentation
- Release of sexual feelings/tensions
- Parental encouragement (often unspoken)
- Proving ability
- Response to pressure at home, such as divorce
- Escape or defense against feelings that are too overwhelming
- Counterbalancing homosexual feelings
- More pleasurable intercourse without a prophylactic or not wanting the woman to deal with messy, difficult-to-use, or dangerous contraceptives.

Be sensitive to the adolescent father's—

- Tendency to be negatively labeled and disregarded.
- Lack of people to talk to.
- Macho exterior covering up confusion and fear.
- Difficulty articulating or making sense out of his feelings.
- Fear for the future.

- Inability to concentrate and tendency to drop out of school.
- Possibly strong feelings about pregnancy resolution that may be overlooked.
- Fears about marrying or supporting a family.
- Need for resources that provide professionally trained counselors to assist him in looking at his feelings and planning for the future.

Parental Responses to Adolescent Pregnancy

"The worst problem we have are the mothers," said one clinic staffer. "You'd think the end of the world had come when they bring in their daughters. But it isn't the fact that the daughter is pregnant that bothers them. It's the fact that she is sexually active. Maybe the mothers feel threatened. I don't know. What I do know is that time and again a mother will say, 'Okay, I'll forgive you this time, but if I ever catch you pregnant again, you've had it.' Then they turn to us and say she won't be needing birth control because she won't be having intercourse again."[4]

"His mother thought I should have the child and give it up for adoption. When I settled on the abortion, she felt we should have the fetus baptized afterwards. Some strange thing like that. She was very upset. I think the thing that upset my boyfriend the most about it was upsetting his mother. But other than that, I don't think he felt bad about it."[5]

"My father doesn't know. He would be very upset at the pregnancy. He thinks of me as a little girl. 'Where are you going?' he always says. 'What time are you going to be home?' I'd feel better if I could talk to him. But I can't. He thinks my mother and I have gone shopping.

"My mother just sort of knew I was pregnant. She said, 'Come for a drive with me. Don't you have something to tell me?' She didn't yell or nothing. She just wanted to know if I'd called to get an appointment for an abortion. I had already called, but it was to get birth control. It was too late. I never got my period."[6]

No parent is likely to respond to the news that a child is either pregnant or responsible

for a pregnancy without some emotion. Yet the nature of that response varies widely. While some parents are outraged, humiliated, defensive, and bewildered, others are proud, excited, and full of anticipation. Still others take it for granted, and while not enthused about the implications, remain rational and supportive, and accept teenage pregnancy as simply a fact of life. Others deny the event completely. When told of the pregnancy they simply refuse to accept it, and go on as if nothing had happened.

Parental attitudes toward the decisión-making process regarding the pregnancy vary as widely as their initial responses. Some parents immediately envision what is to them the obvious outcome—abortion or marriage. Others assume that the adolescent couple will make the ultimate decision and they, as parents. will stand by to help if requested. Still others leave the decision-making process entirely to the young couple, viewing it as their sole responsibility.

Young adolescents have relayed to us the following parental responses to their pregnancy:

> "When I told my mother I was pregnant, she responded by saying, 'Oh good, my first grandchild.' I certainly wasn't that clear that it was such a good thing."
>
> "I told my folks about getting Ann pregnant. My dad commented that no one knows for sure who gets a girl pregnant, and he went on reading the paper. Neither Mom or Dad has mentioned it since."
>
> "I wish I had gone to my parents earlier. They were very supportive and wanted to make sure that I got the best care. My fears were blown way out of proportion. I really thought they would both explode."
>
> "My mother totally freaked out. It was like I had set out to do her in by doing something she no longer could. I think she feels real threatened by my becoming a woman."
>
> "My mother told me that she felt real hurt that I hadn't confided in her earlier. She just said, 'I thought we had an open, trusting relationship,' and then cried for a long time."

"My mom said that she felt guilty because maybe she hadn't given me enough information and guidance. She was pretty shocked to hear that her 13-year-old daughter was pregnant and planning to go ahead and have the baby."

"I told my dad about Jan being pregnant. He simply said, 'Well, what are you and Jan thinking about doing?' and we went on to talk for two hours about marriage, abortion, babies, everything. I'll never forget how he was there when I needed him more than ever."

"My parents responded to me with exasperation when I announced that I was pregnant. My father quietly commented about another mouth to feed and my mother sighed and recalled how she had given birth to me on the kitchen table at 14 also. She went on to talk about how she had wanted more for me—a chance for an easier, better life, outside of this housing project. I knew I had to find a way to get an abortion somehow and was willing to go to anyone and try anything."

"When I told Dad about Judy being pregnant he was really cool. He didn't yell or lecture or anything. He just stopped watching TV and we talked about it. But I was scared as I could tell he was seething inside."

"When I told Mom I was pregnant, she picked up the phone and called her sister in California, and within a week I was on a plane."

"When Mother heard that I was four months pregnant, she immediately went shopping and came home with diapers, bottles, and a bassinet. When I left the house she was cleaning out the back room and looking at wallpaper samples for a baby's room."

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CHAPTER 10

Pregnant Teenagers' Decision Making: Reactions and Options

"It was strange, because I was sitting there waiting for the results, and one of my best friends walks in for a pregnancy test too. We didn't even know about each other. It was very strange. She came in with dark glasses and everything. Hers came out positive too, so she and I kind of experienced it at the same time.

"I was a little bit scared when I found out. I knew I had to make choices."[1]

The young pregnant teenager and father must first admit to the condition before being able to choose a course of action from among the many options available. Several factors influence the decision-making process. These include cultural, racial, and economic background; family structure; self-concept; environment; and available resources. As teenagers' families ascend the economic ladder, more options are available. Abortions, for instance, can be expensive and often require travel for teenagers living in rural areas. Cultural factors are another important influence. White teens have a greater tendency to marry or to terminate the pregnancy by abortion.[2] In addition, they are much more likely to place the child for adoption. Among Blacks, the baby is often raised by the biological parent, her immediate family, or relatives. Rarely is it surrendered to an unknown couple.

Regardless of other factors, teenagers are all at a very vulnerable period in their lives developmentally. In many cases, this is the first adult decision they will make that requires such responsibility, that has so many consequences, and that will significantly impact on the rest of their lives. While some teens are able to make the decision to abort, surrender for adoption, or raise the child, others are filled with only suicidal feelings and a sense of deep despair and panic.

The following section outlines a typical sequence of reactions that male and female teenagers experience in relation to their attempts to cope with the pregnancy—denial, depression, anger, and resolution. Their ability to work through this progression depends on—among other things—their age, their support network, and their level of ego strength. Be advised that adolescents are experts in attempting to hide their feelings or appearing not to care when they care most. An awareness of the stages discussed here can help educators make sense of some of these feelings and behaviors.

Reactions

Denial

It is not uncommon for young teens to delay a pregnancy test for a long time. In fact, many social workers who work with pregnant teenagers know of at least one case where the young woman (not to mention the father and her family) made no acknowledgment of the pregnancy until the time of delivery. This phenomenon of denying in the face of a number of clear signs and symptoms occurs with most teens to varying degrees. Denial is a defense mechanism designed to protect the still vulnerable and fragile ego. The female may deny physical and emotional changes, while the male may deny paternity. Even when the facts are clear, the male may wonder aloud, "Is this child really mine?"

Depression

The adolescent can feel extremely guilty and ashamed for having gotten into this situation. He or she may feel hurt, singled out—why is this happening to me?—embarrassed for his or her family, or devastated by significant others' disappointment. Cultural and economic factors play an important role. While certain families, areas, and neighborhoods may accept and even expect pregnancies, their teenagers may experience depression instead of disbelief because they feel alone, overwhelmed, and without adequate resources for coping. Depressed teens are often unable to verbalize grief and therefore have trouble viewing their situation realistically and asking for help.

Anger

The young pregnant woman has much cause for anger and she may use this as a defense against an overwhelming situation. Her anger may relate to being uninformed or misinformed about her body and reproductive functioning. She may blame her mother for not having given her the information she needed or her boyfriend for not having been responsible for contraception. If the male raped or coerced her into engaging in sexual intercourse, she will be certain to feel enraged. The general anger she experiences relates to feeling vulnerable and unprotected, having to make quick decisions under pressure, feeling ostracized by peers she used to call friends and looked down upon by adults. Her general sense that no one understands her or, worse, that she is being punished only serves to fuel her rage. In all likelihood, those who care most about her may make insensitive comments and feel uneasy in her company. She may feel uncomfortable about her appearance and at the mercy of a whole range of emotions that seem beyond her control. Additionally, she may be restricted in some of her activities or she may find it difficult to get

around at a time when young people are characteristically engaged in many pursuits. She may find systems inflexible to her needs and capabilities or outwardly intolerant of her condition and situation. The greatest amount of anger is likely to concern her feelings of having been taken advantage of and abandoned.

Young men can also harbor a whole host of angry feelings. While they may be treated as the sole perpetrator of the problem, they will not have the support system the woman has to deal with all their emotions, frustrations, and fears. The young man may also wonder: Why me? Why did this have to happen? Why doesn't she have an abortion? How can I stop her from killing my baby, giving it up for adoption, or allowing her parents to raise it? If he is alone, overwhelmed, and ostracized, anger can be a very reasonable response—especially if the support systems and resources are not available to deal with what feels like an impossible load.

All too often we see teens venting their frustrations on their children. They are the unfortunate victims of the frustrations felt on every level—by parents, grandparents, school systems, and community and governmental agencies.

Resolution

Young teens need a number of supportive, caring people in their lives to help them sort through the magnitude of feelings they experience at this crucial time. It is important that these feelings not be buried, acted out on their children, or channeled into drug abuse. Rather, they should be expressed and worked through in order to permit these young people to move on and integrate the pregnancy experience in all its complexities.

While some adolescents move through this process of integration rather quickly and with seemingly few difficulties, others get stuck. All too frequently we hear of teens who felt so overwhelmed, alone, and vulnerable that they gave up

entirely by committing suicide or denying the pregnancy to the very last moment. The level of support needed varies tremendously; it relates to self-concept and the unique situation.

In her book, *In a Different Voice,* Carol Gilligan speaks of the developmental move from selfishness to responsibility, of the importance of first being able to care for oneself before being responsible for another.[3] Included in the Appendix is a passage from the book that we feel clearly illustrates the evolution of one 17-year-old woman's response to her pregnancy and her subsequent decision-making process. While this excerpt exemplifies a working-through process, it is important to bear in mind that there are many young men and women who avoid taking responsibility because of their personal histories, cognitive development, overwhelming and incapacitating fears and anxieties, or a host of other reasons. As Gilligan points out, for a young woman in this position the "inability to arrive at any clear sense of decision only contributes further to her overall sense of failure."[4] We feel the same holds true for the male. For this reason we strongly advocate having services available to aid and support young women and men in making their decisions concerning their pregnancies. These services can make certain that the young people are aware of and have considered all the options so that they can reach some sort of resolution without fear of losing themselves in the process.

The next section focuses on the various options adolescents choose and some of their subsequent feelings about them. The discussion covers abortion, adoption, single parenting, marriage, and foster care.

Options

Everyone has a plan of action, usually designed to respond only to that person's immediate needs. Because the girl herself is presumed to be too young to make correct decisions, she becomes the object of manipulations

designed to help her. Few adults, however, will listen to the girl's feelings, help her explore options, and support her in the choices she makes.

If she asserts her will, she is often undercut by those who "know better." If she remains steadfast, she often becomes a stranger in her own home, literally left to her own designs, carrying with her a festering sense of worthlessness. Even if she establishes her own direction in the face of opposing advice, she worries that she may have made serious errors. If she keeps the baby, it might have been better to give it up; if she gives the baby up, she goes through a wrenching experience. If she marries it may be a mistake; if she remains alone, it may not be best for her baby. In short, the pregnant school-age girl is beset with a tangle of demands and options, not one of which allows her to feel good about herself.[5]

Abortion

"I feel like I have really lost something. I will always think of him (the fetus) and want another."[6]

"I didn't really think of it as a baby. I more or less thought of it as something that was going to be a baby, but not actually a baby. I didn't have any guilty feelings, like I was killing something."[7]

"It kills me that this abortion is going to be on Saturday. That means I won't be able to go out Saturday night. I'll just have to stay home and eat chicken soup."[8]

"My boyfriend is 21. I called him this morning, but no one answered. He said he didn't know if he had the time to come with me for the abortion. If he don't be at the house tomorrow before nine, I'm going to leave him a note saying don't bother to see me again. I'm going to be bold."[9]

"I felt quite alone and bad for awhile, but I got over it. I learned a lot and feel more independent because I made this decision."[10]

According to statistics, the higher the socioeconomic status of the young woman, the greater the likelihood that she will choose to have an abortion, regardless of race.[11] Similarly, the higher her educational aspirations and the stronger her career orientation, the greater the likelihood of abortion. The procedure for teens is most often per-

formed in clinics rather than in hospitals. Statistics show that nearly half of all teens choose abortion to resolve their pregnancies.[12] Furthermore, it is difficult to estimate how many more are unable to obtain an abortion because of cost, fear, or unfamiliarity with the procedure and turn to other alternatives, such as resorting to dangerous self-induced methods, or take their lives.

Young adolescents often view abortion as frightening, dangerous, punitive, and overwhelming. Instead of viewing it as a surgical procedure that many women have undergone and recovered from, they see it as a life-threatening experience. Many teens feel that they have been physically harmed by the ordeal; some have. Nightmares are not uncommon, along with an obsession with death.[13] One teen related her fantasy that she looked in the pan after the abortion had been completed and saw "arms and legs and I was trying to figure out what sex it was."

