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CHAPTER 20

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One of the most troublesome social problems facing our society today is the marked increase over time in the number of adolescents who have become parents but are insufficiently mature, unable, or unwilling to provide the adequate care, protection, and nurture a child needs.

These parents, who are little more than children themselves, and their infants and young children, frequently come to the attention of the Child Welfare system, either through complaints to protective services or when the overwhelmed parents, who initially choose to keep and raise the child, begin to discover what is actually involved in the demands and responsibilities of parenting.

This chapter explores the many issues involved in the phenomenon of childbirth among teenagers, primarily from the perspective of prevention. It reviews behavioral trends in our sexual practices, describes some of the costs created by the absence of a workable system of sexual education and pregnancy prevention, and addresses some of the problems of designing new policies for managing sexual behavior among adolescents in order to minimize the social and psychological costs of early and unwanted sex, pregnancy, and childbearing.

Knowledgeable observers agree that significant and substantial changes have occurred in the sexual practices of the young during the past twenty years. As we shall detail here, rates of sexual activity among

teenagers have soared, and out-of-wedlock childbearing has become more prevalent and conspicuous despite the greater availability and use of contraception and abortion. It is important, however, to put these trends into historical perspective and not to lose sight of the fact that the problems created by premarital sexual behavior are not novel. In many respects we have finally been compelled to face a long-standing contradiction in the management of nomarital sexuality in our society.

The recent sexual revolution, which Shorter (1977) dates in the 1960s, has probably been more evolutionary than is immediately apparent. Virginity was still highly prized in the 1950s, but rates of premarital pregnancy at that time suggest that virginity was often more publically valued than privately observed. In the 1960s premarital sexuality was treated more openly, and hence it appeared as though practices were suddenly changing. Though, undoubtedly, the incidence of intercourse increased dramatically, especially among the very young, it is equally true that "pluralistic ignorance" declined; that is, teenagers no longer felt as obliged to conceal their sexual conduct from others. As the change in sexual standards became more visible, it served to erode the existing social deterrents to premarital sex, thus accelerating the pace of change in the 1970s.

The recent changes in sexual standards should not be viewed in isolation from a more general revision that has been occurring in courtship, marriage, and family formation. Age at marriage has been rising to almost unprecedented levels in response to the growing premium put on education, the precarious economic position of young people, the changing social roles of women, the rapidly increased practice of cohabitation, and the elevated risk of divorce. All of these factors have played some part in changing the meaning of marriage. At one time, in the not so distant past, marriage was part of a tightly ordered transition to adulthood. When individuals married, they typically also initiated their sexual career, established their own household, and rapidly moved on to childbearing. While these events did not always occur strictly in order, the ideal sequence was widely accepted. Increasingly since then, however, the transition to marriage has become a more autonomous event, independent of the passage from virginity to sexuality, the establishment of a new household, or the initiation of childbearing. Accordingly, the significance of sexuality is undergoing change. Adolescents are not prepared to delay intercourse until marriage because they cannot foresee so easily a definite time when marriage will occur. The delay of marriage and the possibility of cohabitation have the consequence of blurring the boundaries of sexual behavior. Since marriage is no longer the appropriate occasion to begin to have sex, it is difficult to establish a normative schedule that regulates the timing of the onset of sexuality. The result is a cultural dilemma: One

system has broken down, but a new one has not yet been established to take its place.

Current Levels and Trends of Teenage Sexuality, Pregnancy, and Childbearing

Teenage childbearing must be viewed as the outcome of a long, elaborate social process. Clearly, sexual relations are a necessary but not sufficient condition for pregnancy, and pregnancy is a necessary but not sufficient condition for childbirth. Specifically, contraception and subfecundity (a reduced biological potential for reproduction) intervene in the first part of the process, and outcomes such as spontaneous, as well as induced, abortions and also stillbirths intervene in the second part. In addition, out-of-wedlock childbirths can be avoided by marriage prior to the birth; and, complications for the mother, father, and infant can be reduced, in varying degrees, by marrying following the birth or by putting the baby up for adoption. The following discussion, both of the incidence of sex, pregnancy, and births among teenagers and of the factors which influence these phenomena, will deal with this complex social process.

As discussed, a rapid increase in the level of teenage sexual activity has taken place in the United States during the last two decades. For example, premarital sexual activity among women aged fifteen to nineteen living in metropolitan areas increased by some two-thirds from 1971 to 1979. At present, roughly 80 percent of young men and 70 percent of young women have sexual intercourse by age nineteen (Zelnik and Kantner, 1980).

As noted by Paulker (1969), the most parsimonious explanation of teenage pregnancy treats it as the outcome of sexual activity and accident, rather than employing any more complex variables and hypotheses. Accordingly, teenage pregnancy rates, particularly for younger teenagers, have risen steadily since 1960 (Baldwin, 1976). The high rate of increase among younger teenagers in particular parallels their high rate of increase in sexual activity.

Nevertheless, several contingencies intervene between sexual activity and childbirth, namely contraception and subfecundity. Contraceptive use reduced the number of teenage pregnancies in 1976 by an estimated figure of 689,000—from a hypothetical figure of more than 1.5 million to an actual figure of around 780,000 (Zelnik and Kantner, 1978). From 1973 to 1978, the proportion of teenagers who became pregnant rose from 10 percent to 11 percent, but the proportion that became pregnant among those who were sexually active fell from 27 percent to 23 percent. A major reason why the overall rate of teenage pregnancy

has risen more slowly than the total level of teenage sexual activity is increased and more consistent contraceptive use (Alan Guttmacher Institute, 1981). The level and regularity of such contraceptive use generally increased throughout the 1970s. However, while the proportion using the most effective methods—the pill and the IUD—almost doubled between 1971 and 1976, this proportion declined by 8 percent between 1976 and 1979. There is now a larger pool of sexually active teenagers, though an increase in the number using the most effective methods has been outweighed by an even larger rise in the number using ineffective methods, particularly withdrawal (Zelnik and Kantner, 1980).

Zelnik and Kantner (1978) find that while teenagers are now generally better prepared to use contraception, their rate of pregnancies has not declined, in part because the rise in sexual activity among the youngest teenagers has not been paralleled by as great an increase in their practice of contraception.

Another source of higher rates of teenage pregnancy may be a biological one: a decline in subfecundity. The age of maturation has been falling throughout the twentieth century, as a result of improved nutrition and medical care (Stickle and Stickle, 1975). With a mean age at menarche at present of 12.5 and a range of 8.5 to 16.5 and an historically typical pattern in which first ovulation occurs two years after menarche, the minimum age for a first pregnancy is 10.5 or even younger. Moreover, postmenarche sexual development has accelerated, so that the age of fecundity has dropped even further (Rauh, 1973).

When an out-of-wedlock teenage pregnancy occurs, it may be resolved in a variety of ways: The woman may let the pregnancy proceed to term and give birth, or she may obtain an abortion; and, if she gives birth, she may marry in order to legitimate the birth, or she may put the child up for adoption, or she may do neither.

