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TEENAGE PREGNANCY, PROFESSIONAL AGENDAS, AND PROBLEM DEFINITIONS

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Many of the adverse consequences associated with adolescent childbearing are due to poverty and inadequate health care. Historically, definitions of the problem have emphasized individual, female culpability. Underlying social and economic factors have received less attention. For many adolescents, the early initiation of sexual activity and the failure to use birth control is associated with their perception of limited life opportunities, as well as sex role socialization inhibiting contraceptive initiative. This paper considers the role of professional groups and service advocates in defining the problem and developing policy alternatives. It examines the processes through which an issue having significant redistributive implications has been defined as one of individual female deviance.

Adolescent pregnancy and childbearing gained prominence as a social problem in the late 1960's. Since that time, popular and political interest has grown, as evidenced by increasing media, professional and philanthropic attention, federal and state legislation, and the proliferation of local services. As a public policy issue, adolescent pregnancy appears to be caught in what Anthony Downs (1972) termed the "excited discovery stage."

There is ample reason for concern about early childbearing. The teen birth rate nearly doubled during the baby boom years, 1945 to 1957. Although the birth rate has since declined to pre-World War II levels, out-of-wedlock childbearing and abortion rates among teens have increased dramatically. Teen pregnancy and abortion rates are significantly higher than in comparable industrial nations with

similar rates of teen sexual activity. Pregnancy rates for women aged 15-17 in the U.S. are more than twice those in England, Wales and Canada, three times higher than in France and Sweden, and nearly nine times those in the Netherlands (Jones et al, 1985).

Early childbearing is associated with poor health consequences for the young mothers and their children, and diminished educational achievement, employment status and income (Hayes, 1987). Annual public welfare, food stamp and Medicaid costs attributable to adolescent childbearing have been estimated at $16.6 billion (Burt, 1986).

As with any social problem, policy responses depend on how the problem is defined (Kingdon, 1984). Historically, the problem definitions of early out-of-wedlock childbearing have emphasized individual female culpability. Until very recently, structural factors including poverty, inadequate health care, sexism and racial discrimination have received little attention. Advocates and policymakers have implicated early childbearing as a *cause* of poverty and its associated ills, neglecting its etiology as a *consequence* of poverty. As a result, remedial policies have been adopted to change individual behavior rather than altering the social conditions which contribute to the behavior.

Efforts to diminish the adverse consequences of early childbearing through services to individuals are both necessary and appropriate. However, such services may be of limited effectiveness unless accompanied by policies addressing the underlying structural dimensions of early childbearing.

This paper considers the social problem career of adolescent pregnancy and childbearing in its historical context. It seeks to explain current policies by examining how service providers and advocates have defined the issue. In raising the issue to national prominence, advocates have been constrained by their respective professional agendas and a political process that is generally unreceptive to proposals challenging the structure of inequality.

Historically, two complementary processes have helped to shape both the definition of the problem and the policy

responses. First, groups claiming jurisdiction have sought to define the problem in ways that were consistent with their professional and organizational missions (Larson, 1977). The professional agendas of many of these groups have emphasized individual behavioral change and social control. Second, the political process itself does not normally permit challenges to prevailling social and economic arrangements. Solutions to social problems must be deemed politically and economically feasible in order to be considered (Kingdon, 1984). Problem definitions and policy proposals that pose substantial resource demands or require income redistribution rarely find a place on the national policy agenda (Bachrach and Baratz, 1970; Schattsneider, 1960).

Until the 1960's, three groups—physicians, social workers and religiously motivated maternity home operators—played an especially significant role in defining the issue and prescribing solutions for it. Their responses were shaped in part by efforts to claim jurisdiction over young unmarried mothers while establishing a basis for professional status. With some exceptions, their respective professional agendas favored interpretations that stressed individual, female culpability instead of the material context of early out-of-wedlock childbearing.

Since the 1960's, a new set of actors has become involved. They include national foundations, coalitions of local service providers, academic researchers, and advocacy groups such as Planned Parenthood, the Alan Guttmacher Institute, the Children's Defense Fund, and various right-to-life organizations. These groups have proposed new approaches such as school-based clinics, birth control advertising, sex education and chastity campaigns. Like earlier approaches, many of these initiatives fail to address the structural context of early out-of-wedlock childbearing.