The more conflicted, ambivalent, or confused the teen, the greater the potential for serious emotional trauma.[14] A grief process following the trauma is quite normal. While some young women note the time when the baby would have been due and wonder about what it would have been like, others simply feel relief from the panic they felt during the preceding days, weeks, and months.[15]

The grief process seems most difficult for middle and late adolescents. These groups express more guilt and are generally more in touch with the reality of the fetus within.[16] Another factor is the length of the pregnancy. If the young woman has already experienced fetal movements, the impact is likely to be greater.[17] Being awake or asleep during the abortion procedure may also be significant.[18] Unfortunately, these young adults are often viewed as deviant rather than in the throes of a developmental crisis; therefore, their self-respect is at risk.[19] It has been shown statistically that teens who have had abortions are more responsible about birth control following the procedure.[20]

Adoption

"I have never forgotten my child. I hope she is well and happy. I hope she will someday want to know me. I will always long for the child I carried, but never held."[21]

"Having a child is the most beautiful experience I've ever had. It haunts me to this day. Please, son, whoever you are and may be, love your adopted parents as if they were your only parents. As much as I love you today let me grieve over the past in peace."[22]

Very few teens choose adoption. The decline in their choosing this option over the years can most likely be attributed to the abortion alternative, the breakdown of the traditional family, and the increased acceptance of single parenthood. Clearly many young women would rather abort or parent than surrender their child after carrying it for nine months. Statistics from 1976 show that 90 percent of unmarried white teenagers and virtually all Black teenagers kept their babies.[23] Cultural differences account for Black babies being taken in by relatives to a larger extent. Profiles of teens who choose to relinquish their child describe them as having parents who satisfy more of their needs than do parents of adolescents who keep their child.[24] The former are described as older, with more parental input, of a higher socioeconomic status, and less influenced by their male partners.[25] They are more likely to have been reared in small cities and to have more traditional attitudes toward abortion and family life.[26] Another factor is their ability or inability to receive public funds to raise the child. Funding policies vary from state to state.

The male partners are often very much involved emotionally, if not physically, in the adoption decision. Some of these young men have stated to us:

"I wanted to raise him but I was too irresponsible, too young . . . I should have . . . ."

"It was taken care of . . . she was sent off to a home for unwed mothers. Our parents said, 'so it would not ruin your whole lives.' "

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"I really acted macho through the whole thing, but I was really frightened underneath."

The adolescent woman who chooses to surrender her child for adoption has many difficult decisions ahead of her. First of all, she must decide where to live during her pregnancy. Some young women feel most comfortable staying at home, while others prefer to move in with friends or relatives. In some areas, group homes exist that are designed specifically to be supportive to pregnant young women.

Surrendering mothers must also decide who would best handle the specifics of their adoption. For example, they may turn to a trusted physician, an attorney, or a placing agency to explore the kind of arrangement that would best suit their needs. A more open adoption might include some involvement in choosing the adoptive parents, correspondence, or visitation; while a closed adoption cuts off all future ties.

Some of the more pressing decisions for these young women include the following: whom to bring as a partner to the childbirth classes, whether to remain fully awake during the pregnancy or to receive an anesthetic, whom to bring into the delivery room to offer support, and when to sign the finalization papers. The decisions seem endless and none seems satisfactory. To further complicate the situation, some hospitals continue to room young women who are giving up their babies in the maternity unit alongside elated new mothers and the continual sounds of crying babies.

Female teenagers have described their adoption experience to us as follows:

"I often felt that everyone was concerned about the baby but no one about me."

"After the birth everything was over . . . I was so busy planning for the baby's future I did not plan my own or think about what it would be like when it was over."

Adolescent women are told the pain of adoption will pass. Unlike those in past years,

birth mothers today have more rights and control over the process. Many opt for more open adoptions, which permit them to stay in contact. They want to tell their story and to know that the child will be well cared for. Some feel that adoptive parents will be able to offer the child more, or have been told that by people they trust or who have power over them. Others see the child as too much of an interruption in their busy young lives. It is common for birth mothers to continue to think of the child on birthdays, holidays, and particularly on Mother's Day. On some level the involvement never goes away, it merely decreases in intensity. They wonder if the child will ever be able to forgive them. Some hope for a reunion in later years, while others do not want vivid reminders of the past, of a painful time, and possibly, to them, one of their biggest mistakes.

It is common for the mother of the young teenager to go through a mourning process similar to that of her daughter after she gives up the child. And in many cases, mothers cannot tolerate watching their young daughters in labor, giving birth to a grandchild they will never know.

Parenting

"But you know, after Renee was born, I mean like the very day after she was born, the whole thrill was gone. I went home and felt like cryin'. All of a sudden it hit me: I'm a mother. And I had this little baby to take care of. I guess it's been all right, but it ain't been easy, it ain't been what I thought it would be. I just like the way little babies look. They're so small 'n cute. I really wanted one. I just didn't realize how much they need you. I mean you really got to take care of 'em 'cause they can't take care of themselves. I guess that's what I meant when I said I've learned my lesson. Thinkin' bout havin' a baby 'n even bein' pregnant with one is a whole lot different than actually havin' one 24 hours a day, havin' to feed it, get up when it does in the middle of the night 'n change its diapers. And there's no relief for me. I'm the only one around to do it; at least mostly, that is. That's a reason why I want to be married. A husband could really help out a lot."[27]

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My little boy, eyes so bright
I'll rock you, I'll love you
I'll care for you tonight

But who's going to care for me?
Who's going to set me free?[28]

"After I had Heidi I couldn't believe how my life changed. I couldn't stand just sitting home all the time watching her, so I started going out every night leaving Heidi with my mother, and if my mother wouldn't watch her, I'd drag Heidi along with me. When she was real little she used to get up a lot during the night, and I hated getting woken up. So sometimes I would just let her cry and cry and it would wake everybody in the house up and we'd all be miserable in the morning. Then when she was about nine months old, Heidi got real sick, so sick I had to take her to the hospital. She was in there for almost two weeks. I was so scared that she was going to die because I didn't take care of her the way I should have. That's when I decided I had to grow up and take some responsibility. I decided I'd have to change and not go out partying or running around. I wanted to be a good mother to Heidi, and that meant changing my style completely. I grew up during those two weeks."[29]

Single Parenting

Raising a child alone can be an overwhelmingly difficult task for anyone. Young teens are at an even greater disadvantage because most have little idea of what is involved and few financial resources. Many teens lack the support systems and the emotional maturity and coping skills that are so necessary not only to survive the experience but also to effectively parent the child. Parenting teens have given us a glimpse into their most difficult situation in their own words:

"All I thought about was the good things . . . leaving home, getting out of school and receiving welfare. I never considered how much responsibility was involved. I really had no idea what motherhood was going to be like. I wish I could just run away and begin again—I really do. I would never have a kid until I was much older."

"I wonder what my life would have been like if I had not had a baby and dropped out of school so young."

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"I'm so jealous of my friends who aren't burdened with this responsibility. They don't know how lucky they are. I listen to some of them talking about wanting to have a kid. They would not even think about it if they knew what was involved. I feel like saying to them, 'Take mine for a day,' so they will know what it is really like. I wish I could have had that experience."

Other young mothers have expressed resentment about the father's typical lack of involvement in the child rearing:

"They don't have to take responsibility. We are forced to."

"He won't even take care of her. He's afraid something will happen while I am gone. Somehow he thinks I just instinctively have the ability to care for her better. He hates listening to her cry and just leaves when he wants. He never takes into account that I listen to it all the time. The only difference is that he can come and go as he wishes. It's not fair."

"My boyfriend was the one that wanted me to have the baby. I just assumed that he would share the responsibility both financially and in taking care of him. Not so, he just comes and goes as he pleases."

Young fathers are not without a whole gamut of emotions themselves. These range from feelings of guilt and anxiety to being blamed and pressured to take responsibility for the situation. The young father is typically not popular with the mother's family, aside from pressure on the home front. This is no small burden. We are not offering excuses here—just a realistic assessment of the situation. While the father has a choice in his role, the mother does not.

Many fathers express concern for the mother but feel too overwhelmed, burdened, angry, and confused—feelings that are not conducive to taking appropriate level-headed action. While some fathers become involved and take partial responsibility for the pregnancy and decision making, others flee out of fear. Questions such as "Will she want to marry me?" go through their minds. Plans are postponed or altered. Everything is turned upside

down. Some of the young fathers have expressed themselves to us as follows:

> "Everybody's pressuring me to 'be responsible.' She could have had an abortion. She was the one who decided to keep it, not me. Now she can take care of it."
>
> "I can't stand her being so dependent on me emotionally and the pressure to support them is just too much. I had to leave school and now work full-time. It's hard getting by on minimum wage. This can't go on."
>
> "I think a lot about how stupid I was. Sure, we used to brag in the locker room after the weekend about how far we would get with our date. No one ever thinks about this. It's certainly not considered cool to hang out and feed, diaper, and love a baby."

Counseling services are not as readily available to the young father and, when present, are not always taken advantage of because of a macho image, fear, or a wish not to get too involved.

Considering these stresses, the high rate of child abuse and neglect, as well as suicide among teenage parents, is not too surprising.[30] These young people—burdened with responsibility, meeting another's needs, and at the same time feeling isolated from peers and humiliated by the situation; lacking parenting skills, adequate child care, jobs, and self-confidence—often feel understandably overwhelmed, trapped, and hopeless. Some young parents, however, tell us that their children fulfill a need they have always had. One mother stated, "I am so close to my daughter. We have this real special bond. My life was so empty before." Unfortunately, children whose roles are centered around fulfilling their parents' needs can suffer grave consequences in terms of personality development and a healthy sense of independence.

Rare adolescents can rise to meet the challenge of parenthood. Seemingly undaunted by the many obstacles and demands, they can develop a sense of self-confidence and self-pride they did not possess earlier. In the vast majority of situations, however, this is not the case. We do know that the

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burden can be significantly lightened for the young parent who resides with her family or relatives. Such a living arrangement not only eases the young mother's tremendous financial burden but also decreases her sense of isolation. Another beneficial effect is the child's interaction with several different adults, which aids in his/her emotional and physical development and sense of well-being. For the mother, there may also be the opportunity for continued schooling and an occasional night out with friends—which can be a welcome relief from the strains of full-time motherhood. Nevertheless, these living arrangements are not without complications. Differences can arise between the caretakers about responsibilities and child care, including such matters as discipline, feeding, and toilet training.

Marriage

Another option for pregnant and parenting adolescents is marriage. While some young couples talk about legitimizing the pregnancy for themselves, the child, the family, or relatives, others are caught up in a vision of obtaining a house, raising a child together, and living happily ever after. What is most important is that teens share their expectations and realize that this is a crisis period, a time when clear decisions are rarely made. Adapting to a newborn baby can be difficult enough without also accommodating to and working out a young marriage. For example, the new father can feel resentful about the attention the baby receives, or angry about the heavy expectations. He may secretly harbor feelings of inadequacy, guilt, or regret about the whole situation. Certainly this will affect not only his mood but also his relationship with the baby and his ability to be supportive of his wife. She, on the other hand, may become enraged at the man she married in response to her pregnancy, who in actuality turns out to take little responsibility for the child's care and upbringing. Teenagers who marry

are much more likely to separate or divorce. The stresses are not conducive to a loving, growing, and fulfilling relationship. Statistics are not encouraging. They show that within five years the usual teenage couple becomes disillusioned and divorces.[31] And, "as a result of this pattern, by age eight, 70 percent of children first-born to women at age 17 or younger have spent part of their childhood in a single-parent household."[32]

Foster Care

It is important that young parents keep in mind, especially during periods of stress, that foster care is an option available to them. If in the beginning the teens need more time to make the decision to parent or place the child in foster care—or if after attempting it, parenting feels too overwhelming—a short break might be the solution. Foster care can provide the space to reexamine their internal and external resources and also to realistically assess the long-term effects for all parties involved of keeping or placing the child. Children need consistency; in all fairness, then, foster care should be viewed as a short-term option. The importance of long-term arrangements cannot be overstated.

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CHAPTER 11

You Are Not Alone: Organizational Responses

As we have indicated in earlier chapters, the number of teenage pregnancies is of epidemic proportions, with far-reaching consequences that constitute a serious national problem. A recent conference of the Council of Chief State School Officers and the National Association of State Boards of Education that addressed the issue produced information on funding and a directory of state-level people who are working with pregnant adolescents.[1] Several states have given the problem emergency status, setting up task forces to address it. Regional networking between states is another indication of concern. For example, in response to high mortality and morbidity rates in their states, a group of southern governors has formed a task force to improve prenatal care.[2]

Like many educators in the field, numerous nonprofit organizations have also been aware of the problem for some time. They have published newsletters, developed resources, sponsored conferences, and supported research and program evaluation. This chapter provides a brief description of the work of some of these groups. Their accomplishments are heartening, but much remains to be done. We encourage readers who find this information useful to share it with friends, colleagues, and parents who also may be concerned about the problem.

The Equality Center (220 I Street, NE, Suite 250, Washington, DC 20002) works on civil rights issues within the schools. This group has studied such matters as enforcement policies related to sex, race, and handicappism. For example, Title IX of the Education Amendments of 1972, which prohibits sex discrimination against students and employees in federally assisted education programs, provides a legal basis for ensuring services to pregnant and parenting adolescents. To help educators understand the implications of this legislation, we are including in the Appendix "The Pregnancy and Parenting Provisions of Title IX," which was adapted by the Equality Center from a study by Margaret Dunkle.[3]

The Family Resource Coalition (230 North Michigan Avenue, Suite 1625, Chicago, IL 60601), a North American network of family support programs, publishes a quarterly newsletter summarizing programs, conferences, and resources. The Coalition's positive presentations can serve to counterbalance the potential helplessness experienced by those who work on the problem when they discover its scope.