A recent analysis estimates that among girls who were fourteen in 1978, around 40 percent will experience a teenage pregnancy, 20 percent will give birth, and 15 percent will have an abortion by age nineteen (Tietze, 1978). The 1973 Supreme Court decision and the subsequent legalization of abortion throughout the United States generated a rapid rise in the number of abortions performed on teenagers. For example, between 1972 and 1976 there was a 60 percent increase for all teenagers, and a 120 percent rise for those under age fifteen.

Of roughly 1,142,000 teenage pregnancies in 1978, 38 percent terminated in abortions, 13 percent in miscarriages, 22 percent in out-of-wedlock births, 10 percent in legitimate but premaritally conceived births, and 17 percent in legitimate births conceived within marriage (Alan Guttmacher Institute, 1981). Almost two-fifths of those fifteen to nineteen years old currently end their pregnancies with abortions, and

more than half of all pregnant girls under age fifteen have abortions (Henshaw, Forrest, Sullivan, and Tietze, 1981). The availability and use of abortion is the major reason why there has been no increase in the teenage birth rate in the last decade. Moreover, the increased availability of abortion produced a leveling out of the trend in the illegitimacy rate in the mid-1970s, although the rate began to increase again in the late 1970s as fewer teenagers married to make their child's birth legitimate (Alan Guttmacher Institute, 1981).

Although there has been a leveling off the teenage birth rate is still reason for concern in the United States at present, since it is among the highest in the world and considerably higher than in most western European societies. The decline in both the rate and number of teenage births is restricted to those who are married; the rate of out-of-wedlock childbearing is rising for both older and younger teenagers. While, at present, most teenagers who give birth are married, if present trends were to continue, that would not be the case for long. In fact, already a majority of births to females under age eighteen occurs out-of-wedlock (see Table 20–1).

A major factor which accounts for the increased rate of out-of-wedlock childbearing is the smaller likelihood of marriage, especially among blacks, as a way of legitimating the birth. During the 1970s, rates of teenage marriage declined by 4 percent among whites and by 45 percent among blacks (Alan Guttmacher Institute, 1981). More specifically, the proportion of premarital teenage pregnancies which are legitimated by marriage prior to the birth has steadily declined in recent decades (see Table 20–1).

Finally, the probability that a teenager will bring her pregnancy to term and then give the baby up for adoption has diminished markedly during the last decade. The major factor is the greater availability of abortion as a way of resolving the dilemma. Currently, in cases where a child is born alive, 87 percent of the mothers keep the child; 5 percent give the child to others (usually relatives) in an informal adoption; and 8 percent give the child up for a formal adoption (Zelnik and Kantner, 1978).

Causes of Teenage Sexual Activity, Pregnancy, and Childbearing

Overview

Theories about the etiology of early childbearing have often failed to take into account the fact that parenthood is the result of a social process. A major tendency has been to search for psychological factors

Age	1950	1955	1960	1965	1970	1975	1977	1978	1979
Number of births (in 1,000s)									
15–19	...	484	587	591	645	582	559	543	549
18–19	...	334	405	402	421	355	345	341	349
15–17	...	150	182	189	224	227	214	203	200
<15	...	5	7	8	12	13	11	10	11
Birthrates (per 1,000 women)									
15–19	81.6	90.3	89.1	70.4	68.3	56.3	53.7	52.4	53.4
18–19	...	...	...	...	114.7	85.7	81.9	81.0	82.4
15–17	...	...	...	...	38.8	36.6	34.5	32.9	33.1
<15	1.0	0.9	0.8	0.8	1.2	1.3	1.2	1.2	1.2
Out-of-wedlock birth rates (per 1,000 unmarried women)									
15–19	12.6	15.1	15.3	16.7	22.4	24.2	25.5	25.4	26.9
18–19	...	...	...	...	32.9	32.8	35.0	35.7	37.8
15–17	...	...	...	...	17.1	19.5	20.7	19.5	20.4
<15									
Ratios of out-of-wedlock births (per 1,000 births)									
15–19	...	142	148	208	295	382	429	441	461
18–19	...	102	107	152	224	298	344	367	386
15–17	...	232	240	327	430	514	566	587	612
<15	...	663	679	785	808	870	882	873	888

Sources:

National Center for Health Statistics, 1978. Final Natality Statistics, 1976. *Monthly Vital Statistics Report*, 26(12). Washington, D.C.: National Center for Health Statistics, U.S. Department of Health and Human Services.

National Center for Health Statistics, 1980. Final Natality Statistics, 1980. *Monthly Vital Statistics Report*, 29(1). Washington, D.C.: National Center for Health Statistics, U.S. Department of Health and Human Services.

which motivate adolescents to enter parenthood prematurely, such as the need for affection, the quest for adult status, the resolution of the Oedipal conflict, the desire to escape parental control, or the inability to foresee a more gratifying future. No doubt some of these reasons apply in some instances. Most studies, however, show that only a small minority of teenagers become parents because they consciously want to have a child (at least at the time of conception). Most become pregnant unwillingly and unwittingly, though to be sure many are reluctant to terminate the pregnancy by abortion once conception occurs. Teenagers typically formulate reasons why they want a child once they have become pregnant, but these reasons do not necessarily explain why the pregnancy initially occurred.

Before embarking on a discussion of the determinants of pregnancy and childbearing, it is important to note that the principal reason teenagers become pregnant is that a large number are sexually active and do not use contraception effectively enough to avoid pregnancy. Teenagers often take risks, engage in wishful thinking, and are careless about preventing pregnancy. In these respects they are not fundamentally different from adults, even those who are married, though teenagers are probably less prepared to take precautions, for a variety of reasons, than their adult counterparts. Later in this chapter, the problem of practicing contraception successfully will be discussed.

Often, teenage women undertake sex as a result of direct pressure from their partners, who may have little or no stake in preventing a pregnancy. Little is known about the interpersonal dynamics of sexual encounters among the very young, but there is reason to suspect that the boundary between enticement and rape is often not very distinct. Research on gender aggression suggests that the introduction to early sexual activity is, for females, frequently involuntary. Early sexual behavior frequently takes the form of a contest in which males attempt to "score" while females put up mild, and sometimes uncertain, resistance. This is not to say that females are not complicitious, but the complicity should be seen as part of a bargain which exchanges status in the peer group for sexual acquiescence.

We do not know very much about the transition to nonvirginity among young adolescents. What we do know suggests that relatively few become sexually active *in order* to become pregnant. While pregnancy may fulfill certain of the teenager's needs, it is often, to use Merton's term, "the unanticipated consequence of purposive social action" (1968). Teenagers have sex to remain popular and frequently become pregnant as a result of unplanned or poorly regulated sexual encounters. Nonetheless, pregnancy may not be an entirely random process, given varying rates of sexual behavior. Some teenagers manage to use contraception successfully, and it may be useful to explore some of the

reasons why certain teenagers are more prone to becoming pregnant than others.