Early Out-of-Wedlock Childbearing in Historical Perspective

Three conditions have been especially important in shaping responses to adolescent premarital pregnancy and

childbearing: a) the social stigma surrounding the issue that is based in part on the morality of the traditional, patriarchal family; b) the subsistence opportunities available to young women, i.e., work, marriage, parental support and financial aid; and c) the availability of contraception, abortion, and adoption. These conditions changed over time; and they differed according to the race and social class of the young woman.

The Rescue Homes

Religiously sponsored rescue homes were among the first organized responses to out-of-wedlock childbearing. The first rescue homes in the U.S. were opened in the 1880's. Their founders viewed the homes as providing "hospitality, kindness and evangelism," (McKinley, 1980, p. 189) and "temporary homes and employment . . . for women and young girls who have led profligate lives or having been betrayed from the path of virtue are sincerely willing to reform . . ." (Wilson, 1933, p. 45). They represented the efforts of middle-class men and women to enforce the ideals of what Sheila Rothman (1978) has termed, "virtuous womanhood." Moral redemption required a complete severance of ties with the outside world, long-term residence, hard work and strict routine (McGregor, 1924, pp. 153-154).

The maternity home was considered the last resort of pregnant, unmarried young white women. (Until the post World War II era, out-of-wedlock childbearing among blacks was ignored both as a matter of public policy and private charity.) Throughout their history, the homes have served a fraction of potential clientele. For the majority, there were informal, private adoptions, and foundling hospitals where they could abandon their babies. They could also try to raise them alone, but this was a difficult task given the limited employment and child care opportunities and the stigma of unmarried parenthood.

Progressive Era Reforms

In the Progressive era, alarm over the high death rate among children separated from their mothers at birth along

with the growing organization and professionalization of social agencies led to campaigns against "baby farms," "bootleg babies" or private placements as the new agencies sought to extend their jurisdictions over adoptions. The U.S. Children's Bureau was established in 1912 and its first effort was aimed at reducing infant mortality, a task that necessarily involved addressing the plight of the unmarried mother and her child. Children's Bureau studies showed that about half the infants taken from their mothers at birth died. National and state conferences were organized to address the issue of illegitimacy, and a growing concensus among social work professionals held that babies and mothers should be kept together, at least for the first three to six months.

Some reformers called for general improvements in wages and living standards as well as preventive public health measures. The new public health approach was exemplified by New York City's sixty-eight Baby Health Stations. They distributed safe milk at reduced prices, provided nutritional advice and child care instruction, and made referrals to dispensaries, hospitals and social agencies. Nurses, trained at newly established nursing schools, staffed the centers (Rothman, 1978).

This community-based approach was embodied in the nations's first maternal and child health legislation, the 1921 Sheppard-Towner Act. It provided federal matching grants to the states to establish female-operated well baby clinics and to educate women about motherhood. The American Medical Association, realizing the potential of the new preventive medicine, subsequently declared pregnancy to be a "medical problem," coming within the jurisdiction of physicians. They denounced Sheppard-Towner as a "Bolshevist plot," and in 1929, succeeded in having it repealed (Rothman, 1978).

Birth Control

The growth of the medical profession brought skirmishes between physicians and women reformers about authority over women's sexual and reproductive lives. Margaret Sanger's birth control cursade gained acceptance in the

1920's only after she altered her approach by advocating it as a health measure instead of a women's rights, free speech issue. She enlisted the cooperation of the medical profession in making birth control information and devices, primarily the pesary, available to women. Sanger had earlier advocated the Dutch approach that relied on female public health nurses to distribute diaphrams and instruct on their use. She abandoned this approach as the price for gaining the support of organized medicine. But this concession effectively guaranteed that contraception would be limited to middle-class women who saw doctors (Gordon, 1977; Rothman, 1978; Shapiro, 1985).

Aid to Dependent Children and Stigmatized Parenthood

In theory, the federal Aid to Dependent Children program, adopted as part of the 1935 Social Security Act, made the keeping of her child a more viable option for the unmarried mother. However, due to the continuing stigma of unmarried parenthood and the demand for white adoptable babies, it remained a very limited option until after World War II.