The Children's Defense Fund (122 C Street, NW, Washington, DC 20001) is involved in many aspects of care and prevention for children. In addition to gathering data, the Fund publishes a newsletter, develops extensive resource materials, and sponsors conferences. A recent conference report on *Preventing Children Having Children* reflects the group's understanding of the problem.[4] A selection from this report appears in the Appendix.

Another element of the CDF prevention focus is the Prenatal Care Campaign, which includes a kit for the use of workers in this area to gather support. The following is a summary of the campaign goals:

First: Prenatal care will save thousands of infant lives and prevent needless birth defects.

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Second: Teens are more likely than adult mothers to have low birthweight babies, to lack prenatal care, and to suffer maternal death.

Third: Prenatal care is an area where we can articulate clear goals and track progress.

Fourth: Currently, the nation is making insufficient progress toward reaching these goals.

Fifth: Prenatal care saves money and lowers infant mortality in the most cost-efficient way.

Sixth: Comprehensive prenatal care is a way to reach teens during the first pregnancy and counsel them in ways to avoid pregnancies.

Seventh: The importance of prenatal care is an issue on which many different people can agree and work.[5]

Another recent CDF publication looks at the effect of tax policies on the poor.[6] *The Impact of Federal Taxes on Poor Families* provides an analysis that is helpful in understanding the effect of economic policies on personal life choices. According to this study, working families with poverty-level wages paid between 9 and 12 percent of their income in combined federal taxes in 1984. Single-parent families carried an even greater tax burden because they receive fewer tax deductions. In other words, increasing taxes on the poor and near poor lessens the money available to families for supporting children. Thus "in this respect the tax policy of the last four years has virtually been a tax on childhood—an antifamily tax policy that mirrors the budget cuts which have also disproportionately hurt children."[7] If the trend to penalize the poor continues, we expect to see even more teenage pregnancies. With fewer opportunities and choices available to help them develop successful identities through jobs and careers, more and more young people will choose the role of parent, regardless of their financial or emotional ability to handle the responsibility.

SIECUS (Sex Information and Education Council of the United States, 80 Fifth Avenue, Suite 801, New York, NY 10011) focuses on

educating educators and parents about sex education. This group publishes resource material that provides information and strategies useful in instituting sex education programs. Current projects include conducting specialized training workshops for Hispanic parents. "Step by Step," an excerpt from the SIECUS book on sex education, appears in the Appendix.[8]

Planned Parenthood Federation of America (Department of Education, 810 Seventh Avenue, New York, NY 10019) develops programs for family planning education, as well as for sexuality and health education. These programs are disseminated by 190 affiliates across the country that provide services and education to their communities, including (1) resources, (2) program designs, and (3) approaches to organizing. For example, "Let's Talk: Campaign for Responsible Parenthood" was designed to begin a communitywide dialogue on the causes of teenage pregnancy. It involved a media campaign using radio, TV, and newspapers. It also used buttons, bumper stickers, and carrier bags containing the campaign logo "Let's Talk." At the same time, local groups received materials to help them organize. These included a movie, a manual, and a discussion guide. The results: over 1,200 adults became involved in some way, and over 500 professionals requested additional information.

The Ford Foundation (320 East 43rd Street, New York, NY 10017) works with community foundations, state agencies, and other funders to support and evaluate 15 teenage pregnancy programs across the country. Seven of the programs focus on services to teenage mothers; the remaining eight focus on the needs of teenage fathers. This research recognizes the importance of exploring and supporting the role and responsibility of the teen father, as well as that of the mother, in the life of their child.

The Teen Father Collaboration (Bank Street College of Education, 610 West 112th Street, New York, NY 10025) explains the clear need for these programs as follows:

- New research about the important role fathers play in the development of their children
- More frequent requests by young parents of both sexes for service programs that include fathers
- The recognition by growing numbers of service providers that programs which isolate young mothers from the support of their partners are far from effective in solving the problems associated with adolescent pregnancy and parenthood.[9]

Teen fathers reported some of the benefits they received from involvement with the Collaboration in the newsletter *Update* as follows: "Getting help has led to less family violence, fewer feelings of social isolation, greater self-esteem, a more active role in their child's life and a sense of hope about their own and their family's future."[10]

Project Redirection (c/o Manpower Demonstration Research Corporation, 3 Park Avenue, New York, NY 10016), for teenage mothers, has as its goal to encourage young participants to take advantage of the necessary health care, and educational, employability training, and family planning services most often available elsewhere in the community, but coordinated to meet each teen's needs. Encouragement is ongoing, personal, and specific. For this reason, the program incorporates two innovative features:

- Each teen is assigned to a community woman, an older volunteer who guides her through the program and acts as a role model.
- The teen, along with her community woman and a program staff member, develops an Individual Participant Plan, a signed contract outlining long-term goals and plans and how to pursue them through the program.[11]

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Program directors report that teens and staff praise the contributions of the community woman, describing her as "the glue that holds the program together."

Adolescent Health Services, St. Paul Maternal and Infant Care (MIC) Project (St. Paul-Ramsey Medical Center, 640 Jackson Street, St. Paul, MN 55101), established in 1973, is an innovative in-school program that services an inner-city area with a large minority population (approximately 40 percent). A summary of its program components appears in the Appendix.

FEED (Facilitative Environments Encouraging Development, Hunter College, Box 20, 695 Park Avenue, New York, NY 10021) is a primary prevention program designed for junior high or middle school students. First, students are taught the basic principles of child care and development; then, they work with both normal and handicapped children in preschools, hospitals, and clinic settings. A description of this program appears in the Appendix.

Afterword

"We have met the enemy, and he is us."
—Pogo

It is irrefutable that schools have enormous potential for initiating action that will both better serve pregnant and parenting adolescents, and seriously reduce the number of unwanted teenage pregnancies. The information, the techniques, and the program models are available. What is lacking is not the way, but the will. Why is that so?

There is, of course, no way of knowing the answer to that question with any certainty. We cannot pretend to understand how each one of thousands of schools determines its policies and procedures. However, after working in schools for many years, and conducting extensive research for this book, we have some ideas about the reasons for hesitancy in the schools. In short, we believe that reluctance to address the consequences of increasing sexual activity is a matter of the heart.

Surveys show that students, parents, and the public, in large majorities, favor sexuality education in the schools. The research data demonstrates conclusively that sexually active teenagers for the most part are both ill-informed and ill-equipped for intercourse. Yet the schools respond with uncharacteristic timidity. Why, then, rather than being proactive—the first on the scene to articulate and address an obvious educational need—have the schools been hesitant, cautious, indifferent, and steadfastly reluctant to focus attention on the issue?

It is our sense that the timidity of the schools stems not so much from the intimidation of the small but passionately vocal minority opposition, nor from any philosophical posture that precludes such educational endeavors, but rather from the more personal reason that teenage sexuality runs counter to firmly held moral convictions.

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The ideal of premarital chastity has deep roots in American culture (notwithstanding the extensive history of teenage fertility in this country). And despite several decades of steadily increasing teenage sexual activity, there is reason to believe that many people, including educators, still think of out-of-wedlock teenage virginity as an ideal norm, viewing exceptions as deviant behavior (less so for males and older teens). To the extent that those values lie in the hearts of the men and women who staff our schools, there is a resistance to addressing the needs of sexually active teens that may be more impervious than all other forms of resistance.

All adolescents need affection, respect, and approval, and to be connected to others in meaningful relationships. More and more, as adolescents are displaced from other roles in the society, teachers are sometimes the only adults available to provide for those needs. Yet our experience has shown that when adolescents are most in need of these reassurances, educators are least able to supply them. In other words, for large numbers of people, including educators, sexually active adolescents have violated such sacred social norms that they have forfeited the positive regard they might otherwise have enjoyed. (This is less true for males than for females.) Consequently, at a time in their lives when these young people desperately need to be treated with respect, dignity, openness, even affection, they are frequently walled off with cold stares, pointing fingers, disapproving countenances, and lectures. This attitude, that is unable to see the child in need because the image of sexual misconduct looms so large, probably has as much to do with these students leaving school as *all other factors combined.* And, since we have no reason to believe that teenage sexual activity will decrease in the foreseeable future, these deeply held personal values have immense significance for future relationships between teachers and students. If pregnant and parenting adolescents are *perceived* as deviants and are therefore deserving of exclusion from regular

school activities, laws and school policies that support these students will have minimum impact. If programmatic consideration for pregnant and parenting adolescents is not forthcoming, or receives a low priority, out of fear that supportive and positive responses serve both to reward deviant behavior and to encourage those who are not yet sexually active to become so, we are denying these students our best efforts.

Finally, we remind all educators of the need to continue making the schools more accessible, more inclusive, and more democratic. And in the case of sexually active adolescents, this may mean refraining from judging them by our own standards, and thereby freeing our natural compassion for the students we serve.

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Appendix

Sampling of Community Networking Services Specifically for Adolescent Pregnancy

Mental Health

a. Backup to guidance counselors for consultation and crisis situations
b. Regular weekly hours for student counseling/therapy appointments
c. In-school group sessions to include young parents support group, sexual identity support group, self-esteem and other related adolescent issues

Resource Library

(In-school or drop-in center organized by community service group or teens)

a. Pamphlets available on issues related to teens (relationships, sexuality, birth control, venereal disease, parenting)
b. Referral notebook listing all community support services

Drop-In Center

(Located near junior and senior high schools, funded by Department of Education, Department of Mental Health, Department of Social Services, or other youth-serving organization

a. Teen hotline/help tapes (24 hours)
b. Peer support/teen outreach component
c. Advocacy/counseling
d. Support groups
e. Special support services to teen fathers
f. Parenting education
g. Transportation

Pregnancy Prevention

(Organized by parents, teachers, service groups)

a. Life-planning workshops
b. Internships/esteemed roles for teens
c. Job training programs
d. Family planning services to include education, birth control, relationship counseling

Pregnancy Intervention	
(Family planning, nurse practitioner, adoption/abortion center; Women, Infants, and Children Feeding Program)	a. Pregnancy testing b. Options counseling and referral c. Nutritional counseling d. Referral to health care provider
Health Care	
(In-school physician, nurse practitioner, health educator hours)	a. General health screening/treatment b. Gynecological care (VD screening and birth control) c. Prenatal counseling/childbirth education
Home Health Care	
(Visiting nurses)	a. Maternal and child health nursing b. Monitoring pregnant and parenting teens and their infants c. Instruction in infant care d. Pre- and postnatal education e. Childbirth education
Parent Aide Program	
(Adolescent-serving agency to coordinate recruiting, training, and supervising volunteers)	a. Support/mentor relationship b. Teaching of parenting skills and child development c. Transportation and aid coordinating these services d. Leisure activities
Financial Assistance	
(Department of Public Welfare)	a. Emergency assistance, general relief, food stamps, ADC, Medicaid, vouchers for classes, GED testing
(Employment and Training)	b. Child care and transportation stipends
(Women, Infants, and Children Supplemental Feeding Program)	c. Food vouchers
Transportation	
	a. Service agencies can reimburse teens for bus fare b. School bus/affiliated agency van c. Stipend provided through employment and training program

Day Care

(Department of Social Services)
(Local day-care program or drop-in center)

a. Local office for children
b. Slots for infants of teen parents at nearby day-care nurseries
c. In-school day-care program
d. Family day care
e. Relative babysitting
f. Protective slots
g. Flexible evening hours
h. Project Head Start

Education

a. Home tutoring following delivery until teen can return to school
b. Support services to permit young parents to remain in school
c. Alternative program
d. Technical school
e. Literacy program
f. Upward Bound
g. Special programs for non-graduates at local community colleges
h. Migrant education program

Employment/Vocational Training

(Division of Employment Security, Employment and Training Program, Job Partnership Training Act, technical schools, job skills training sites, Job Corps, Work Incentive Program)

a. Life planning/career counseling
b. Information on opportunities/programs
c. Internships
d. Summer employment
e. Job placement

Recreation

(YMCA/YWCA, Girl's Club, Boy's Club)

a. Youth after-school program
b. Support services (child care)
c. Specialized exercise programs for pregnant and postpartum teens

APPENDIX

Policy Statement on School-Age Parents*

The Boston School Committee supports the development of a full range of academic and support services programs for school-age parents and parents-to-be in the Boston Public Schools. The School Committee believes that such programs are needed in order to assist and encourage all students to achieve the academic and vocational skills required to reach their maximum potential.

The School Committee encourages school-age parents and parents-to-be to continue their education in the least restrictive setting while receiving health, social service and day-care services. Efforts to maximize their educational participation shall be a cooperative undertaking between the School Department and community agencies providing services to this population. No Boston Public School student shall be systematically excluded from educational participation because of pregnancy. Efforts to serve pregnant teens and young school-age parents shall focus on both students who have dropped out of school and students who are enrolled in the Boston Public Schools. Community agencies shall be made aware of the School Committee policy in an effort to identify those students that have dropped out due to their parenting obligations.

Accordingly, the following guidelines are established:

1. Pregnant students and school-age parents are encouraged to remain in school as long as possible but may be permitted two options: (a) to apply for a leave of absence with the approval of the Headmaster/Principal of the school in which the student is enrolled, or (b) to apply for a limited leave of absence. During the limited Leave, parenting students who initiate and maintain contact with their assigned school and teachers and who meet course requirements for academic achievement shall be marked as "constructively present." It is the responsibility of the student to maintain contact with the school and complete assignments during absence. It is the responsibility of the individual school to offer the opportunity to make up missed work. If a student is in need of home instruction for verifiable medical reasons, it shall be provided.

*Boston School Committee, Boston Public Schools, December 13, 1983.