Psychological Factors

Daniels (1969) finds a source of teenage pregnancy in a "dependency–deprivation syndrome," comprised of family instability, competition for attention between the adolescent and her siblings, physical punishment, and an emotionally unrewarding relationship between the teenager and her mother. Friedman (1971) holds that female delinquents who "act out" sexually are characterized by emotionally deprived family backgrounds, unfulfilled needs for closeness and tenderness, rejection by parents, failure in the area of parental control, inappropriate sexual identities among the parents and thus among the adolescents, and sexual threats by one parent or the other. J. D. Paulker (1969) sees teenage sexual intercourse as motivated by an unconscious need for love, perhaps rooted in a lack of love in early childhood. Alternatively, Rainwater (1965) views lower class sexual behavior, pregnancy, and childbearing as ways of legitimating one's manhood or womanhood, which can be scarce commodities, given deprivation and exclusion by the wider society and a resulting loss of self-esteem. In all of these theories, sex, pregnancy, and childbearing fill a gap in the teenager's own life and often in that of her family of origin as well. Nevertheless, it is important to keep in mind that these descriptions of the functions of childbearing may involve post hoc rationalizations and should not necessarily be taken as explanations of the onset of sexual activity or pregnancy per se.

The foregoing ideas about psychological factors have found their most elaborate formulation to date in Bolton's (1980) review of literature and theoretical statement about the associations between teenage pregnancy and child abuse and neglect. The dynamic factors related to both parental abuse and neglect of children and the children's own pregnancy and childbearing as teenagers include, among the parents, unrealistic expectations of their children and a distorted view of their needs, lack of knowledge about child development and child care, unresolved dependency needs which create a role reversal between parents and children, rejection of the children early in their childhood, and poor relations between the parents themselves. Among the children, as consequences of parental attitudes, the dynamics are low self-esteem, fear of rejection, a low tolerance for frustration, and feelings of isolation.

Irrational and punitive parental behavior, including inconsistent affection and discipline as well as physical and emotional violence, retards the child's development. Such parental behavior produces in the growing child an inability to trust others and a poor self-image, combined

with intense dependency needs. (See also Helfer, 1975, on the World of Abnormal Rearing Cycle.) These dependency needs cannot be consciously acknowledged, but they may eventually be fulfilled when the girl, now a teenager, gets pregnant and feels that she can now have "someone of my own to belong to" (Daniels, 1969). (This theory, thus, may better serve to explain the teenage mother's adaptation to the pregnancy than to account for the occurrence of the pregnancy itself.) The teenage mother is often emotionally, if not residentially, isolated from her parents, from the father of the child, and from her friends. And, even in the event of a marriage, the partners' relations are often inadequate. To complicate the problems produced by the teenage mother's isolation, she may be too immature and resentful to appreciate the infant's needs and may blame the child for her own problems. Her expectations are often too high and her level of knowledge too low. Finally, various health problems, particularly those resulting from poor prenatal care, may exacerbate the teenage mother's childrearing difficulties and heighten her frustration, leading to the possibility of abuse and neglect of her child.

Bolton's theory clearly describes a cyclical process. As the individual reared in a dysfunctional family situation seeks to compensate for the emotional deprivations in his or her own background, he or she sets up precisely the same potential need for compensation in his or her own offspring. These processes involve a direct or indirect transmission of dysfunctional child-rearing values or practices from one generation to the next. However, in this case, as in other cases of an intergenerational vicious cycle of family problems, recurring institutional problems, such as high unemployment among the poor and among minorities, contribute at least as much to the problem. For example, Polansky, Hally, and Polansky (1974) note that maltreatment is a product of both inadequate standards of child care and problems of poverty and family instability. And, Gelles (1979) emphasizes the roots of child abuse both in our society's high levels of unemployment and poverty, which inevitably generate parental frustration, and in our acceptance of violence as a means of child discipline.

We have included Bolton's rather speculative formulation because of its relevance both to the welfare of teenagers in their own childhood and adolescence and to the welfare of their own children. Nevertheless, it must be noted that virtually no research evidence exists to support these ideas.

Economic Factors

Another theory, labeled the "brood sow" theory by Placek and Hendershot (1974), is that poor teenagers have children in order to collect

welfare benefits and to become independent of their parents. A variety of sources of evidence contradict this thesis. Furstenberg (1976) finds that few of the teenage mothers in his Baltimore sample wanted to get pregnant. More specifically, the vast majority were shocked and distressed when they learned that they were pregnant, as were their parents. These reactions provide particularly useful data insofar as they tap initial emotional reactions rather than rationalizations after the fact. Also, the welfare mothers in Furstenberg's sample were not significantly more likely to get pregnant again after they went on relief than the young mothers who were not receiving public assistance. This finding suggests that there is no reason to single out the welfare mothers as unwilling or unable to regulate their childbearing. Moreover, most of the teenage mothers in Baltimore studied by Furstenberg and Crawford (1978) stayed close to home, especially during the early years of the study; rather than seeking independence and rejecting parental aid, most of them availed themselves of such support. Similarly, Presser (1974) finds no differences in variables which might indicate motivation or intention to get pregnant between those teenagers who actually became pregnant and those who did not. Finally, an analysis of national sample survey data by state of residence indicates that "the level of AFDC benefits and the AFDC acceptance rate do not seem to serve as incentives to childbearing outside of marriage for either blacks or whites" (Moore and Caldwell, 1977).

While there is little, if any, evidence for the "brood sow" theory, this conclusion should not imply that economic circumstances play no role in the processes which lead to teenage pregnancy and childbearing. Considerable evidence indicates that the teenage father's occupational and economic prospects are a major determinant of the teenage mother's decision to marry him in order to legitimate an out-of-wedlock conception (Bowerman, Irish, and Pope, 1963–1966; Coombs and Friedman, 1970; Furstenberg, 1970, 1976; Rains, 1971; Rainwater, 1965). However, a finding by Rapoport (1964) suggests not only this possibility but also another one: Delay of marriage is associated not only with cases where the man's income is inadequate to support a family, but also with those where lengthy specialized training is necessary for his career. The man's interest in promoting his career development may be contrary to the woman's interest in attaining some measure of financial security through his support. In many cases, the premature assumption of family responsibilities limits a man's ability to promote his career, although such responsibilities may also spur achievement. In this regard, research indicates that the teenage father's economic status and prospects may influence his choice of sexual partners and his contraceptive practice, as well as his willingness to marry the mother in the event of an untimely pregnancy (Rainwater, 1965; Whyte, 1943). Still another possibility is that the couple may feel, perhaps with good reason, that their economic

prospects will not improve with time; therefore, they may ask, "why should we wait?". The fact that such early and inauspicious marriages are highly likely to break down may not deter the couple, even if they can foresee such a likelihood.