While there was no legal prohibition against helping children born out of wedlock, the stigma was a barrier to their eligibility. Only 3.5 percent of children receiving ADC benefits during fy 1937 were with unmarried mothers. Five of the thirty states reporting accepted no children born out-of-wedlock, and another eleven states had accepted less than fifty each (Labarree, 1939). There were several apparent reasons for this low percentage, but all reflected the stigma of illegitimacy in one way or another.

Many state Mothers' Aid statutes had prohibited allowances to children born out of wedlock, and it was some time before more liberal state statutes were adopted. In addition, with limited funds available, localities informally restricted eligibility to exclude the children of unmarried mothers (Labarree, 1939). A contemporary observer noted the "extraordinary ingenuity with which some local public relief agencies are finding excuses for not granting relief to

unmarried mothers" (Brisley, 1938, p. 68). These restrictions notwithstanding, many unmarried women were reluctant to risk the public exposure that an application for assistance necessarily entailed. Although the procedures were nominally confidential, the investigations of paternity, residence, family support and employment, and review by a local board, precluded secrecy (Judge, 1951).

Social Work and Unmarried Parenthood

The social work profession had initially emphasized the environmental components of social problems as well as their individual, psychological manifestations. This was the thrust of Mary Richmond's influential books, *Social Diagnosis* (1917) and *What is Social Casework?* (1922), both of which sought to establish a scientific basis for the emerging profession.

The professionalization of social work also provided a rationale for challenging the jurisdiction of the medical profession over family relations. One author noted that physicians too often claimed, "No unmarried mother wants to keep her baby." She suggested that this is an issue for the social worker, not the doctor, to decide since, ". . . the unmarried mother and her child are intensive case work problems ... and she [should] be given the same opportunity that is given to other offenders in the light of our new understanding of human behavior" (Drury, 1925, p. 41).

Social work, in its striving for a professional identity, eagerly embraced psychoanalytic theory in the 1930's and 1940's. Freudian theory provided a congenial fit with American individualism. The subsequent adoption of ego-psychology, with its emphasis on the strength of the conscious ego, reinforced the endemic social Darwinism that identified poverty and social problems as the fault of those so effected (Wilson, 1977). In contrast to Mary Richmond's *Social Diagnosis*, Virginia Robinson's 1930 book, *A Changing Psychology in Social Case Work*, denigrated the old "sociologic approach," with its concern for the environment, and maintained instead, "that all social work is mental hygiene. Case work not founded on the point of view of

personality and adjustment . . . is simply poor casework, superficial in diagnosis and blind in treatment" (Robinson, 1930, pp. 36, 48). This emphasis on the individual personality became a prevalent force within the profession and served to deflect attention from social and economic reform (Lubove, 1977). That emphasis, together with the emergence of public welfare under the Social Security Act provided the conditions for what has been described as private social welfare's disengagement from the poor (Cloward & Epstein, 1965).

In the 1940's and 1950's, a new kind of negative stereotype was applied to the young, unmarried mother. In the new formulation, the unmarried pregnant girl was not just immoral. She was neurotic. Social workers knew "from psychiatric orientation and from casework experience that most unmarried pregnancy has a neurotic base. It is frequently a symptom of unresolved love-hate parental relationships, originating in early childhood" (Sherz, 1947). Her own assessment of her situation represented a self-serving effort to deny the neurotic basis of the behavior and manipulate her would-be helpers. In blunt terms, "Most unmarried mothers are serious neurotics . . ." (Young, 1947, p. 28).

A leading text of the day, and according to its publishers, the "first book length treatment of [this] major social problem," was social worker Leontine Young's *Out of Wedlock* (1954). It became required reading in schools of social work for at least a decade, and its diagnostic and treatment prescriptions, based on an imprecise rendering of concepts of Sigmund Freud and Helen Deutsch, became the accepted orthodoxy. In this view:

> . . . very few of these girls are interested in men. . . . For many, their only sexual experience seems to be the relationship which results in pregnancy, and this has usually been brief and unhappy. . . . An astonishing number of unmarried mothers meet the fathers of their babies in casual, unconventional fashion. They "pick up" a man in trains, in hotels, at dances and large parties, or they meet him on "blind dates" with casual acquaintances. . . . She is like a person in a trance who goes through all the motions but has neither awareness

> nor understanding of their meaning. Hence her failure to think of self-protection. . . . Why should a girl so blind herself? What does she want so badly that she is willing to pay so high a price for it? Obviously, she wants a baby—but specifically, an out-of-wedlock baby—without a husband (Young, 1954, p. 28).