2. A school-age parent shall be deemed "constructively present" if she cannot attend school on a given day due to the verifiable illness of her child or as a result of pre/postnatal complications. Such verification shall require a doctor's certification.
3. The use of flexible scheduling, including options such as flexible campus and summer/evening school enrollment, shall be encouraged to accommodate the student's parenting responsibilities.
4. The School Department supports existing programs and the establishment of new programs for pregnant students and school-age parents such as competency-based diploma programs, Graduate Equivalency Diploma (GED), external diploma programs, and off-site educational programs such as community-based educational programs.
5. The School Department shall develop and implement a sex education curriculum for all grade levels in accordance with approved policy. The School Department shall institute a family life skills curriculum as part of the science and/or health curriculum. In conjunction with the family life skills curriculum, internship components at day-care centers will be explored.

Attitudes, Motivations, and Behaviors That Affect the Probability of Unintended Pregnancy and Welfare Dependency*

Stage	*Attitudes, Motivations, and Behaviors*
1. Engage in sexual activity	a. No/Low alternatives or future goals b. Ignorance of consequences c. Inability to plan d. Peer pressure, including attracting and keeping partner e. Ignorance of level of peer sexual activity f. Inability to discuss with significant other g. Loneliness h. Low self-esteem i. Bad relationship with parents j. "Pro-love" cultural stimuli k. "Pro-sex" cultural stimuli l. Fun, excitement m. Double standard, sex role stereotyping n. Confirmation of attractiveness o. Support for sex-role identity
2. Contraceptive use	a. Ignorance or lack of cognitive maturity to understand: physiological processes contraceptive techniques consequences of pregnancy probability of pregnancy b. Positive valuation of pregnancy or associated status; adult status c. Fear of parents finding out losing partner talking with partner d. Actual negative side effects of contraceptive use; feared side effects of contraception e. Erratic sexual activity schedule: unexpected sex f. Availability of contraception: cost of contraception g. Denial of sexual activity: guilt h. Ideology (it's not natural: sex should be spontaneous)

*Copyright 1982 by the Urban Institute. Reprinted from Kristin A. Moore and Martha R. Burt, *Private Crisis, Public Cost: Policy Perspectives on Teenage Childbearing* (Washington, D.C.: Urban Institute Press, 1982), Table 13, pp. 137–38).

	i. Risk-taking j. Thoughtlessness: lack of planfulness k. Inconvenience of contracepting l. Fear or embarrassment of physical examination
3. Birth and retention of out-of-wedlock baby	a. Denial of pregnancy b. Unacceptability of abortion to self, family, baby's father, community c. Unacceptability of adoption to self, family, baby's father, community d. Positive valuation of motherhood and having baby e. Good support system for child care f. Baby fulfills (at least temporarily) need for attachment, being needed, purpose in life, loneliness abatement, rivalry with own mother or siblings g. Greater acceptability of nonmarital childbearing h. Welfare availability (for some) i. Bond with baby's father j. Poor performance in other roles (e.g., school failure) k. Acceptance of motherhood is punishment ("you make your bed, now lie in it") l. Adult status m. No/Low understanding of difficulty of parenting
4. Marriage and birth	a. Social/Moral pressure to marry b. Adult status of marriage c. Marriage secures relationship with baby's father, love d. Dependency (can't support self and baby without marriage) e. Same motivations as in (3) f. Already had marriage plans g. Father unemployed, uses drugs, in jail, already married
5. Welfare dependency	a. Low job skills b. Incomplete education c. Subsequent births d. Poor or nonexistent child care e. Poor job training and remedial education programs f. Poor job-search and self-presentation skills g. Lack of jobs that provide wage and fringe benefits for self-support h. Traditional attitudes regarding maternal employment

What Must Be Done About Children Having Children*

by Dorothy I. Height
President, National Council of Negro Women

Teen-age parenthood itself is not new in the Black community. We know from our history that during slavery Black women married in their late teens and had children soon thereafter. Even in the mid-'40s, about four out of ten Black women became mothers before their 20th birthdays; and as we approach the mid-1980s, that figure remains the same.

Why then are increasing numbers of Black leaders and researchers declaring teen-age pregnancy and parenthood so serious a problem? What makes it a disproportionately severe problem for Black America?

The statistical facts have changed dramatically in one area: Today an overwhelming majority of all Black children are born to single teen-age mothers. In 1980, for example, a disproportionate number of births were to non-White mothers. Fifty-seven percent of births to those under 17 were to Black teens, as were a third of births to mothers 15 to 17 years of age. Among these, 36 percent were first births.

In ever-growing numbers, the Black teenagers who have babies never do marry. They head their own households, depend primarily on public assistance and find themselves at age 30 grandmothers to their unwed children's babies. Overall, the picture is not encouraging for the future with Black teens 15 to 17 more than twice as likely as their White counterparts to remain unmarried—93 percent vs. 45 percent, respectively.

The new family pattern emerging today encompasses the young single parent, the children she began bearing in her teens, and her grandchildren. Fewer and fewer of the new mothers turn to the fathers of their children for help. This is tragic but understandable. The young men are rarely in a position to support a young mother and child, with unemployment among male teenagers in the 47 percent range. Thus there is little in place in terms of a positive model of a healthy family for the newest generation to emulate.

Most of the 156,000 Black mothers between 15 and 19 years old live hard, even desperate, lives. But the

*Excerpted from *Ebony*, March 1985, pp. 76, 78, 80, 82, 84.

problems related to teen-age pregnancy go beyond personal tragedy. "It must be regarded as a natural catastrophe in our midst," Eleanor Holmes Norton has said, "a threat to the future of Black people without equal."

The problem of Black teen pregnancy is pervasive and is more complex than simply increased numbers on the welfare rolls. With every single mother struggling alone in poverty, the Black community becomes weaker. We have always known poverty, but we have always found strength in our families. Our tradition of strong, extended families, more than anything else, has helped us cope with poverty and racism. Today we see families breaking down into smaller, poorer units with many young mothers living in isolation. History reminds us that our life tradition as a people was wholly encompassed by our kinships and tribes. Therefore no children and mothers were ever unsheltered and unprotected.

What does it take to break this cycle of feminine poverty? A concerted, multi-dimensional effort is needed to confront and solve the complex problems of children having children. Preventing children from having children must become a major priority for our community and the society. The problem must be faced by all—individuals, families, organizations, as well as churches, which are the backbone of our community. Our community leaders and government must join forces to combat the problem. Equally important is the need to work in earnest to empower our communities in order to awaken our instinctive bonding and affirmation of our extended families.

Proposed solutions must focus on the lack of opportunities available to Black youth. It is a sad commentary that young women say, "At last I am somebody and I have somebody to love me," as they hold a newborn baby, or that young men feel they prove their manhood by fathering children they do not want. And since studies suggest our girls do not so much decide to have babies, as fail to decide not to, we must investigate why their lives are so aimless, and how we can once again help them find meaning, direction and self-esteem.

While I do not believe there is a simple answer or solution to this situation, I do believe there are a few basic steps that all of us can and must take. The first imperative for action is education and that includes enlightened school policies. At-risk youths need special incentives to motivate them to stay in school, and teen parents must be offered realistic opportunities to enable them to return to school. In addition to basic education, teen parents need child care, employment, flexible working hours, counselling and a support system of care and nurturing.

As we strive for economic self-sufficiency, we must continue to press our government for job programs which include training in areas designed to meet the require-

ments of today's labor market. The private sector must be urged to open its doors so that, once trained, these young people will be given jobs commensurate with their training. Our past experience with job programs has led us to conclude that simply to have a "tuition-free" training program is not enough. The expenditures involved in going to school or in job-hunting, such as local travel expenses, cannot become a burden to an already overburdened individual. And when the teen mother is enrolled in a program, she must be provided with child care.

In addition to the above emphasis, we must aggressively develop more effective sex education strategies and challenge society's silence on the result of sexual activity too early in life. There needs to be a hard look at the sex-charged environment in which children grow up. The time is now for all of us to place our money, time and energy where the need is greatest. We must help teenagers understand the risks. Young children need a clear message to delay sex until they are able to deal with all of its consequences.

Much of our success will depend upon our ability to communicate openly with our children through our churches, schools, families and other support systems. Strategic attention must be given the role of the media in shaping a culture that seems so fraught with elements for its own destruction. We must communicate clearly the values which bring better life options to our children and youths. As we do this, it will be necessary to come to grips with the confused messages sent by adults to children. The values of the children have to be examined in tandem with those of adults.

One major effort currently under way involves several organizations working in a collaborative program nationwide to assist local citizens and communities in taking coordinated and informed action on the problem of teen pregnancy. Spearheaded by the Children's Defense Fund, along with national organizations under the umbrella of the National Council of Negro Women, the Association of Leagues, the National Coalition of 100 Black Women, and the March of Dimes, a newly initiated program—Child Watch—is blossoming around the country. The invitation to participate is open to all.

Schools Must Ease the Impact of Teen-Age Pregnancy and Parenthood*

by Margaret C. Dunkle and Susan M. Bailey

The feminization of poverty has become one of the most important and difficult issues in the struggle for sex equity. Women of all ages and children constitute 80 percent of all citizens touched by poverty, according to the League of Women Voters. Teen-age pregnancy and parenting are important predictors of long-term poverty; families headed by young mothers are seven times more likely to be poor than other families, according to the Alan Guttmacher Institute. And the younger the mother was when she had her first child, the lower her annual income. All of these factors add up to a bleak future for teen-age mothers.

Teen-age pregnancy and parenting are not the special problems of any single socioeconomic, geographic, or ethnic group. In fact, close to two-thirds (63 percent) of the more than 200,000 young women under age 18 who gave birth in 1979 were white, according to an Urban Institute study. At the same time, the problems of teen-age pregnancy and parenting disproportionately affect low-income, minority students. More than one in four black babies (compared with one in seven white babies) were born to teen-age mothers in 1979, according to the Children's Defense Fund. Researchers Kristin A. Moore and Martha R. Burt of the Urban Institute have speculated that "one reason for socioeconomic and racial differences in sexual activity and the probability of pregnancy is the differential opportunity structure faced by low-income and minority teen-agers."

Pregnant teen-agers and pre-teens are students in our elementary and secondary schools—that is, until they drop out, as so many do. Forty-one percent of all female students who leave before completing high school do so because of pregnancy and/or marriage, according to the National Center for Education Statistics. These pregnant and parenting teen-agers often begin a cycle of poverty that, unless people and institutions intervene, continues from generation to generation.

It has become increasingly evident that high rates of teen-age pregnancy go hand-in-hand with low educational levels and low job and career expectations. Although the

*Reprinted with permission from *Education Week* 4, no. 8, October 24, 1984.

research in this area is limited, it appears that young women who are highly motivated to go on with their schooling and get jobs are likely to delay sex and pregnancy. Moreover, research by the Urban Institute and others shows that the incidence of pregnancy goes up as the level of education falls, and it goes down as educational levels and employment rates rise. It follows, then, that school actions that encourage low expectations among female students can, in fact, unintentionally encourage early pregnancy.

A teacher who did not allow a pregnant student to make up work missed because of a clinic appointment, a school rule that barred parenting students from school honors (such as the National Honor Society), or a policy of considering pregnancy- or child-related absences as unexcused all could nudge a pregnant or parenting student out of the classroom—and ultimately encourage both rapid repeat pregnancies and long-term economic dependence for young mothers.

The different socialization of girls and boys in our society often subtly encourages teen-age pregnancy and childbirth. Girls are generally taught to place more value on physical attractiveness, marriage, family, and homemaking than on careers and economic independence, even though almost all of them will be in the labor force for most of their lives. If the aspirations, opportunities, and employability of girls can be enhanced, then schools will be providing powerful incentives to prevent teen-age pregnancy and premature parenting. Sex-education courses alone are not sufficient.

High-quality education opens new options for all students. All of us in education need to work to eliminate barriers that channel girls out of the high-quality courses and vocational training that lead to high-paying jobs. We need to help girls get beyond societal stereotypes and make choices based on their abilities, not their sex. This may be the most effective way to prevent teen-age pregnancy in the first place.

Historically, school involvement in issues of teen-age pregnancy and parenting has been passive or punitive. Pregnant teen-agers have been relegated to separate classes and programs if, indeed, they were allowed to stay in school at all. This segregation grew out of a medical model of care, in which the pregnant student (the "patient") is removed from the regular classroom setting and placed in a special program until her baby is born. According to a 1981 study by Gail Zellman of the Rand Corporation, some school administrators regard visibly pregnant students as "morally inferior as well as intellectually and socially disadvantaged."

Considerations of intent aside, however, the medical model stops at exactly the point at which services are needed most—after childbirth, when the teen-ager is faced with new and demanding responsibilities.

A Children's Survival Bill: A Positive Agenda for Children*

Wise investment in children now is sound economic policy in a time of fiscal restraint. Research proves that children's programs that provide services like prenatal care and immunization save us more money than we spend on them. It costs about ten dollars to provide a baby with a series of immunizations, compared to hundreds of thousands of dollars for a lifetime of care for a child with severe disabilities caused by preventable sickness. Every dollar spent on comprehensive prenatal care saves two dollars in health care in the first year of an infant's life alone.

Second, investment in children is an intergenerational compact which protects our future security. Children need help during the eighteen years it takes them to reach adulthood. But today's adults will later turn to these children for support during retirement years. In the future, there will be more elderly people for the nation's economy to support. To protect ourselves in our old age, we must see to it that today's and tomorrow's children grow into productive and compassionate adults, because the security of all of us will come to rest on their shoulders.

But the children of the 1980s are an endangered group. Children are the poorest age group in America. The child poverty rate is at its highest level in twenty years. More than one in five children in this country lives in poverty. One in four preschoolers is poor. Black and white, Hispanic and Asian, millions of children are now suffering the range of problems caused by poverty.

Too many children live in single-parent households. If that parent is a mother under the age of 25, this is almost a guarantee of a lifetime in poverty. These children are four times more likely to be poor than those in two-parent families. In 1983, 73.8 percent of young-single-parent white families and 84.8 percent of young single-parent black families were poor.