Various other noneconomic factors, including the lower age at which girls begin to have sexual intercourse and to become pregnant, may contribute to the declining rates of marriage as a way of dealing with the problems of teenage pregnancy. Changing sex roles may play a part in accounting for such lower marriage rates, along with general apprehension about the chances of marital stability, and interest in the option of cohabitation, which allows adolescents to hedge their bets. Pregnant teenagers, even those who opt to give birth, may now be less committed to the idea of marriage, particularly if they perceive the difficulties they would face in an ill-timed marriage.

One of the most significant factors accounting for the diminishing likelihood of marriage following pregnancy, however, *is* an economic one: rising rates of youth unemployment. Such rates, as is well known, exceed 50 percent in many communities. In such a hopeless environment, prospects of economic and, in turn, marital success, are bleak.

Intrafamily Communication about Sex

In contrast to the theories described earlier which argue that teenagers are motivated, at some level, to become parents, it is more likely that pregnancy and parenthood are consequences of the inability or unwillingness not only of teenagers, but also of society in general and parents in particular to confront the issue of teenage sexuality. Specifically, parents, despite their hopes, do not play a major role as sexual socializers of their children, except in the negative sense of implying, through their silence, that they disapprove of their children's sexual activity. For example, one survey showed that 73 percent of teenage women had received information about sex from their friends, while only 5 percent had received it from their parents (Connell and Jacobson, 1971). And, Tryer, Mazlen, and Bradshaw (1978) argue that the parents' fears heighten the teenage woman's anxiety about deciding to take responsibility for sexual activity and contraception and thus make her more embarrassed to seek information from either her parents themselves or from other knowledgeable sources such as physicians.

The key family relationship bearing on the teenage woman's orientation toward sex and contraception is her relationship with her mother. Various problems in mother–daughter relations have been thought to be associated with the daughter's pregnancy: generally poor quality relations (Cheetham, 1977); the daughter's dislike of her mother or evalua-

tion of her as an inadequate role model (Abernathy, 1974); or an emotionally disturbed, ambivalent, or unrewarding relationship between the two (Daniels, 1969; Friedman, 1971; Kane, 1973). While there is some evidence, albeit of a tentative nature, that poor quality relations in the family are associated with early sexuality and pregnancy, the link between these factors has not been well explored. One plausible reason, as suggested above, has to do with resulting problems in communication that accompany strain in parent–child relations. Yet communication about sex is *generally* inadequate between parents and children, regardless of the overall quality of family interaction.

In this regard, some social class variations in intrafamily sexual communication are worth noting. The conventional view is that lower- and working-class parents are more permissive than middle-class parents regarding their daughters' sexuality. Recent reports, however, strongly suggest that, rather than being more tolerant, such lower status parents are actually more restrictive. The reluctance of lower-class mothers to talk with their daughters may be a product of their lack of knowledge and vocabulary about sexuality and contraception, as well as their anxiety about such communication being misconstrued as an endorsement. The result is a mutual denial on the part of both mother and daughter, which has the unintended consequence of increasing the likelihood of pregnancy, especially insofar as it decreases the likelihood of contraceptive use.

Factors Affecting Contraceptive Use

Individuals who receive family planning information and instruction are, of course, less likely to experience an unplanned pregnancy. Several studies suggest, however, that even among those teenagers equipped with the means of contraception, many have difficulty using them faithfully over a sustained period of time (Ricketts, 1973). While psychological factors undoubtedly play an important part in the rate of contraceptive use among teenagers, we should recognize from the outset that contraception is not easy to use over a lengthy period of time, even for adults.

What accounts for teenagers' failure to use contraception or to do so consistently? An important factor is the guilt which teenagers feel about the sexual activity. Consistent contraceptive practice requires an acknowledgement that sexual relations can be planned and controlled rather than remaining purely spontaneous and uncontrollable. Most teenagers who plan to have sex and to use contraception have accepted their sexuality and come to terms with the guilt often associated with implicit or explicit parental disapproval. But, among those who have not

made such an accomodation, contraceptive use may exacerbate feelings of immorality or even promiscuity; in such cases, denial of sex as an act for which one is responsible often reduces these feelings but simultaneously increases the risk of pregnancy.

Research shows that the likelihood of contraceptive use rises with the frequency of intercourse, the development of a relationship characterized by exclusivity and commitment (rather than a merely casual sexual encounter), and the event of marriage itself. Rains (1971) proposes a model of the stages in the teenage female's neutralization of guilt about her sexuality and contraceptive practice. Basically, according to this model, she does not practice contraception until she feels that she is in love and is in a relationship characterized by commitment (see also Kantner and Zelnik, 1972). In such a stable relationship, sex becomes more predictable; the male is more reliable; there is more at stake for both the male and the female, should a pregnancy occur; and the female has more power in the relationship, as a result of the male's commitment.

Another complication for teenagers lies in the biological fact that there is an interval between the age of menarche and the age of first ovulation, usually lasting around two years, during which conception is impossible. As more and more teenagers become sexually active during this "safe" period, an increasing number develop the mistaken impression that pregnancy cannot occur thereafter. As a result, they deny the risk of pregnancy. Further complicating this process is the egocentrism of adolescents, noted by Cvetkovich et al. (1975) and Elkind (1967), which promotes the development of a "personal fable" of invulnerability to harm, including pregnancy.

Another hazardous way in which teenage girls cope with guilt is to abdicate responsibility for sex and contraception to their boyfriends. For example, among the sporadic contraceptive users in Furstenberg's (1976) sample, 54 percent said that the responsibility for birth control was their partner's rather than their own. This abdication is problematic for at least two reasons. First, as we noted earlier, males may have very different interests and goals from those of females; for instance, they may seek sexual conquests as means of enhancing their status in their peer group. Second, even when males have less exploitative motivations, they know less about sex and contraception than females (and neither males nor females are very well-informed to begin with).

One finding which highlights just how great the risk of pregnancy is for younger adolescents is that the younger the age at first sexual intercourse, the greater the risk of pregnancy during the first months of exposure: specifically, half of all premarital teenage pregnancies occur during the first six months of sexual activity (Zabin, Kantner, and Zelnik, 1979). The less frequent use of contraceptives by such inexperienced teenagers outweighs any biological advantage resulting from

their subfecundity. Moreover, for a variety of reasons, unmarried teenagers who become pregnant during the first few months of sexual experience, and especially those who subsequently give birth, are more likely to become pregnant again during their teens (Trussel and Menken, 1978). Viewed from the other side, the older the age at first coitus, the greater the probability of using a medical, that is, effective, means of contraception. Additional factors which have been found to predict contraceptive use include age, education, frequency (and, presumably, acceptance) of sexual intercourse, specific attitudes about sexuality, and the existence of a stable heterosexual relationship (Kantner and Zelnik, 1972). Contraceptive regularity may also be a function of one's fear of pregnancy, which, in turn, may result from having been pregnant in the past, having a friend who was or is in that position, or being close to the attainment of a goal such as completing high school.