Implicit in this interpretation is a denial of female sexuality, a disregard for the role of male partners, and an assumption that pregnancy is desired. Consistent with a post World War II preoccupation with "domineering women," Young and her contemporaries attributed the problem to improper parenting by the girl's mother: "The great majority of unwed mothers come from homes dominated by the mother . . . a woman who has never accepted her own femininity. . ." (Young, 1954). This characterization reinforced female culpability and anticipated subsequent culture of poverty arguments.

Unfit and Unworthy: Securing the Relinquishment of the Child

If the unmarried mother was a "serious neurotic" exhibiting "delinquent behavior," her fitness as a parent was open to question. The new psychoanalytically-oriented social worker unequivocally supported what had by then become standard practice, namely the surrendering of the baby for adoption. The babies were a valued commodity in the adoption market, and the social workers and adoption agencies served an important brokerage function.

There were two reasons cited for the young unmarried mother's presumed unfitness to raise her child, one psychological and the other circumstantial. First, the baby was considered a byproduct of the delinquency of an immature, neurotic girl who lacked the personal prerequisites for responsible parenthood: "Our experience has shown that with rare exceptions it is the neurotic girl who keeps her child" (Scherz, 1947, p. 61). Second, the community's disapprobation and the relative lack of community resources, including public assistance and child care, were deemed in-

surmountable obstacles to her keeping her baby. If an argument could be made that one of these two obstacles might be overcome, the two taken together were almost invariably considered as barring her raising the child (Sherz, 1947; Young, 1953).

The maternity homes were a key component in the evolving network of specialized agencies dealing with the unwed mother and her child. By the 1950's and 1960's, the more modern maternity homes reflected a peculiar mixture of therapeutic case work intervention and moral rescue. They served "essentially respectable girls who had made a mistake," never-married girls pregnant for the first time (Rains, 1970, p. 220). The major functions of the homes were concealment and the moral reinstatement of the girl through her acceptance of responsibility for her mistake. While adoption was considered in theory an open issue, in practice, one's intention to surrender was taken as a foregone conclusion. Failure to accept psychological responsibility for their pregnancies or persistence in seeking to keep the baby was viewed as "denial" (Judge, 1951; Rains, 1970).

The maternity homes began to die out in the 1960's despite the sharply rising rate and incidence of adolescent childbearing after World War II. Salvation Army officials "watched in despair as social acceptance of teenage and single-parent pregnancy, changed public morals, steeply rising costs . . . and—hardest of all to bear—abortion . . ." emptied their facilities (McKinley, 1980, p. 207).

Between 1945 and 1957, the baby boom years, there was a sharp increase in the adolescent birth rate, paralleling that for older age groups. There followed a liberalization of attitudes about sexual behavior to what had occurred in the 1920's. There were also significant developments in the technology and availability of contraception and abortion, and a shift among young white women from the relinquishment to the keeping of their babies born out of wedlock. The 1960's brought a major expansion of welfare state programs and greater governmental attention to a variety of social problems including many related to early childbearing. New programmatic interventions were developed, and

government-sponsored research yielded considerable information about the causes and consequences of adolescent pregnancy and childbearing.

The Teenage Pregnancy Epidemic

The adolescent birth rate (15-19) in this century was relatively stable, fluctuating between about 50 to 60 per 1,000 until 1946. It then climbed from 51.5 to a high of 96.3 per 1,000 in 1957, the peak year of the baby boom (Furstenberg, 1981; Moore, 1985). The rate has declined steadily since then, reaching prewar levels in the late 1970's. Births per 1,000 females, 15-19, were 89.1 in 1960, 68.3 in 1970, 53.7 in 1977, and 52.9 in 1981 (Moore, 1985; Vinovskis, 1981).

Underlying these trends were changes in sexual behavior, attitudes and public policies. The period from 1965 to 1975, the time of the sexual revolution, was marked by a decline in abstinence codes and a much greater acceptance of sexuality for all age groups. The shift in attitudes toward a code of what Ira Riess (1980) characterized as "permissiveness with affection" is illustrated by opinion poll responses. In 1963, 80 percent of adult respondents disapproved of premarital intercourse; but by 1975, only 30 percent disapproved (Riess, 1980).