Child poverty is also growing because teenage mothers are having children at a rate of half a million a year, and over 50 percent of these young women are single, thus adding another turn to the cycle of poverty. Adolescent pregnancy poses a complex problem for all communities—black, white and Hispanic.

*Reprinted with permission from *Special Report*, Children's Defense Fund, 122 C St., NW, Washington, D.C., 1985.

Many children in traditional two-parent families are poor because their parents are unemployed—still. Despite our economic recovery, there are 5.4 million children with at least one parent unemployed and another 5.4 million children with no parent in the labor force.

But poverty is only one strike against our children's future and that of our nation. Our children are not as healthy as they should be. America ranks seventeenth in the world in keeping infants alive during their first year of life—behind many other industrialized nations. One in three children in America has never seen a dentist.

More children are reported abused each year in state after state. Families are falling apart, forcing children into the already overloaded foster care system.

Millions of children are left alone during the day while parents work at low-paying jobs because decent child care is either unavailable or unaffordable.

Too few adolescents are acquiring adequate skills for gainful employment. As a result, they are missing the opportunity to contribute to themselves or to their country's health and prosperity.

In these times of tight budgetary limits, society cannot afford to pay the high costs of waste and neglect. For example, it costs

- over $12,000 a year to house an inmate in a state prison, and
- over $16,000 a year for institutional care for a foster child.

Society cannot afford these high costs in the best of times, and the federal government most assuredly cannot afford them in the face of the largest budget deficit in history.

Just as prudent and economically sound steps must be taken to deal with the deficit crisis, so must proven, cost-effective steps be taken to rescue children from the crises they face. It is time to invest in our youth before they become ill, are left alone, have a baby, or drop out of school.

The Children's Survival Bill is an important first step toward these goals. It is a sound and balanced deficit reduction package. The Bill invests additional federal resources—about $14 billion—in cost-effective programs known to prevent child abuse and neglect, infant mortality and ill-health, malnutrition, illiteracy, teen pregnancy, despair, and dependency. The Bill proposes to offset these costs and yield a net of more than $25 billion in deficit reduction by eliminating tax loopholes now sheltering wealthy corporations and individuals, by imposing taxes on luxury items, and by eliminating fu[illegible]g for the controversial MX nuclear missile. There are, of c[illegible] a number of additional tax and military proposals that co[illegible] substituted to generate comparable savings.

A section-by-section summary of the new Children's Survival Bill follows. Title I, "Essential Preventive Programs for Children," makes positive investment in children, adolescents, and their families:

- Section 1 helps keep families together through investments in federal programs for troubled children and families.
- Section 2 provides low-income families with affordable, quality child care so that children are not left alone or under inadequate care while their parents work or go to school.
- Section 3 ensures mothers and children access to prenatal care and health services in order to prevent infant mortality, birth defects, and costly childhood sickness and disease.
- Section 4 helps children and adolescents gain the education and skills they need for self-sufficiency in adulthood.
- Section 5 provides children and families with more adequate food and nutrition.
- Section 6 assists children and families most in need with a minimal level of support and opportunity for self-sufficiency.
- Section 7 brings tax fairness to working families in poverty, especially large and single-parent families.
- Section 8 helps adolescents and young adults gain job training and employment at wages that allow for self-sufficiency.

The sections relating most directly to pregnant and parenting adolescents are as follows:

(c) *Extend Aid to Adolescents and Others with Special Needs:* The following provisions recognize the special help adolescents, including teen parents, need in order to support themselves and their families.

(1) *Eliminate Provisions Which Penalize Families Where Minor Parents Reside with Their Parents:* Encourages family stability by repealing the provision that requires the deeming of a grandparent's income to a grandchild for purposes of AFDC eligibility and benefit levels even when the grandparent is not contributing to the child's support. Also repeals a provision that requires the inclusion of all parents and minor siblings, except step siblings and Supplemental Security Income (SSI) recipients, in the AFDC unit. These provisions are particularly detrimental to adolescent mothers attempting to provide adequate care for their young children by residing with parents or other family members, and their elimination will cost approximately $140 million.

(2) *Aid for High School and Vocational School Students 18 and Over:* Encourages graduation from high school and vocational school by requiring states to continue AFDC

benefits to children in school through age 20. This will allow many low-income disadvantaged students to complete their education at a cost of approximately $160 million.

(3) *Aid for Pregnant Women:* Encourages infant health by requiring states to provide AFDC to pregnant women with no other children from the point the pregnancy is medically verified, rather than allowing coverage only from the sixth month. This will make prenatal care more likely and help ensure adequate nutrition and shelter during the pregnancy at a cost of approximately $30 million.

(d) *Two-Parent Families:* The following provisions require that all states implement the AFDC-Unemployed Parent Program and take steps to minimize the negative impact of AFDC requirements for children living with stepparents.

(1) *Coverage of Families Under the AFDC-Unemployed Parent Program:* Helps children in needy families where both parents are unemployed by requiring states to provide assistance, with a state option for revising categorical restrictions that limit coverage. This will help families stay together and ensure family stability at an estimated cost of $1.2 billion.

(2) *Fairer Treatment of Stepparents:* Conforms treatment of stepparent income in determining AFDC eligibility and benefit levels more closely to that of other AFDC family members. Currently some of a stepparent's income must be deemed available to the AFDC unit with which he is residing regardless of his actual contribution or legal obligation to do so. This provision will increase the amount the stepparent is allowed to disregard for his own support, and allows stepparents employed part time—as well as those employed full time—the full $75 work expense deduction applied to other workers in the AFDC unit. The provision is estimated to cost no more than $50 million.

Excerpt from *In a Different Voice**

These are the words of Josie:

> I started feeling real good about being pregnant instead of feeling really bad, because I wasn't looking at the situation realistically. I was looking at it from my own sort of selfish needs, because I was lonely. Things weren't really going good for me, so I was looking at it that I could have a baby that I could take care of or something that was part of me, and that made me feel good. But I wasn't looking at the realistic side, at the responsibility I would have to take on. I came to this decision that I was going to have an abortion because I realized how much responsibility goes with having a child. Like you have to be there; you can't be out of the house all the time, which is one thing I like to do. And I decided that I have to take on responsibility for myself and I have to work out a lot of things.

Describing her former mode of judgment, the wish to have a baby as a way of combating loneliness and making connection, Josie now criticizes that judgment as both "selfish" and "unrealistic." The contradiction between the wish for a baby and the wish for freedom to be "out of the house all the time"—that is, between connection and independence—is resolved in terms of a new priority. As the criterion for judgment shifts, the dilemma assumes a moral dimension, and the conflict between wish and necessity is cast as a disparity between "would" and "should." In this construction the "selfishness" of willful decision is counterposed to the "responsibility" of moral choice:

> What I want to do is have the baby, but what I feel I should do, which is what I need to do, is have an abortion right now, because sometimes what you want isn't right. Sometimes what is necessary comes before what you want, because it might not always lead to the right thing.

Pregnancy itself confirms femininity, as Josie says: "I started feeling really good. Being pregnant, I started feeling like a woman." But the abortion decision becomes for her an opportunity for the adult exercise of responsible choice:

> (How would you describe yourself to yourself?) I am looking at myself differently in the way that I have had a really heavy decision put upon me, and I have really never had too many hard

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> decisions in my life, and I have made it. It has taken some responsibility to do this. I have changed in that way, that I have made a hard decision. And that has been good. Because before, I would not have looked at it realistically, in my opinion. I would have gone by what I wanted to do, and I wanted it, and even if it wasn't right. So I see myself as becoming more mature in ways of making decisions and taking care of myself, doing something for myself. I think it is going to help me in other ways, if I have other decisions to make put upon me, which would take some responsibility. And I would know that I could make them.

In the epiphany of this cognitive reconstruction, the old becomes transformed in the new. The wish to "do something for myself" remains, but the terms of its fulfillment change. For Josie, the abortion decision affirms both femininity and adulthood in its integration of care and responsibility. Morality, says another adolescent, "is the way you think about yourself. Sooner or later you have to make up your mind to start taking care of yourself. Abortion, if you do it for the right reasons, is helping yourself to start over and do different things."

Since this transition signals an enhancement in self-worth, it requires a conception of self that includes the possibility for doing "the right thing," the ability to see in oneself the potential for being good and therefore worthy of social inclusion. When such confidence is seriously in doubt, the transitional issues may be raised, but development is impeded.

The Pregnancy and Parenting Provisions of Title IX*

Title IX of the Education Amendments of 1972 prohibits sex discrimination against students and employees in federally assisted education programs. The key section of Title IX states:

> No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance.

The Title IX regulation, originally issued in 1975, provides strong protections against sex discrimination for pregnant and parenting students. The law prohibits schools from discriminating against pregnant students, whether they are married or unmarried. Also, schools cannot discriminate against a student because of childbirth, false pregnancy, termination of pregnancy or recovery from these conditions.

Important provisions of Title IX regarding *pregnancy* are:

- A school cannot discriminate in admission on the basis of pregnancy, childbirth, termination of pregnancy or recovery.
- Once admitted, a school cannot discriminate against a pregnant student in classes, programs, or extracurricular activities.
- A school must treat pregnancy like it treats other temporary physical disabilities. For example, medical and health plans and insurance policies offered through the school must treat pregnancy like other temporary disabilities in all respects.
- While a school may offer separate classes or activities for pregnant students, it cannot force or coerce pregnant students to participate in these classes: participation must be *completely voluntary* and pregnant students must be permitted to stay in the regular classroom if they so choose.
- Separate programs or classes for pregnant students must be comparable to those available to other students.
- A school can require certification from a physician that a pregnant student is physically and emotionally able to partic-

*Adapted by the Equality Center from *Adolescent Pregnancy and Parenting: Evaluating School Policies and Programs from a Sex Equity Perspective* by Margaret C. Dunkle (Washington, D.C.: Council of Chief State School Officers, 1984). Reprinted with permission.

ipate in classes and other activities *only if* it makes the same requirements of other students with medical conditions.

- A school must grant leave for pregnancy if the pregnant student's doctor says that it is medically necessary. After this leave, the student must be reinstated to the status she had when the leave began.

Regarding *parenting*, Title IX prohibits schools from discriminating on the basis of parental or marital status. Schools may not apply rules concerning a student's actual or potential parental, family or marital status which treat students differently on the basis of sex. A school which denied unwed mothers, but not unwed fathers, participation in school activities (such as the National Honor Society) would violate Title IX. In addition, apparently neutral policies regarding *all* parenting students are likely to disproportionately affect teenage *mothers* (as opposed to teenage fathers) and consequently constitute a Title IX violation.

Other federal and state provisions also provide protections from discrimination on the basis of sex, pregnancy or parenting. Courts have invalidated rules excluding or expelling pregnant students (or unmarried mothers) on constitutional grounds. In 1981 Congress added provisions to federal health and social services block grants prohibiting sex-discriminatory services. Many states also have laws or other provisions which make sex discrimination in the delivery of health services illegal.

All of these provisions provide a strong incentive for schools to change programs and policies which discriminate against pregnant and parenting adolescents. Perhaps most importantly, however, a review of ongoing programs from a sex equity perspective can provide a good opportunity to assess the overall quality and adequacy of services to these students.

Preventing Children Having Children*

MOST TEENAGE MOTHERS MARRY THEIR CHILDREN'S FATHERS EITHER BEFORE OR SHORTLY AFTER THE BABY IS BORN.

NOT ANYMORE. In 1950, one teen birth in seven was to an unwed mother. In 1982, half of all teen births were to single mothers. And marriage rarely occurs shortly after the baby is born. Part of the reason more teen mothers are choosing to raise their children alone is that society is more accepting of unwed mothers today than it was 30 years ago (teens do not make up the majority of unwed mothers, however, two-thirds are women over age 20). In the black community especially, teen mothers aren't marrying because their children's fathers are unable to support a family—only two black teenage males in ten hold a job. Marriage, when it does occur, is a mixed blessing. Teen mothers are twice as likely to separate or divorce than women who marry in their twenties. One-quarter of the women who marry before age 18 are separated from their husbands within five years. They are then left with few options and more children.

THERE ARE NO DISINCENTIVES TO GETTING PREGNANT ANYMORE, YOUNG MOTHERS CAN EVEN STAY TO FINISH SCHOOL.

THEY DON'T. Only 55 percent of the 18- and 19-year-olds who gave birth in 1982 had completed high school. Eighty-three percent of the 17-year-old mothers were without high school diplomas. The earlier the age at which a student becomes a mother, the less likely she will complete her education. Teen mothers now have the right to stay in school, but few have the financial ability or support systems to solve the child care and transportation problems that keep them from attending.

*Reprinted with permission from *Conference Report of the Children's Defense Fund*, Children's Defense Fund, 122 C St., NW, Washington, D.C., 1985.

MOST TEENAGE MOTHERS DECIDE TO BECOME PREGNANT SO THAT THEY CAN COLLECT WELFARE.

NOT TRUE. Almost 90 percent of the pregnancies among unwed teens are unintended. Among those few teens who are married, only half planned their pregnancies. Pregnancies happen because teens do not plan, not because they do. The availability of welfare may influence some young mothers' decisions about setting up their own households, but research has repeatedly shown that teens do not get pregnant in order to receive welfare. There are, as always, the exceptions. But if 16- and 17-year-old girls are finding that their best option is to start a family alone and try to support it on $258 a month, haven't we done something wrong?

Step by Step*

The most effective strategy for "winning the battle" for a new sex education program is anticipation: an active, positive strategy, taking the initiative, being so well prepared, having achieved so much parent/community support in advance, that no real opposition develops. However, should the proposed program—or an ongoing program—come under attack, many of the following steps or processes will be equally useful.

Rather than looking at this list as a blueprint, communities should select and adapt whichever steps meet their needs.