Finally, a common problem among adolescents generally, and among those who are poor and/or members of minority groups in particular, is a sense of powerlessness to affect their fate; such fatalism clearly undermines efforts to control one's fertility (Fox, 1975; Chilman, 1979; McDonald, 1970). Among the psychological correlates of this orientation are low self-esteem, low ego strength, and a low sense of competence (Rosen, Hudson, and Martindale, 1976). Among the sociological correlates are reduced aspirations, which, in fact, are often a realistic adaptation to the lack of opportunities available to the poor, as well as to blacks and other minority group members.

The Consequences of Teenage Childbearing

Unlike the investigations of the cause of early childbearing, the studies of the consequences have produced remarkably consistent and compelling results. Some observers have intimated that because the issue of teenage childbearing is not really a new one, its social significance has been exaggerated. However, in the face of the evidence on the serious deleterious effects of premature parenthood on mother, child, and family, the charge that the problem is overblown seems unjustified and even cynical. In the following discussion it will become apparent that the medical, psychological, and social risks associated with early childbearing are considerable.

Health

A large body of research findings details the effects of teenage childbearing on the health of both mother and child. Despite the gravity and range of the implications which we shall document, however, few, if

any, of these studies employ careful statistical controls for race, socioeconomic status, or other relevant social or demographic factors whose effects may be confounded with those of early childbearing. Thus, conclusions beyond those stated at the end of this section must await further research. For example, the relationship between the mother's age and prematurity or low birth weight almost disappears when family income is controlled (Kovar, 1968). Similarly, birth weight has been found to be a function less of age or parity than of the trimester in which prenatal care was first provided, which, in turn, is a function of socioeconomic status (Wiener and Milton, 1970). Early pregnancy, as a separate condition, may not always be hazardous in and of itself; it often becomes hazardous because it places already vulnerable individuals at even greater risk.

With the cautions stated above about the lack of statistical controls in mind, we can review the findings in the literature. Nationally, the death rate for infants born to teenagers is 2.4 times that for infants born to older mothers, and the maternal death rate is 1.6 times as great for teenagers as for others (Thornburg, 1979). Moreover, the maternal death risk of those under fifteen is 2½ times that of those aged twenty to twenty-four (18.0 versus 7.1 deaths per 100,000 live births).

Not surprisingly, non-fatal medical complications are also more common among teenage mothers. Anemia is 92 percent more likely among teenage mothers than among those twenty to twenty-four; toxemia is 15 percent more common; and complications resulting from a premature birth are 23 percent more likely (Alan Guttmacher Institute, 1981). Mothers under age sixteen are twice as likely as those aged twenty to twenty-four to have premature or low birth weight babies (those under 5.5 pounds) (National Center for Health Statistics, 1980). Low birth weight, in turn, is a major cause of infant death, asphyxia, and a variety of birth injuries and handicaps (Menken, 1972; Newcombe and Tarendale, 1964; Pasamanick and Lilienfeld, 1956).

All of these pregnancy complications are more likely to occur when the mother fails to get proper prenatal care. A greater likelihood of such a lack of care exists when the mother is poor, non-white, and/or unmarried (Herzog and Bernstein, 1964; Jones and Placek, 1981). Such a lack of prenatal care has serious consequences: the infant death rate is 116.6 per 100,000 live births for those who do not receive such care, but only 32.2 for infants who do receive it (Pakter, O'Hare, Nelson, and Sorgar, 1973). Various factors account for the fact that many teenagers do not obtain adequate services during the course of their pregnancy. Problems in the health care delivery system may present insurmountable barriers to some disadvantaged pregnant teenagers. Moreover, their own problems may complicate the situation—for example, they may be seeking to conceal the pregnancy. In addition, they may not realize the value of

obtaining preventive services rather than just responding to emergencies or other acute illnesses (a propensity which is often reinforced by the current organization of the health care delivery system) and they may be indifferent to medical symptoms which are significant, but not painful or otherwise problematic. And, finally, even when teenagers realize the importance of such services, they often cannot afford them. For all of these reasons, many pregnant teenagers wait until the second or even the third trimester to seek vital prenatal services.

In summary, research has regularly shown that very young mothers and their children are subject to increased health risks during pregnancy, around the time of birth, and during the first year of the infant's life. To our knowledge, no studies have attempted to document longer-term effects. Higher rates of fetal mortality are found for women under age twenty. Also, infants of teenage mothers have higher mortality rates both in the first month of life, when mortality results primarily from problems existing at birth, and in the remainder of the first year, when environmental conditions play a greater role (National Academy of Sciences, 1975).

Education

Researchers have consistently found that teenage mothers are more likely to drop out of school than women who delay their first childbirth until they are in their twenties (Bacon, 1974; Chilman, 1979; Moore et al., 1978). Moreover, women who have their first child out of wedlock have considerably less chance of completing their schooling than those who delay motherhood until after marriage (Card and Wise, 1978; Cutright, 1973). Significantly, these differences are not merely a product of the woman's background. In fact, the detrimental effect on educational attainment of an early or out-of-wedlock first childbirth is even greater than the detrimental effect of minority status, poor socioeconomic background, or a low level of academic aptitude. For this reason, it is fair to conclude that early or out-of-wedlock parenthood is a major *cause* of low educational attainment. Much further evidence documents that teenage parenthood is a causal factor—between one-half and two-thirds of all female high school dropouts cite pregnancy and/or marriage as their principal reason for leaving school (Coombs and Cooley, 1968; Furstenberg, 1976; Huber, 1970; Moore et al., 1978; Mott and Shaw, 1978; Presser, 1976; Trussel, 1976).

While most studies have focused on failure to complete high school, one must ask whether the long-term sequelae are as adverse as the short-term effects. Research that follows the teenage mothers' careers over a span of a decade or more has the disadvantage of informing us

about consequences for previous rather than current cohorts of young mothers, but it is still valuable for providing a long-term view. The results of such studies are consistent: The earlier the age at first birth, the fewer the years of schooling the mother ever completes (Bacon, 1974; Moore and Hofferth, 1978; Trussel, 1976; Waite and Moore, 1978).

Undoubtedly, an important reason why teenage mothers fail to complete their education lies in the enormous difficulties of simultaneously meeting the demands of school, marriage, and child-rearing. In this regard, some recent evidence shows that marriage may actually be the principal complicating factor. Women whose teenage childbearing leads to an early marriage are twice as likely to drop out of high school as teenage parents who remain unmarried (Moore et al., 1978). One possible implication of this link between early marriage and lower educational attainment is that, as fewer teenagers marry, even when confronted by the possibility of an out-of-wedlock birth, their likelihood of completing their schooling will increase.