The earlier abstinence codes had been reinforced by professional practices and public policies. In limiting the availability of contraception, public policies had offered a choice between abstinence or pregnancy (Rodman et al., 1984). There was little change in the technology, availability or use of contraception from the 1930's until the early 60's when the birth control pill and IUD became available. Until then, the level of effective use provided little or no protection (Cutright, 1972a). A series of Supreme Court decisions between 1965 and 1980 struck down state laws prohibiting the dispensing and use of contraceptives and upheld minors' rights to contraceptive services (Rodman et al, 1984). Despite these changes, however, significant administrative, financial and social barriers continued to inhibit access to contraception, especially among the young.

From Private Concern to Public Issue: The Emergence of Teen Pregnancy as a SocialProblem

In the early 1960's, the U.S. Children's Bureau and the service constituency it fostered sought to implicate adolescent childbearing as a cause of other concerns of the day such as juvenile delinquency, poverty, illegitimacy, welfare dependency, and the "population problem." Prior to that time, teenage pregnancy and out-of-wedlock childbearing had been considered an individual, private matter. The expansion of government social programs in the 1960's and early 1970's also provided resources for the establishment of local adolescent pregnancy programs, support for advocacy groups, and money for research.

One behavioral change that had a direct bearing on subsequent policy responses was the dramatic shift among young white unmarried women from relinquishing their babies for adoption to keeping them as black women had always done. This restricted the supply of white infants available for adoption, thereby contributing to the "baby famine" (Benet, 1976). In the 1960's, about 90 percent of babies born out-of-wedlock were relinquished for adoption. By the mid-1970's, about 90 percent were kept by their mothers (Vinovskis, 1981). As Steiner (1981) observed, "As long as it was unthinkable for a visible, unwed adolescent to keep her child, neither prevention nor long-run services to mother and child got much attention even from the most compassionate policy-makers" (pp. 72-73).

The federal policy interest in adolescent pregnancy derived in part from its recognition as a problem of middle class whites. Its transition from being viewed as a black phenomenon to being perceived as more general and wide spread was accompanied by a shift in causal explanation and terminology. Early, out-of-wedlock childbearing among blacks had been attributed to inherent sociological and cultural factors such as the supposed weakness of family structures, and the alleged acceptance of illegitimacy in the black community. White illegitimacy was more prone to individualistic, psychological and moral explanations (Ladner,

1972). Now, with white adolescents keeping their babies, increasing professional concern was expressed about the health and developmental implications for the infants. Single adolescent parenthood was presumed by many to be invariably detrimental, although, as shown below, the research evidence presents different picture.

Policy Development and Federal Law: The Adolescent Health Services and Pregnancy Prevention Act of 1978

In 1963, the Children's Bureau funded a demonstration project serving pregnant adolescent girls at Washington, D.C.'s Webster School. It offered prenatal care, counselling, and education, and became a prototype for subsequent efforts to establish local comprehensive service programs. By 1967, thirty-five local programs had been launched with Children's Bureau funding. The central concept involved the provision of short term health, educational and social services, usually by several different agencies.

This concern for pregnant and parenting adolescents fit within the traditional purview of the Children's Bureau and permitted the Bureau to embrace an issue of increasing public and political concern at a time when the Bureau's status was threatened by reorganization (Nelson, 1984). The Economic Opportunity Act of 1964 gave new impetus to the Bureau's efforts to foster the development of local comprehensive service programs for pregnant and parenting adolescents. A number of local programs were started with Economic Opportunity Act funds and maintained with the aid of other federal anti-poverty grants in the 1960's. Interest in creating a special adolescent pregnancy program increased sharply after the 1973 Roe v. Wade decision provided constitutional protection for abortion. In 1975, during the Ford Administration, Senator Edward Kennedy introduced the School-Age Mother and Child Health Act and conducted hearings on it in his Health Subcommittee. The rationale for this and comparable bills introduced by Representative Albert H. Quie and Senator Birch Bayh was to provide "life

support" services to teenage girls and their children, and foster the preservation of life (Steiner, 1981).