- Create a parents' support committee
- Develop a community support network
- Create a curriculum advisory group, including parents
- Hold a PTA/parents-only meeting, spelling out:
  - Curriculum and materials
  - Qualities, qualifications, and training of teachers
  - Course schedules
  - Written homework assignments
  - Sessions/classes for parents
  - Permission options for parents
  - Parent-teacher complaint committee
  - Plans for reports to parents
  - Post-semester critique
- Cultivate the media
- Define parents' role at public/school board meetings.

*From *Winning the Battle for Sex Education* by Irving R. Dickman. Copyright 1982 by the Sex Information and Education Council of the United States. Reprinted with permission.

Components of an In-School Program*

St. Paul Maternal and Infant Care Project

- HEALTH EDUCATION includes prenatal, parenting, and family life/sexuality education for both junior and senior high school students. There are also support groups for adolescent parenting, parenting an adolescent parent, and chemical dependency. Other components of the program focus on a healthy lifestyle, nutrition and weight counseling, and exercise programs.
- HEALTH CLINIC offers physicals for athletics, work, and college; immunizations; a weight-control program; VD testing and treatment; pap smears; contraceptive information and counseling; and prenatal and postpartum care.
- CONTRACEPTION INFORMATION is provided by an evening adolescent clinic at a nearby medical center.
- EARLY EDUCATION PROGRAM provides educational and vocational experience for students, while providing daycare services for children of teen parents. Young parents must also participate in a child development class for which they receive one credit.
- RESULTS

1976–77	59 births p/1,000
1983–84	26 births p/1,000

- Thus births were reduced by 56 percent.
- The citywide average for 1982 was 62 p/1,000.
- Fewer teen obstetrical complications, a lower incidence of premature births and better infant outcomes.
- Approximately 87 percent of adolescent mothers remain in school or graduate compared to 49.9 percent nationally.
- Conservative estimate of approximately $3,000,000 savings to the community in medical costs and AFDC payments in one year.

*Information provided author in conversation with Adolescent Health Services, St. Paul Maternal and Infant Care (MIC) Project.

FEED (Facilitative Environments Encouraging Development)*

Why Is FEED Needed?

Techniques of child care which enable an infant to develop to its fullest potential are well established in theory, but they are frequently not practiced in everyday life. This denial is a pressing human problem, one which can waste the lives of children and lead to social problems as the children grow up.

Junior high school students are at a point in their development when the decisions they make, experiences they have and self-concepts they form will greatly influence their future lives. The students are eager for something meaningful to do. The ability to think abstractly is growing, but this age group still feels a great need for concrete learning experiences. Particularly important to them is the capacity to handle real-life situations. School work for many students of this age becomes a chore. They complain frequently that this work is "unrelated to their lives." A mastery of practical skills is essential for their self-respect. . . .

FEED is designed to bridge the gap between theory and practice for young adolescents, many of whom encounter child care responsibilities every day and most of whom will have these responsibilities as adults.

What Schools Should Participate in FEED?

FEED programs can be developed in any school of any size that is willing to:

- have students study child development;
- release students during school hours for practicum experiences;
- allocate staff for coordinating student activity at the various sites;
- cooperatively plan and implement the program with professional staff in health care facilities and child care centers.

*Excerpt from *FEED Fact Sheet* (New York: FEED, n.d.). Reprinted with permission.

The following quotations are from students who participated in the program:

"It's not just girl's stuff . . . It takes two, you know, to raise a child, really to have a family, and I think that boys should get a chance to experience it (FEED) too, so they'll know how to work with the child, too."

"I was working with a girl, a little baby. She wasn't one yet, and she was neglected. Her mother had her when she was real young . . . they said you couldn't get her to respond, but when I got finished with her she was responding quite well."

"When I sing to little kids it makes me feel good . . . they act like they really like it."

Excerpt from *Teen Pregnancy: What Is Being Done? A State-by-State Look**

We find unacceptable a million, mostly unwanted, teen pregnancies each year; 500,000 births, more than half to unmarried teens; and, 400,000 abortions.

Not only is it unacceptable, but as this Committee has heard, it is devastating for the vast majority of the teen parents. They will earn less, they will complete fewer years of education, their infants will be at risk, and their early marriages will be more likely to end in divorce.

Such devastation is not necessary. Other countries do much better. And there are currently examples throughout this country of programs that can reduce both the incidence of unwanted pregnancy, and the ensuing consequences. So we know that the private pain and public cost of teen pregnancy need not be inevitable.

The choice is now up to policymakers, at every level. We can expand opportunities for adolescents to participate more fully in society, including the opportunity to gain better control over their own lives by having the necessary information and services to make responsible choices about parenting. And we can give parents of these adolescents the help they are seeking.

Or we can continue to condemn and ignore this national tragedy, allowing it to take its toll on young people and the nation.

This is not to suggest that it is easy to deal with the problems of adolescence, especially those involving sexual activity. As we were told at one of our early hearings:

> Because we give adolescents almost no opportunities for acknowledged competence beyond academics and athletics, and because we fail to invite the contributions they are ready to make to their communities, many adolescents are barred from adult recognition. In so doing, we abandon them to the peer group which, while more often than not supportive and generous, is equally shaky and needy (15).

It is within this often confused, and relatively immature context, that the problems of teen pregnancy must be understood. For many of the teens involved, poverty is also

*A Report of the Select Committee on Children, Youth, and Families, U.S. House of Representatives, 99th Congress, 1st Session, Together with Additional and Minority Views, 1985 (Washington, D.C.: U.S. Government Printing Office, 1986), pp. 354–62, 364–68.

a daily fact of life, and is a further constraint on their opportunities.

That is why we feel so strongly about reaching young people with adequate prevention and intervention efforts. They need, by their age and circumstances, our best and most honest guidance regarding questions of sexual behavior, pregnancy, and parenthood.

We believe we can do better by focusing much more on preventing unwanted teen pregnancies. Those who are concerned about the issue of adolescent pregnancy and parenthood agree that preventing teenage pregnancy is a priority.

We know contraception works. We know sex education can make a real contribution. We know comprehensive health care is essential. And we know there are emerging prevention models, like school-based clinics, that have already shown enormous potential.

This Report makes all too clear that these proven and promising preventive approaches are everywhere too few, under-emphasized, and uncoordinated.

We can be certain what will happen if we continue along this path.

We will see hundreds of thousands more teen parents each year, looking at a future of almost certain poverty.

We will see their infants, from the outset, at much great risk of mortality and morbidity. We will watch these families struggle to overcome great odds. We will see their children perform less well than others in school, increasing the likelihood that they too will drop out of school, beginning a repeat of the same high-risk cycle.

In addition to the private tragedy of teen pregnancy, this Report confirms the astounding costs of teen pregnancy. Literally tens-of-billions of public and private dollars are spent each year caring for the basic needs of these infants, and their parents.

Persistence and Magnitude of Teen Pregnancy Causes Parents to Seek Help

During the 1970s, millions more teenagers became sexually active, and at younger ages. In the 1980s, this increase has slowed and may even be reversing (9). The pregnancy rate among teens has followed a similar pattern—with an increase in the 1970s and considerable slowing of the increase since 1980 (5).

We are heartened that these trends may be turning around.

But the fact remains that too many teenagers become pregnant or bear children when they are not ready or able to shoulder the emotional, physical, or fiscal responsibil-

ities of being parents. In 1982 (the most recent year for which comparable information is available), 1,110,287 young women through age 19 became pregnant, and 523,531 gave birth (1). Of those who gave birth, 51 percent were unmarried (8).

These persistent trends have greatly affected public attitudes regarding adolescent behavior and parents' roles.

As evidenced in a recent Lou Harris poll, many more parents are now talking with their children about sex, but the topic of birth control is not often included in those conversations.

Parents admit they need help now, and overwhelmingly support sex education in schools. They believe eliminating such education would lead to more teen pregnancies. Also, a two-to-one majority of adults favor public schools linking up with family planning clinics, so that teens can learn about contraceptives and obtain them (10).

Contraception Is Effective Prevention

While contraception alone cannot solve the problem of teenage pregnancy, contraception has had a significant impact on averting unwanted pregnancies and births.

According to one study, absent the use of contraceptives, in 1976 there would have been 680,000 additional pregnancies among unmarried sexually active 15-19 year olds. A separate analysis showed that enrollment by teens in family planning clinics averted 119,000 births and an estimated 331,000 pregnancies in 1976. Combining these two findings, it appears that family planning programs were responsible for half of the averted unintended pregnancies in 1976 (14).

We also know that, contrary to what many believe, teens can be effective contraceptive users. In other countries where the rate of sexual activity is as high as in the United States, the teen pregnancy rate is significantly lower. In the Netherlands, Sweden, France, Canada, and England and Wales, contraceptive services and sex education are more readily available and teens use contraceptives consistently and effectively (6). Even in the United States in 1982, teenagers aged 15-19 had the highest annual visitation rate to all sources of family planning services (private, clinics, and counselors) than all other age groups (9).

The evidence shows plainly, though, that teens are likely to become pregnant during the first six months of sexual activity—the time period when they are delaying contraceptive use. The fact is that too many teens do not use a contraceptive at first intercourse (more than 75 percent of teens under age 15; 59 percent of 15-17 year olds; and 45 percent of 18-19 year olds), and delay seeking contraception for six months to two years, depending on their age (2).

Studies have found that teenagers delay seeking contraception for the following reasons: (1) belief that time of month was low risk; (2) their youth; (3) infrequent sex; (4) general belief they could not get pregnant; and (5) difficulty in obtaining contraceptives (2).

Thus, while contraception can be effective, it is too frequently unavailable or unused when sexual activity begins.

Sex Education Can Help Reduce Teen Pregnancy

We realize that sex education remains a controversial topic. Many have questioned whether schools are a proper place for sex education. Others have questioned the effectiveness of such efforts in influencing rates of sexual activity, contraceptive use, and pregnancy and birth rates.

We believe, however, that many types of sex education can contribute to reducing teen pregnancy. Studies show that sex education leads neither to higher levels of teenage pregnancy nor to greater sexual activity (7). In fact, a 1982 study found that teenagers who received sex education were more likely to use some method of birth control. One study combining data from 1976 and 1979 found a lower pregnancy rate among females who had received sexuality education than among those who had not (7).

Another recent study, which examined the association between sex education and adolescent sexual behavior, showed that 15-16 year old adolescents who had taken a course in sex education were less likely to be sexually experienced. This study also showed that parental roles are supplemented, not undermined, by sex education programs (4).

More Family Planning Sought by States

The family planning program is the major source of prevention services to adolescents. An estimated 34 percent of those served are women under the age of 20.

Although controversial to some, according to our survey, states view family planning as very effective. Several states noted that this program assists in the provision of services to teens and encourages greater family involvement. Ten states recommended increasing the availability and accessibility of family planning services.

School-based Education/Clinic Services Are Even More Effective

Recent research, using more sophisticated methodology, has also shown that when education is combined with clinic services at an accessible location, teen pregnancy is reduced.

In this research study, nine different prevention programs were evaluated and compared for relative effectiveness[1]. While most programs increased knowledge among teens, no program significantly increased or decreased rates of sexual intercourse. None of the non-clinic programs had a significant impact upon reported use of different methods of birth control. *Only the education/clinic approach increased the use of birth control and substantially reduced the number of births. It also increased the proportion of pregnant adolescents who remained in school, and decreased the number of repeat pregnancies among them* (7).

This study was based upon the comprehensive high school-based clinic program in St. Paul, Minnesota, which the Select Committee visited in 1983, and *corroborates the earlier information given to the Committee showing a 56 percent reduction in the fertility rate. Since our visit the program has been expanded and has shown consistent results.*

Another particularly noteworthy education/clinic program begun in 1981 in two Baltimore schools reduced pregnancy rates among sexually active adolescent females, while overall teenage pregnancy rates in Baltimore were on the rise. Services provided included sexuality education, counseling, and referral for contraceptives (11).

Mounting evidence suggests that low self-esteem and poor prospects for the future, including too few academic or employment opportunities, may contribute to a teenager's decison to have a child (3, 12, 13).

School-based clinics, by providing a range of services to adolescents, can detect other health, academic, social and family problems that may contribute to low self-esteem and lowered prospects for future self-sufficiency. For example, during the first three months of operation, seventy-five percent of the visits to DuSable High School's clinic were unrelated to family planning. They revealed previously undetected health and emotional problems that were amenable to treatment (17). Similar information has emerged from clinics in Dallas, Kansas City and St. Paul.

In St. Paul, more than 60 percent of the clinic visits were for services unrelated to family planning or pregnancy, including child abuse, mental health problems, financial problems and weight control. Treatment of minor and acute illness, and preventive health care accounted for more than one-third of all the visits (16).

[1] Programs selected: (1) A comprehensive, semester-long course for juniors and seniors; (2) A one-year course for juniors and a semester seminar for seniors; (3) A one-year freshman course and a semester course and a semester-long junior/senior seminar; (4) An integrated K–12 program; (5) A five-session course in schools, including a parent/child program; (6) A six-session course in schools, including a peer education program; (7) A 10–16 session course for youth groups; (8) An all-day conference; (9) A high school education/clinic program.

Part of the success of comprehensive school-based clinics is due to their broad base of support in the community. Each program draws together parents and students, schools and health agencies, churches and social service providers, and governmental and private resources. And each program organizes its services to fit the environment, facilities, and concerns of the teenagers it is designed to serve. . . .

Conclusion

It is not enough to lament the problem of unwanted teen pregnancy and parenting, or to chastise its victims.

Everyone regrets the number of unwanted pregnancies and births to teens, the abortions, and the lack of services to those who become teen parents and their infants.

Everyone agrees that, for the majority of these teens and their children, life will be much more difficult than it is for others.

What is important is to start building on the base of knowledge that we have about our teenage population, and on the information we have about coping with a wide range of problems that affect teens in America.