In spite of the fact that many teenage mothers choose a full-time homemaker role rather than preparing themselves for employment, strong evidence suggests that a teenager pregnancy is not merely a convenient excuse to drop out of school. A majority of teenage mothers resume school after delivery (Furstenberg, 1976; Moore et al., 1978). Moreover, an early birth is not an insurmountable barrier to graduation from high school, as shown by the fact that a majority of the young mothers in Furstenberg's Baltimore study managed to complete this level of schooling. Nevertheless, finishing high school is obviously not just a matter of choosing to do so. As one might expect, teenage mothers from advantageous socioeconomic and family backgrounds are more likely to recoup their losses by completing high school than those with poorer backgrounds.

Occupational and Economic Achievement

Not surprisingly, teenage childbearing also seriously injures a woman's occupational and economic prospects. As was true for the effects on schooling, these consequences are both independent of and even more severe than the disadvantages resulting from minority status or poor socioeconomic background or a low level of academic aptitude (Card and Wise, 1978).

The material detriments of early parenthood can be traced to a variety of sources. Typically, teenage mothers have lower levels of education and experience difficulty in obtaining employment. They are less likely to have enduring marriages and, therefore, cannot count on the economic support of a spouse. They have higher levels and more rapid

rates of childbearing and thus are unable to find employment without child-care assistance. For all of these reasons, teenage childbearers are more likely to become dependent on public assistance (Moore and Hofferth, 1978). Even if her family lends a hand, as they often do, a teenage mother's family rarely can shoulder the entire burden of support.

Thus, the consequences of early childbearing for economic independence depend primarily on the woman's marital career. In this regard, it should be noted that the ultimate economic position of women who marry and whose marriages subsequently break up is worse than that of women who never marry (Furstenberg, 1976). For all teenage parents—single, married, or formerly married—child care is essential to their efforts to find stable employment. Thus, a supportive kinship network that can provide child care is a critical condition determining whether young mothers can work or must rely on welfare (Furstenberg and Crawford, 1978).

Another key factor in the socioeconomic career of the young mother is her fertility pattern following the birth of her first child. Those women who avoid further childbearing are much more likely to be steadily employed than multiparous women. In fact, marital status is largely irrelevant to work patterns when the number of children is held constant. A large family further complicates the already difficult problem of arranging for child care. As noted, the presence of a young child presents an especially severe barrier to employment.

Subsequent Fertility

Research has shown that the younger a woman's age at first childbirth, the greater the level and pace of her fertility (up to fifteen years later) and the greater the proportion of illegitimate and unwanted births (Bonham and Placek, 1975; Bumpass et al., 1978; Menken, 1972; Trussel and Menken, 1978). However, women with an illegitimate first birth do not subsequently bear more children than women whose first birth was within wedlock. In addition, the consequences of early childbearing vary little by race or level of educational attainment. In fact age at first birth accounts for around half of all racial and educational differences in completed fertility. These results suggest a need for family planning services among all groups of adolescents, younger and older, single and married.

The second child typically represents a major setback to the future plans of the younger mother, proving especially damaging to her prospects of economic self-sufficiency. Existing evidence indicates that a pregnancy in early adolescence signals the beginning of a rapid succes-

sion of unwanted births. Although estimates vary, depending on the experiences of the women following the first birth, most studies show that at least one-half of all teenage mothers experience a second pregnancy within thirty-six months of the first delivery (Ricketts, 1973).

Consequences for the Children of Early Childbearers

Among the few studies addressing this topic is Card and Wise's (1978) reanalysis of the Project TALENT data. They find that the children of teenage mothers, while in high school, have lower cognitive test scores, lower grades, and lower educational expectations than their classmates whose parents were at least in their twenties when they were born. As these children grow older (toward age 30), they have lower levels of education, earlier first marriages, and higher rates of marital dissolution. Nevertheless, most of the observed cognitive differences are the result of disadvantages in socioeconomic and family background, particularly higher rates of family instability. Card and Wise propose a recurrent pattern of disadvantage: Early childbearing results in marital dissolution, which in turn leads to cognitive impairment to the child and subsequent educational deficits. And, this educational disadvantage helps to perpetuate, among the offspring of early childbearers, the same cycle of early marriage and childbearing and high fertility which their parents first experienced.

Several explanations might account for the differences in cognitive achievement. They could be traced to physiological conditions such as prematurity, low birth weight, and complications at delivery. An alternative explanation might be that early childbearers are themselves less intellectually endowed, and the differences observed among the children could be linked to genetic factors or to the parent's capacity to provide early infant stimulation. Finally, possibly the young age of the mother may make her a less capable child rearer, which would, in turn, be reflected in the child's slower rate of development of cognitive skills.

Some evidence with which to evaluate these competing interpretations has been marshalled in a recent review by Baldwin and Cain (1980). Their review indicates that the effects of young maternal age on low birth weight and perinatal infant mortality are highly dependent on the quality of prenatal care available to the mother. However, regarding observed deficits in the children's cognitive development, much of the problem lies in the social and economic consequences of early parenthood. In one sense, then, early childbearing contributes to an intergenerational perpetuation of poverty and disadvantage. On the other hand, it should be noted that no vicious cycle, this one included, can persist without society's continued indifference to the problem of economic inequality.

Teenage Childbearing and Family Support

In her extensive review of the literature on the social aspects of adolescent childbearing, Chilman (1979) discusses the need for research on the financial aid, child care, and social and psychological support that grandparents can provide to teenage parents, and on the effects of the provision of such support on the relationships between the generations and on the lives of the grandparents. Two recent analyses conducted by the authors bear on these questions.

The Baltimore study data contain a record of the composition of the teenage mother's household at each of four points during the first five years after delivery. When inspected longitudinally, these data on residential situations show that mothers were much more likely to receive substantial amounts of familial financial assistance and child-care support when they remained with relatives (cf. Cantor, Rosenthal, and Wilke, 1975). Moving out of the parental household, whether to marry or to establish an independent residence, not only reduced the subsidies provided by the family in the form of room and board, but also lessened the chances that a relative would be available to provide day care.

Not surprisingly, then, most mothers stayed close to home, especially during the early years of the study. At pregnancy, when most of the women were in their early or middle teens, nearly 90 percent lived with a parent or another close relative. Separation from the family of origin became more common in the ensuing years, but even five years after the birth of their child, nearly half (46%) remained with their parents or other kin. One popular stereotype of the teenage mother portrays her as a social isolate, removed from parental or conjugal support, but our data belie this image: Only 26 percent of the young mothers were living alone at the time of the five-year follow-up.

The teenager's family shouldered much more responsibility when she remained single than when she married. Especially in the early years of the study, most of the women moved away from their families only after they had married. From responses to unstructured questions, we learned that a major deterrent to marriage was that it might require forfeiting family support. The decision to remain in the home after marriage may, of course, be dictated by economic considerations, but we suspect that it also reflects ambivalence about substituting a tenuous conjugal bond for a functioning family network.