President Carter's Adolescent Pregnancy Initiative

President Carter and his Secretary of Health Education and Welfare, Joseph Califano, were both on record as opposing abortion, but were looking for some way to appease both anti-abortion and pro-choice advocates (Steiner, 1981). The Administration's legislative proposal was based on a HEW March 17, 1977 Special Task Force memorandum recommending a "Family Development Program," that would "provide practical, ethical and *politically viable alternatives to abortion* [and] verifiable improvements in family life" ("Family Development Program," March 17, 1977, p. 656). The prototype for the proposed national program was the Johns Hopkins Medical School comprehensive services center supported by the Kennedy Foundation, an approach adopted at the urging of Eunice Kennedy Shriver (Steiner, 1981).

The Adolescent Health Services and Pregnancy Prevention Act of 1978 stressed short term, coordinated services to the already pregnant, advocacy of sexual abstinence, and promotion of adoption. It was repealed under the 1981 Omnibus Reconciliation Act (OBRA) and replaced by Title XX of the Public Health Service Act. Title XX represented a retreat from the modest objectives of the 1978 law in several respects. In defining the problem as one of fragmented and uncoordinated services, it failed to address the absence of many key service components. By establishing a demonstration grant program, it institutionalized the inadequate funding levels and offered no options for the thousands of localities that could not qualify for assistance. Most importantly, it further de-emphasized family planning services. Annual appropriations for either law have never exceeded the $13.4 million allocation for FY 1984. Altogether, fewer than 100 programs received grants between 1979 and 1984.

Even before the passage of federal legislation, a number of localities had initiated local programs. A 1976 survey identified 1,132 programs; however, only 4.8 percent, i.e. 54,

provided pre and postnatal care, education and social services (Eddinger & Forbush, 1977). A subsequent study identified 1,117 local programs of which 25 percent (274) were deemed comprehensive because they listed the ten core services identified in the 1978 Act (JRB Associates, 1981). As these surveys showed, a number of communities established programs, but few were comprehensive. This is not surprising in view of the conditions under which these programs operated.

A study of local programs found the constraints so formidable that only under exceptional circumstances could comprehensive services be sustained. The constraints included the absence of a firm funding base, an insufficient health and welfare infrastructure, negative attitudes toward a stigmatized population, and an unproven interventive technology. A gender-based division of labor further impeded access to resources. The female program staff often had difficulty in convincing male resource gate keepers of the urgency of what was commonly regarded as a female issue. When programs were established in schools, they frequently served organizational interests by removing pregnant students from the regular classrooms and isolating them in special self-contained programs for the duration of their pregnancies (Weatherley et al., 1986; Perlman & Weatherley, 1986). Evaluations of federal demonstration projects have found that while some may have improved pregnancy outcomes of some participants, they have generally been unsuccessful in reducing welfare dependency, school leaving, and repeat pregnancies, or in providing employment, all goals of these programs (Burt et al., 1984; Polit & Kahn, 1985).

Opening the Policy Window

The exigencies of political agenda building demand that a social issue be perceived as a national crisis in order to gain the attention of policy decision-makers. Advocates have strong incentives to dramatize the adverse consequences of a social condition and minimize the costs and difficulty of

ameliorative efforts. As a result, policy advocates have often emphasized the dire consequences of teenage pregnancy while obscuring its etiology in poverty, racism and sexism.

Three kinds of processes have been involved in sustaining popular and official perceptions of teenage pregnancy as a crisis demanding governmental attention: a) rhetorical devices stressing the gravity of the problem and the threat it poses to the social order; b) issue expansion, whereby teen pregnancy is implicated as a cause of other recognized social problems; and c) selective utilization of empirical evidence. Rhetorical devices include the use of medical metaphors such as "epidemic" and "contagion," and labeling the issue as "a crisis." Young unmarried mothers are described as "children" and "immature," irrespective of their age, individual circumstances and maturity, and their children are referred to as "illegitimate." The dramatic rhetoric and sense of crisis it conveys, and the potential for gripping pictoral representation has made the issue an appealing subject for the media, thereby reinforcing the interest of political actors (Declerq, 1978; Vinovskis, 1981).

Beginning in the 1960's, policy advocates portrayed teenage childbearing as a cause of poverty, crime, delinquency, school drop out, unemployment, child abuse, welfare dependency, mental retardation, and a variety of health and developmental problems. The seriousness of the problem was reinforced by a selective presentation of the empirical evidence. Statistical data were reported in ways that suggested a growing problem. This was done, for example, by lumping together the 17-19 year olds who have the most children with less mature, younger girls; by reporting the increasing *numbers* of births to the baby boom cohort which was actually experiencing falling birth *rates*; and stressing rates of increase among the youngest girls, aged 10-14, from 0.8 births per 1,000 in 1966 to 1.1 in 1983, without mentioning the relatively small numbers involved—9,773 in 1982 (Levine & Adams, 1985).