This effort must begin by seriously dealing with what may be the single most devastating event in a young adolescent's life—an unwanted teenage pregnancy.

To take seriously our responsibilities as parents, providers and policymakers, we have an obligation to provide better, more consistent, and more honest guidance and opportunities for teens than we have.

We believe that this Report provides more than enough evidence to suggest that very great progress can be made. Some states and communities have begun to take up the challenge. The state and local innovations identified in this report should serve as models in this important effort.

They cannot do it alone. Without a great effort on our part, the crisis-oriented, uncoordinated, and piecemeal efforts which states have described to us as totally inadequate will continue.

It is our hope that this Report will galvanize a more concentrated commitment to America's adolescents from both public and private talent and resources.

—George Miller, Chairman; William Lehman; Patricia Schroeder; Matthew F. McHugh; Ted Weiss; Beryl Anthony, Jr.; Barbara Boxer; Sander M. Levin; Bruce A. Morrison; J. Roy Rowland; Gerry Sikorski; Alan Wheat; Matthew G. Martinez; Lane Evans; Hamilton Fish, Jr.; Nancy L. Johnson

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Teenage Pregnancy and the Press*

Steps to Cut Teen Pregnancies

Maryland has the nation's fourth highest percentage of births to unmarried teens. Baltimore is No. 1 in teenage births in cities of its size. Grim statistics. A new study, by the Governor's Task Force on Teen Pregnancy headed by University of Maryland chancellor John Slaughter, has sounded a clarion call for new approaches. Some of its recommendations are worth repeating here:

- Redrafting child-support laws to reflect "grandparental responsibility." Parents who are themselves children have little ability to provide for babies, or to properly care for them without help from their own parents. Thus, the task force calls for vigorous moves by state agencies to determine paternity, for denying independent welfare grants to minor parents and for shifting the financial-support responsibility to the teenagers' parents. Also urged are new social-service policies to keep teen mothers and fathers in their parental homes.

- Redirecting educational, health-care, and social-services policies to keep young people in school. "Educational opportunity is a major factor in the prevention of teen pregnancy and in the support of parenting teens and their children," the report said, both because poor school performance erodes the "healthy self-concept and self-esteem which are the first lines of defense against unwise irresponsible sexual behavior," and because education is the key to the job opportunities and life options" which motivate teens to avoid the risk of pregnancies.

Moreover, teen parents need extra help to build skills and win jobs so that they can provide for their offspring. The report calls for "bold new approaches" in public-private partnerships to provide that job training for teen mothers and fathers and for comprehensive, school-based health care to make sure teen mothers get good prenatal care.

*The Baltimore Sun, November 9, 1985. Reprinted with permission of The Baltimore Sun.

The statistics are grim, the task force concluded, but the future does not have to be. Instead of merely lamenting the facts, the report transcends "complexity and difficulty to convey the message that opportunities exist for Maryland to find solutions to this problem," and to "take the lead and provide a model for the prevention of teen pregnancy. . . ." Amen to that. The task force has proposed some bold steps that many people will find unpalatable. The alternative, continuing as before, will result in a bigger mess than now exists. So it's time for the people of Maryland to get cracking on the solutions.

Public Schools Strive to
Keep Teenage Mothers in Classroom*

by Jean Davidson

When Farragut High School senior Jeanette Thomas heads for U.S. history class, her 5-year-old son goes to preschool in a nearby classroom, along with the children of other Farragut students.

"I like having him here so I can visit during my free periods," said Thomas, who also has a 2-year-old daughter. "We really need the day care because so many kids are having babies."

Pregnant girls and teenage mothers can be found in most Chicago public high school classrooms and, increasingly, behind grammar school desks as well.

Circumscribed though their futures may be, those who return to the classroom and graduate from high school are the lucky ones. An estimated half of all pregnant girls in Chicago drop out of school, sending themselves and often their offspring into a cycle of failure, dependence and poverty.

Farragut preschool teacher Jan Simmons, who lovingly refers to her 25 charges as "my babies," laments that many will never overcome the physical and intellectual deprivation of their home environments.

"Some of the 3-year-olds are functioning at an 18-month level. They use grunts and nods instead of verbalizing their needs because no one requires them to say 'Yes' or 'No' or 'Can I please have a glass of water?' If they have follow-up, perhaps half of these kids will do well. But even the worst among them will probably surpass the ones who didn't have the good fortune to come here."

Chicago public school nurses reported 2,937 student pregnancies from last September to May 31. About 70 of Farragut's 1,000 female students become mothers each year, a figure dwarfed by the birth rate at Du Sable High School, one of the highest in the city. About 200 of Du Sable's 900 girls bear children annually.

The preschool at Farragut, 2349 S. Christiana Ave., is one of several Chicago school programs designed to discourage student pregnancies, keep mothers in school and give their babies a head start on learning. Like the city's first public school day care center for the children of students,

established three years ago at Crane High School, 2245 W. Jackson Blvd., Farragut's preschool doubles as a laboratory for child care classes.

Other efforts to aid inner-city girls include a privately funded clinic offering prenatal care, medical exams and birth control counseling at Austin High School, 231 N. Pine Ave., and a clinic that also will dispense birth control to students at Du Sable, 4936 S. Wabash Ave., when it opens this summer. In addition, an intensive sex education program has targeted four elementary schools in communities where the numbers of teenage mothers are large.

Though the percentage of teenagers among all Chicago females to give birth declined to 19.6 percent in 1983 from a peak of almost 25 percent in 1973, the mothers are getting younger.

Of 10,648 infants born in 1983 to mothers under age 20 in Chicago, 328 were born to girls 14 or younger. The youngest mother receiving state Aid to Families with Dependent Childern is 9.

"It's not just 15- and 16-year-olds," said school board member William Farrow. "Some are still babies themselves. They've built themselves a dead end. And pity their children. Chances are they will emulate their mothers and perpetuate something that should not be."

As with many social ills, the problems of teenage pregnancy are concentrated among poor and minority youth, who have limited access to birth control and perceive even fewer life opportunities.

Though ignorance about birth control and peer pressure, low self-esteem, yearning for love and the influence of sexual messages in the media often are blamed for youth pregnancies many think the underlying problem is the lack of incentive not to get pregnant.

"If somebody is doing well in her academic life and is headed for a decent job, she is much less likely to put her life up for grabs by having a child at 16," said Jennifer Knauss, executive director of the Illinois Caucus on Teenage Pregnancy, a coalition of churches and youth service agencies.

"But if you don't have that hope, bearing a child may be the only mark of adulthood you can look forward to."

Patricia, a giggling, fresh-faced girl of 15, said she had planned to delay motherhood another year, but just couldn't wait. The Farragut sophomore, expecting her first child in September, said her favorite pastimes are listening to the radio and playing hide and seek and tag.

"I just want my baby to be here so I can play with it," she said, tugging at her maternity blouse. "I guess there might be times when there isn't enough food or money. But it will be okay."

At Harper High School, 6520 S. Wood St., as many as one-fourth of the 600 female students are mothers. "It's more the rule than the exception," said Assistant Principal Sandra Lollie. "If you don't have a child, you are questioned."

One 17-year-old Harper student with a 10-month-old son said she deliberately got pregnant to rebel against the warnings of her mother who bore her first child at 15 and did not want her daughter to repeat the pattern.

"I wanted to get back at her," the girl said. "I ain't going to let her tell me what to do."

Teachers, school nurses, principals and social workers despair over so many girls' passive acceptance of the events that dramatically alter their lives. Some sexually active youngsters hold an "it won't happen to me" attitude about pregnancy and then reject abortion or adoption as alternatives to motherhood. If they see their lives as limited as a result, many do not admit it.

"They act like they don't have any control over their own lives. They act like pregnancy is something that just happens to them," said Mary Holyk, a social worker at the Chicago Comprehensive Care Center who works at Tubman Alternative High School, 4607 S. Greenwood Ave.

Tubman, which serves 268 students ages 12 to 20, is one of four Chicago public schools for expectant mothers.

"There is very little realistic future planning," said Denise Williams, another Tubman counselor. "I've had several tell me, 'I want to be a lawyer.' They're getting D's in school. They have no conception of what it takes."

Jeanette Thomas, who quit classes for a year after the birth of her son, bucked the odds when she returned to Farragut. Now 20, she will graduate in June.

"I didn't really want a baby," Thomas said. 'It's like something happening to you that you don't know nothing about."

Many young mothers were born to teenagers themselves, joining what one Chicago principal calls "the 15-year cycle." Sometimes, even less than 15 years separates the generations.

"We're seeing rapid cycles of children having children, and these quick generations are becoming an underclass of destitute people," Knauss said.

"There are grandmothers who are 27 or 28. Nobody has any sense of what will happen when the children who are raised and socialized by teenagers become adults. There is a real danger they could form a permanent underclass."

In Chicago, about 70 percent of unmarried teenage mothers are black. The highest teenage birth rates are

in the impoverished communities of Austin, where 643 infants, or 25 percent of all community births, were to young mothers in 1983; Grand Boulevard, where 408 children, or 37 percent of all births, were to young mothers; and Englewood, where 445 infants, or 36 percent of the births, were to young mothers.

Youth and poverty also contribute to an infant death rate of 25 out of every 1,000 live births to Chicago mothers under 15, almost twice the mortality rate for the babies of older mothers, according to the Illinois Department of Public Health.

Teenagers, less prepared to cope with the frustrations and restrictions of motherhood, also are more likely to abuse or neglect their children, experts say. Of 12,000 cases under investigation by the Illinois Department of Children and Family Services, 2,500 involved mothers who bore children as teenagers.

Farragut home economics chairman Cecilia Morton, who won a $1,000 teacher incentive grant that helped establish the school's day care center, thinks parenting classes should be mandatory for all Chicago public school students.

"The chance of abuse occurring is much greater if they don't understand what to expect from this cute little baby," she said. "These girls need to have positive goals in life besides motherhood. If they come back to school after their babies are born, sometimes it's not too late."

Teen-age Pregnancy*

Altered Dreams and New Realities

by Marilyn Gardner
Staff writer of *The Christian Science Monitor*

When school buses arrive at the Lincoln Downtown Educational Center here every weekday morning, not all the young passengers are students. As the doors open, several teen-age girls lift infants out of car seats, hoist diaper bags and book bags, and head for a first-floor day-care center in the school.

In this former classroom, now filled with cribs and changing tables, the young mothers chat briefly with their babies' caregivers. Then they climb two flights of stairs to begin their own day as students at the Lady Pitts Center, a public school for pregnant girls, most of whom are single.

Diaper bags and book bags—the two objects stand as symbols of one of the most complex social issues in America today: teen-age pregnancy. With 1 million teen pregnancies a year and more than half a million births to teen-agers, the United States leads every country in the Western world. Here in Milwaukee nearly 30 percent of black babies are born to teen-agers—the highest rate in the nation. These statistics take on a sobering realism at the Lady Pitts Center as 350 girls a year in Grades 6-12 gather for classes each day. The youngest is 12, the oldest 19. As they meet in the halls between classes and stop at the office with questions and problems, the students form a microcosm illustrating the challenges and altered dreams that early motherhood brings.

"I'm the only girl in the family, and my father wanted me to be somebody," says 16-year-old Theresa, one of six students who agreed to be interviewed on the condition that real names not be used. "Being a doctor has always been a childhood goal and a fantasy of mine. Before I got pregnant my father was just a lot of support, and so was my mother. They had college funds and everything. I'm not saying this is going to stop me, but. . ." Her voice trails off.

"When I take on this responsibility, I know there are certain things I won't be able to get, like clothes," adds Yolanda, a 16-year-old whose baby is due this month. "If I

want to spend money, I just look down at my stomach and I say, Nope."

For these six girls, an unplanned pregnancy was largely the result of a haphazard approach to contraception. Although one 14-year-old became pregnant during her first sexual encounter ("my boyfriend's scared of birth control"), four took birth-control pills briefly, then stopped.

"My girls are not ignorant about contraception," says Peggy Clapp, assistant principal at Lady Pitts. "But when some of them were talking to me the other day they said, 'We got ourselves into this predicament way before we ever learned how to talk to the guy and discuss this thing.' The girls were too shy. They weren't going to talk about somebody getting pregnant or not getting pregnant, and somebody using something or not using something."

Part of that shyness may also stem from ignorance. Although all received sex education in school, many of their questions remained unanswered.

"My mother isn't the type of person who would talk about things like that," says 16-year-old Tracy, "but you hear about it from friends."

A lack of full and accurate information about reproduction is only part of the problem, of course. In her work with 3,500 pregnant teens over a 10-year period at Lady Pitts, Miss Clapp has observed other subtle pressures and recurring patterns:

"Sometimes girls think, 'My sister was pregnant, and I m going to get pregnant too. She got clothes, she didn't have to do certain things, she got special foods, so I'm going to do the same thing.' You see it going right straight down in the family.

"You also may see the grandmother-to-be pregnant as well as the daughter. They're sort of competing. My youngest grandmother has been 28. If they were 15 when they had their first child, maybe they're 30 now. The average probably is in her mid-30's, maybe late-30s."

Noting that a dozen students are in their second pregnancy, Miss Clapp says, "The younger ones' parents take over the babies because the girls are children themselves. But the more they take it over, the more the girl is likely to go out and have another one and say, 'This one is going to be mine.' The older girls also have outside pressure, because the guy will say, 'If you could have a baby by him, you can have a baby by me.' "

Still, these situations cannot explain the deeper causes of teen-age pregnancy. Miss Clapp places much of the blame on the larger community.

"Where in society did we go wrong that we're not giving these kids goals of achievement?" she asks. "They need a feeling that 'Hey, there's something out there

that I'm going to do — I've got to spend my time accomplishing and achieving something, not producing a child.'

"They're not getting a sense of self-worth," she continues. "There are no clubs to speak of in high school anymore. They can't find their little niche. What is there for these girls to do, and what is there for them to go home to?"