Given the inclination of all but a few parents to lend assistance, the family's ability to aid their daughter became a major factor shaping the young mothers' residential careers. Tenagers were much more likely to remain in couple-headed households than in female-headed households, and those in couple-headed households were also more likely to return to and remain in school. Evidently, either the greater economic resources of the couple-headed families were used to purchase child-

care services, or, more likely, the grandmother remained at home to care for the child while the young mother resumed her education. Moreover, space was more abundant in two-parent households, providing less pressure on the young mother to leave the parental home. Young mothers were more likely to move out of their parents' household when a second pregnancy occurred, and such a repeat pregnancy occurred more frequently in female-headed families, which were already pressed for space and generally strained for resources.

Teenagers who remained with their parents were more likely to advance educationally and economically, compared to their peers who left home before or immediately after their child was born. Also, most participants in the Baltimore study stayed home, at least in part, because they were being provided with child-care assistance by a parent, a sibling, or another relative. The last two interviews, three and five years after the first birth, revealed that the young mothers who lived at home received more help from family members than those who were not residing with relatives. Losing these advantages often forced them to terminate their education, or, in the event they were working, to quit their jobs.

How did these collaborative child-care arrangements affect the well-being of the mother and her offspring? The information obtained directly from the children themselves indicates the benefits of collaborative care. On a test of cognitive performance, the Pre-School Inventory, children of unmarried mothers achieved significantly higher scores when their parents were not their full-time caretakers. Perhaps children receive more stimulation when they have multiple caretakers, or perhaps the quality of care is higher when the mother receives supervision from an experienced relative or when she is simply relieved of full-time responsibility for child care.

Summary of Consequences

Taken as a whole, the research literature lends firm support to the proposition that early childbearing creates high social and economic costs for both teenage parents and society as a whole. One of the repeated findings concerns the role of education. Card and Wise (1978) found that even when race, socioeconomic background, academic aptitude and achievement, and educational expectations are held constant, the young parents are more likely to curtail education than those whose initial childbearing is postponed. Taken together with other studies of the economic consequences of teenage childbearing (indicating lack of education as the primary cause of low occupational status and income), the

results concerning educational effects lead inevitably to the conclusion that programs geared toward helping young parents further their studies may help alleviate the deleterious consequences of early childbearing.

Regarding the children of teenage parents, Baldwin and Cain (1980), in their review of a broad spectrum of studies, find few consequences for the child that are directly related to parental youth. Indeed, even the well-documented increased risk of perinatal morbidity and mortality of infants born to teenage mothers may be eliminated with excellent prenatal care. It is true that increased health risks continue during the first year of life, especially if there is no adult other than the teenage mother to care for the child. Still, low socioeconomic status is the villain in most cases. Since young parents are disproportionately poorer and less well-educated, and since early childbearing often leaves the parents poor and poorly educated, their children are really the victims of these circumstances rather than of young parental age per se.

What can be done to aid parents and children? The importance of family support networks is emphasized in the research conducted by Furstenberg and Crawford (1978) and in the studies reviewed by Baldwin and Cain (1980). These investigations do not suggest that special programs should be designed for the children of teenage parents. Indeed, such categorical programs would be inappropriate and could be damaging insofar as they would stigmatize the children. Rather, the findings strongly suggest that the appropriate focus of program intervention is on the young parents—starting before the birth and extending well beyond it—to prevent the health, educational, and economic hardships that are transmitted to the children through the handicaps imposed on the young parents.

Implications for Social Programs

What can be done to lift or lighten the burdens imposed by premature parenthood? Much of the social welfare literature on teenage parenthood concentrates on constructing ameliorative social programs for young parents. However, we feel that prevention strategies would be far less expensive and much more effective.

Prevention Programs

Professionals working with teenagers are constantly amazed at how little they know about sexual functioning and contraception. It is widely

assumed that in the present era of sexual enlightment, young people have become reasonably sophisticated in their knowledge and attitudes. However, much of the information which young people receive, including that from the mass media, is inaccurate. Most teenagers are ill-informed when they begin to have sexual relations, and most do not become much more knowledgeable thereafter.

Programs of sexual education tend to provide too little information too late. Although there is widespread public support for such instructional programs, many communities only institute sex education in senior high school, if at all. Nine out of ten parents of teenagers support sex education, and 8 out of 10 favor programs in the public schools. Moreover, most of the public (7 out of 10) advocate including material about birth control. Still, despite this public endorsement of sex education, only ten states and the District of Columbia require or even encourage it in the curriculum. Not surprisingly, then, only a minority of teenagers report having had a sex education course in school, and less than one-third report having received information about contraception (Alan Guttmacher Institute, 1981).

As things stand, teenagers are often kept ignorant until they become pregnant. Although there is no evidence to support the belief that sex education programs increase the likelihood of sexual experience during the teenage years, the fear of "promoting promiscuity" still deters the development of preventive programs. Unfortunately, as a result, most teenagers only visit a clinic after a conception or a pregnancy scare (Presser, 1974).

Clearly, we must rethink the relatively passive approach we have taken in preparing young people for the responsibilities of sexual activity. As noted by Furstenberg, Lincoln, and Menken:

> Our best strategy is to prevent as many unwanted pregnancies as possible in the first place. To do this, society will have to make the difficult decision to transmit the knowledge and the means of pregnancy prevention to *all* teenagers—not just those known to be sexually active. There is the chance that some, thereby, may be encouraged to experiment with sex somewhat earlier than they would have done otherwise, although there is no evidence that provision of information about sexual decision-making or contraception encourages teenagers to initiate sexual intercourse earlier than they might have done without such information. (1981:15)

DESCRIPTION OF EXISTING PROGRAMS. A survey of 125 cities with populations of at least 100,000 showed that most (107) had some special programs for pregnant teenagers, but few (31) of these programs served 1,000 or more clients per year, and fewer still were comprehensive pro-

grams. The emphasis is typically only on education rather than on additional services to prevent pregnancy (Alan Guttmacher Institute, 1981). The network of contraceptive services available to teenagers has expanded enormously. These services, virtually nonexistent in the mid-1960s, have been extended to well over one million teenagers in recent years. Specifically, the number of teenagers who visited family planning clinics rose from 214,000 in 1969 to 1.5 million in 1978. Most of the increase is accounted for by larger numbers of younger clients, and, nearly as many teenagers see private physicians as attend clinics. The influence of clinics on contraceptive use has prevented some 689,000 unwanted births and probably an even larger number of abortions (assuming that the majority of adolescents who use contraceptives would prefer having an abortion to bearing a child). That is the bright side of the picture.

In a less optimistic vein, Dryfoos and Heisler (1978) also report that a majority of teenagers at risk of pregnancy still do *not* receive family planning services from public or private agencies or private physicians. Contraceptive services are still unavailable to one-half of all sexually active female teenagers and to a far higher proportion of males. The unavailability of services for females is clearly problematic; and insofar as we cannot identify high-risk cases well enough to target services to them, it would be wiser simply to make such services available to all. The irony in not extending preventive efforts to males is that while male contraceptives are technically inferior, male teenagers themselves are more influential than their partners in making decisions regarding sex and contraception.

RECOMMENDATIONS FOR THE IMPROVEMENT OF PREVENTION PROGRAMS. More clinics are needed to serve the expanding population of sexually experienced teenagers. Moreover, clinics must deliver their services differently if they are to attract and hold a teenage clientele (Edwards, Steinman, Arnold, and Hakanson, 1980). Programs designed for the convenience of the health provider may not suit teenagers. Evening and weekend hours, outreach programs with neighborhood follow-up efforts, and allowances for unscheduled visits may be inconvenient to service deliverers, but they will better serve the special needs of teenage clients.

Program designers must also tailor services to the needs of very different groups of teenagers. Because of their similarity in age, there is some tendency to regard teenagers as homogeneous. However, teenage populations are quite diverse, because of differences in sexual experience, psychological development, social background, and fertility goals. The challenge for program planners is to provide a variety of alternative

approaches suited to the various causes of teenage pregnancy and to the divergent demands of young people in need of services (Osofsky and Osofsky, 1978). Furthermore, there is a general need for coordination of the entire human service delivery system and a specific need for new organizations to enhance coordination in the area of pregnancy prevention, particularly through monitoring and evaluating the services provided to teenagers.

Teenage Males and Fathers

The teenage male is often the key decision-maker regarding contraception, particularly when the female abdicates responsibility. At the same time, the male and the female may have very different interests and goals, especially where the teenage male subculture places a premium on sexual conquests. Clearly, more attention needs to be paid to the education and sensitization of teenage males to issues of both sex and contraception.

Turning to the males who father children, the consequences for their socioeconomic careers are typically not as severe as those for females, given that males do not experience pregnancy and typically are not required to assume responsibility for early child care. Nevertheless, males still experience educational deficits and subsequent occupational and economic career costs. Moreover, in the case of married couples who experience a premarital pregnancy, the male's ultimate levels of education, income, and assets are lower than in the case of couples whose first child is conceived within marriage (Coombs and Freedman, 1970; Freedman and Coombs, 1966). The focus of efforts to aid young fathers must be on their socioeconomic career development, insofar as the subsequent welfare of father, mother, and children hinges on their economic position.

Promoting Family Involvement

The family, including parents, siblings, and extended kin, are implicated in the entire process of unplanned parenthood. The degree of involvement by family members has an important bearing on when and how the teenager becomes sexually active and on her efforts to avert a conception (Fox, 1981). Moreover, families play a central role in assisting the pregnant teenager (Furstenberg and Crawford, 1978). The family undoubtedly provides more services, economic and child-care services in particular, than all outside sources combined. Yet, it has been vir-

tually untapped by programs to assist the teenager. To the contrary, programs have often designed services that either do not take account of the family assistance to teenagers, or, worse still, undermine the network of familial support.

In hindsight, it seems very plain that many of the early programs for teenagers were designed to minimize family involvement. Some programs did so deliberately, out of an ideological commitment to the teenager's right to privacy. Other programs were pervaded by an ethos of individualism, that is, services were directed to individuals with little regard for the social context in which those individuals lived. These family planners may have assumed too quickly that teenagers were simply another population of neglected consumers, who only required, with some minor modifications, the same kind of services available to mature adults. In making this assumption, the family planners did not take account of the vulnerable situation of the teenage client and, in particular, the delicate issue of sometimes providing services to her without her family's knowledge and support. In any event, regardless of whether the practice was intentional or not, the family was often not so much excluded as ignored in these two types of initial efforts to reach adolescent clients. Finally, a third group of family planners viewed parents as culturally backward and, in their counseling efforts, either covertly or overtly attempted to bypass the family, directing services exclusively to the teenagers. We believe that all of these policies have been unwise and unwarranted. It is true that parents are often confused about how to train their children to become sexually responsible, and it is probably also the case that most parents look to other agencies for support in this task. However, parents do not necessarily wish to abdicate their role, and many would probably welcome the opportunity to collaborate with family planning agencies.

Recent evidence suggests that more and more family planning programs have been reaching out to the family. One survey shows that a substantial proportion of family planning programs have designed services for parents or are attempting to involve the family in services provided to their teenage clients (National Family Planning and Reproduction Health Association, 1982).

One example is provided by the efforts of the Family Planning Council of Southeastern Pennsylvania, which recently undertook an experimental project to promote family involvement with teenagers seeking contraceptive services (see Furstenberg, Herceg-Baron, and Jemail, 1981). Its aim is to build family support for using birth control by fostering more open communication about sexuality between the teenager and a designated family member. With the teenager's full knowledge and consent, family planning counselors attempt to approach the

family, usually through the teenager herself, and to discuss ways of assisting her to prevent an unwanted pregnancy.

The initial problem faced in implementing the project was not resistance on the part of the teenager, or her family, but resistance from family planning counselors who lacked the skills and the conceptual approach that would equip them to involve family members in preventive services. Some viewed their role as primarily educational and could not accept the idea that they should broaden their function to intervene more actively in the family system. Others accepted the wisdom of the approach, but found it difficult to implement in clinic settings which were geared for highly concentrated, short-term services.

In addition, of course, some teenagers themselves resist the idea of involving family members. Nevertheless, only a small proportion (16 percent) of teenagers who were randomly assigned to the family support treatment group were unwilling to avail themselves of the family support services after they were briefed on the program. Thus, few teenagers are categorically opposed to having family planning clinics make contact with their families, so long as they have some role in deciding who is contacted and what method of contact is used.

The experimental efforts of the Pennsylvania program have shown that some teenagers welcome a greater measure of family support when they seek contraceptive assistance. However, parents or even siblings are not always regarded as reliable confidants. More importantly, family members are sometimes unwilling to play more than a passive role in the sexual socialization and support of the teenagers.

An ominous development that may obscure the potentially supportive roles families can play is the political drive for parental notification. At present, sentiment is mounting among a small minority for mandating parental notification when adolescents seek contraception. No evidence supports the belief that parental notification will improve family communication, reduce teenage sexual activity, or increase contraceptive vigilance. More likely, notification requirements will encourage teenagers to stay away from family planning programs, to rely on nonmedical methods of birth control, or to falsify the information that they provide to contraceptive clinics.

Our knowledge is lacking in how to foster greater responsibility among the young regarding decisions about whether or not to become sexually active or to take measures to prevent unwanted pregnancies. Still, it is easy to forget that, until two decades ago, there were virtually no programs providing sex education in the schools or providing contraceptive services to teenagers. The laissez-faire approach taken toward teenage sexuality and pregnancy in the past did not succeed either in controlling premarital sexual activity or in preventing unwanted and untimely pregnancies. But we must also realize that there are no quick

or simple ways of dealing with the problems of unwanted teenage sexual activity, pregnancy, and childbearing. However, remarkable changes have occurred in the last twenty years, and the impatience of planners and policy makers with finding "solutions" must be seen in this perspective.