To help students find a purpose and greater self-esteem, the school emphasizes the importance of education. It also offers courses in child development, as well as career and vocational planning.

"Last year I wanted to go to school, but it didn't really excite me," Jacqueline says. "This year I feel like I have to go. I need all the education I can get to support my baby. I have to get a job. It ain't just me in this battle anymore."

Adds Theresa, "After I got pregnant, at first I was discouraged. Then I came here, and you hear from some of the teachers that it might be hard, but whoever said that life would be easy? I'm willing to try. There's opportunities out there."

That kind of determination surfaces often in this little group as students talk about their desire to become independent.

"I think your parents should help you a little bit, but I think your boyfriend should help the most," says Anita, 15. "Sometimes parents help too much. They say, 'You bring the baby home, I'll take care of it, you do whatever you want to.' That's not right. You should do most of the stuff because it's your baby."

Similarly, they reject the idea of long-term dependence on welfare.

"I'd rather work," Yolanda says. "It's nice to get that welfare money to help you out at first when you ain't got nothing, but then when you find something you can do on your own it's better to go for it. You might get less money, but you'll take better care of the money that you make honestly than money someone has given you."

Still, for all their hope and youthful optimism, the girls face enormous challenges. By law, they must leave Lady Pitts at the end of the year, and many drop out after returning to their regular school.

Speaking of the sadness she feels when she hears about these failures, Miss Clapp says, "We felt we helped them so much. We hoped and we prayed that everything was going to be the best it could, even though we'd like to be able to do more. They're just caught up in such a dreadful situation. They may be doing much better than they ever anticipated being able to do, but we had dreams bigger than they could dream."

What will it take to fulfill more of those

dreams and lower the teen-age birthrate?

"I truly believe we have to start with the infants," Miss Clapp says. "It's going to be their generation. To effect a turnaround we have to work with them all the way from infancy on. Sort of like Head Start, but bring it down even younger, so they don't get the pattern of having inferior feelings immediately.

"You also have to work with the teen mother to have her realize she's got to get an education, get some career and vocational planning. Let her know she's a worthwhile person. She made a mistake, but she must not take it out on herself and her child.

"And teen fathers, even though we're not able to do much with them, have to have the same type of exposure," she continues. "Because if you were to find them, they would also be dropouts from school and dropouts from work. In many instances they're waiting for the girl to go on welfare so they can take the benefit of her welfare payments."

Finally, Miss Clapp says, "Parents must be role models. Moms cannot say, 'Daughters, I don't want you having your boyfriends in the bedroom,' when it's OK for Mom to bring her boyfriend into the bedroom, or Dad to bring his girlfriend into the bedroom. And that's where a lot of them are coming from in single-parent families."

Just before the bell rings and the girls leave for their next class, they consider one last question: What advice would they give to a younger sister?

"Tell her about the consequences, things you have to stop doing, things you can't do no more," says Jacqueline.

Others nod their heads, and Theresa says, "I told my stepfather's daughter, 'You don't want to get pregnant. I'm not asking if you are sexually active, but if you are, I'm just letting you know that I'm sure you're not ready for the responsibility. I'm two years older than you, and I wasn't ready to accept the responsibility when I first found out.'

"I told her, 'Don't be scared to talk to somebody. Because that's what happened to me — I was scared to talk to my mother. If you want any advice come to me. Just don't get pregnant.' "

Harris Poll Reveals Americans' Strong Desire for Solution to Teen Pregnancy Problem*

NEW YORK CITY, November 4, 1985—An overwhelming majority of Americans are seriously concerned about the problem of teenage pregnancy and largely agree on the solutions to that problem, according to the results of a nationwide poll conducted by Louis Harris & Associates for Planned Parenthood Federation of America (PPFA).

The Planned Parenthood Poll measured public opinion about solving the teen pregnancy problem; the way television treats sexual matters, including messages about birth control; support for international family planning programs; and abortion. Telephone interviewers called 2,500 homes nationwide during August and September 1985.

"We are heartened by the level of support we have for the programs we are advocating to solve the teen pregnancy problem," said Faye Wattleton, president of PPFA. "The fact that 84 percent of adults now recognize this to be the serious problem it is, and, in response to open-ended questions, say that parents can help by increasing open communication about sex and birth control, proves our message is getting across.

"While more parents are talking with their children, though, few report that they are discussing birth control," Ms. Wattleton said. "This indicates parents have difficulty is undertaking this aspect of sexuality education and maps a strategy for Planned Parenthood to expand its efforts in this area," she said.

Most Planned Parenthood affiliates already conduct programs designed to strengthen parent-child communications, including workshops, teen theater groups, and sponsorship of October as National Family Sexuality Education Month.

Perhaps because parents are reluctant to talk with their children about such sensitive subjects, most people look to the schools and television to do the job, according to Humphrey Taylor, president of the Harris polling firm. "Fully 78 percent of the American public would like to see messages about birth control on TV, and 85 percent want sex education offered in the public schools. By an overwhelming 2-1 majority, 67 percent of Americans favor laws requiring public schools to establish links with family planning clinics so that teenagers can learn about contraceptives and obtain them."

*Excerpt from News Release of Planned Parenthood Federation of America, Inc. Reprinted with permission.

School Health-Clinic Movement
Is Spreading Across the Nation*

Opponents Fear Centers Will Spur Teen-Age Sexual Activity

by Jay Mathews

LOS ANGELES, Dec. 6—A movement to place health and birth control clinics in public schools, introduced in a few midwestern cities in the mid-1970s, has begun to spread nationwide in the wake of rising concern over teen-age pregnancies.

Despite vehement opposition from those who fear that the clinics will encourage sexual activity among teen-agers, the facilities have been set up in 35 schools across the country and 75 more are planned. Last month, Los Angeles became the largest U.S. city to approve a pilot clinic after a report that high school pregnancy rates dropped 64 percent in the first three years of a similar program in St. Paul, Minn.

Like controversial rules requiring passing grades to participate in high school athletics, the school-based health-clinic movement appears to be an example of experimental social programs born in communities far from Washington but converging on the nation's capital. A public hearing is scheduled Wednesday to consider placing such a clinic at Washington's Anacostia High School, and some suburban Washington communities are expressing interest, Planned Parenthood officials said.

The clinics have been established independently by various private groups and funded by a mix of public and private funds. Most of the clinics have been set up in schools serving low-income, usually predominantly black neighborhoods where teen-age pregnancy rates are highest. Most clinics require parental consent before distributing birth-control devices. Organizers say parents have offered little or no resistance and some support.

"We have allowed six months [illegible] year for community development before we set up a c[illegible]," said Jennifer Young, associate director of Kansas City's Adolescent Resources Corp. "We do not assume the community wants the service until we ask them."

Judith Senderowitz, executive director of the Washington-based Center for Population Options, emphasized that the clinics are designed not only to provide birth control

information and devices but to offer broad-based health care to children whose families cannot afford doctors.

"By and large, the communities that have developed this have done it without much contact with each other," she said. Her private non-profit group added a unit, the Support Center for School-based Clinics, in April to help coordinate efforts to establish clinics in more cities.

Patrick Fagan, director of the antiabortion Child and Family Protection Institute in Washington, denounced the movement as part of a national effort to "win acceptance of teen sexual behavior." Given the clinic movement's improving organizational techniques, "I think this whole issue is the most serious fight that we will have on our hands for years to come," he said.

Lou Sheldon, California state chairman of an Anaheim-based organization called Traditional Values, opposed the Los Angeles pilot clinic as a "demolition of parental rights." He warned that students would forge their parents' signatures on consent forms. It would be better, he said, to try to encourage abstinence by noting the diseases that can be transmitted sexually.

Senderowitz said the health-clinic movement had "practically no" opposition until a controversy erupted in Chicago this year over a new clinic at DuSable High School. An article in the Rupert Murdoch-owned Chicago Sun-Times about the clinic was headlined "The Pill Goes to School," Senderowitz said. The resulting dispute led the school board to reconsider and approve, by a much narrower margin, its original decision to allow the clinic.

The publicity surrounding the Chicago opposition led to the proposal for a clinic here. Los Angeles school board member Jackie Goldberg had taught for years in low-income area high schools with high pregnancy rates. She saw a television report on the Chicago controversy and concluded that a similar program would work here.

Board member Roberta Weintraub, an anti-busing activist who often differs with Goldberg, agreed to cosponsor the proposal. It was approved, 6 to 1. Lawyers are studying the proposed requirement for a parental consent form; Goldberg said case law indicates that the clinics may not be able to refuse birth-control devices to a student who requests them.

She said she and other board members were particularly moved by evidence of potential teen-age health problems not related to birth control. A clinic in West Dallas, Tex., found that up to 30 percent of its patients had undiagnosed health problems, including 100 heart murmurs.

Still, much of the interest in the clinics has been stimulated by statistics from the pro-birth control Alan Guttmacher Institute indicating U.S. girls 15 to 19 years old

have a 1-in-10 pregnancy rate, one of the highest in the world. Fagan charged that this figure is distorted because it includes married teenagers.

The St. Paul clinics, as well as others, report that a majority of patients seek help unrelated to birth control. But the St. Paul pregnancy figures have done much to sell the program. According to Ann Ricketts, administrator of the St. Paul Maternity and Health Care Project, live births to female students at schools with clinics dropped from 59 per 1,000 in 1976-77 to 21 per 1,000 in 1979-80. The rate this last school year was 37 per 1,000 compared to a 1982 fertility rate for all city residents in that age group of 62.5 per 1,000.

Rosann Wisman, executive director of Planned Parenthood in the Washington area, said she and coordinator Sharon Robinson are contacting local school officials about setting up clinics. The most enthusiastic so far, Robinson said, is Anacostia High School principal Walton Breckenridge.

Breckenridge said he will hold a public meeting at the school at 7 p.m. Wednesday to test community reaction. Planned Parenthood is seeking foundation grants to support the clinic's $150,000 annual budget. "I'm generally in favor of it," Breckenridge said, "but we will find out what people think at the meeting."

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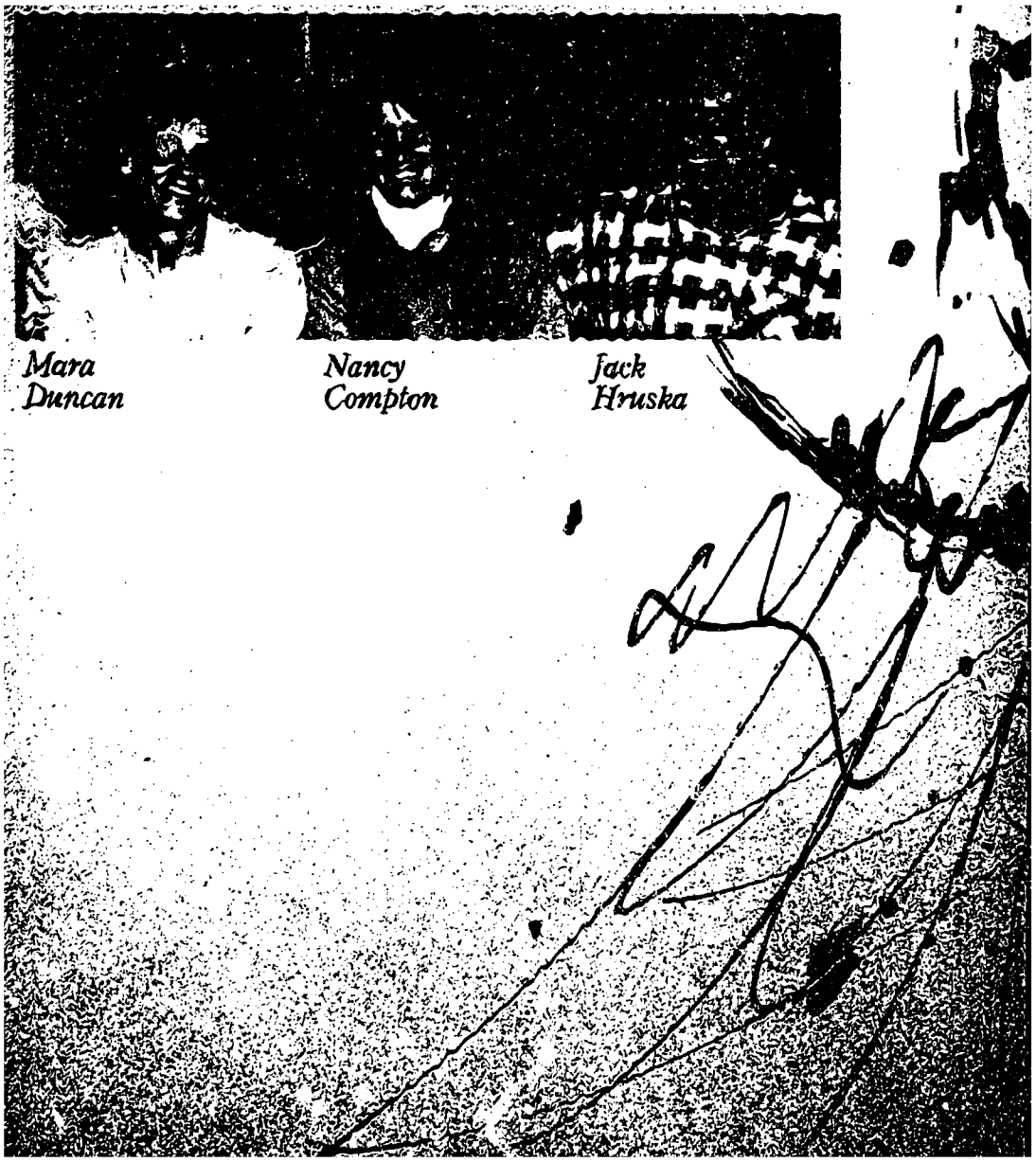

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