Most common was the attribution to teen pregnancy of a series of dire consequences, an association based on the

ecological fallacy. There is a large body of literature documenting the ill effects and social costs of early childbearing and parenthood. However, many of these adverse consequences result not from pregnancy per se but from poverty and the unequal access to resources and services. Nonetheless, individualistic interpretations of the issue persist. This is not only because out-of-wedlock parenthood is a violation of maternity norms (Schur, 1984), but also because there is no constituency to support the redistributive policies that a structural interpretation would imply. Interest groups are constrained to put forth strategies consistent with the electoral interests of political actors.

Teenage mothers were innacurately deemed biologically too immature for safe childbearing; their high premature delivery rate was considered inevitable, unaffected by even the most comprehensive prenatal care (Alan Guttmacher Institute, 1976, p. 21). They were said to be more prone to child abuse (Bolton, 1980), though empirical studies have failed to confirm this (Gelles, 1986). It was often asserted that teen pregnancy caused school leaving (Alan Guttmacher Institute, 1976; Fine and Pape, 1982), though half the young mothers who have left school dropped out *before* becoming pregnant.

A *Time* magazine cover story captures the popular theme of female culpability. The article, "Children having children: Teen pregnancies are corroding America's social fabric," states:

> Teen pregnancy imposes lasting hardships on two generations: parent and child. Teen mothers are, for instance, many times as likely as other women with young children to live below the poverty level. According to one study, only half of those who give birth before age 18 complete high school (as compared with 96% of those who postpone childbearing). On the average, they earn half as much money and are far more likely to be dependent on welfare: 71% of females under 30 who receive Aid to Families with Dependent Children had their first child as a teenager.
>
> As infants, the offspring of teen mothers have high rates of illness and mortality. Later in life, they often experience educational and emotional problems. Many are victims of child abuse at the hands of parents too immature to understand

> why their baby is crying or how their doll-like plaything has suddenly developed a will of its own. Finally, these children of children are prone to dropping out and becoming teenage parents themselves. According to one study, 82% of girls who give birth at age 15 or younger were daughters of teenage mothers.
>
> With disadvantage creating disadvantage, it is no wonder that teen pregnancy is widely viewed as the very hub of the U.S. poverty cycle (*Time*, Dec. 9, 1985, p. 84).

Such interpretations notwithstanding, there is a substantial body of evidence confirming that many of the problems associated with teen pregnancy and childbearing are due to poverty, exacerbated by inadequate health and welfare services. Poor teenagers are more prone to bear children as well as drop out of school, be unemployed, receive public assistance and have health problems (Cutright, 1972b; Menken, 1972, p. 334; Osofsky & Kendall, 1973, p. 115).

More recent research has reaffirmed the links between poverty, poor health care, and the ill effects of teen pregnancy. Baldwin and Cain's review of the research (1980) led to the conclusion that the perinatal and neonatal risks of early childbearing were directly related to the quality of prenatal care. They cited a study of 9,125 births in Copenhagen, Denmark that found that the children of younger mothers, drawn from a lower socioeconomic group, actually had *lower* rates of stillbirth and neonatal mortality than the children of older, more economically secure mothers. The younger mothers and their children also had better indicators of general health. These excellent results for young women at apparently high risk were attributed to the superior system of prenatal care. Similar results were also reported in American studies when high quality prenatal care was provided.

A summary of research reviews states, ". . . studies fro the 1960s did not isolate the affects of age from race, SES, legitimation status, etc., and concluded that by virtue of being adolescent, the mother was at high risk of poor outcome, as was her baby. . . . But adolescent mothers, even those less than 15 . . . are not at substantially greater risk" than older mothers of similar SES and race (Mc Anarney & Thiede, 1983, p. 378).

Class and Race Dimensions of Adolescent Childbearing

Concerns about teenage illegitimacy, especially among blacks, and the attendant welfare costs have been cited among the reasons for passage of the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978 (Vinovskis, 1981). Some of the reasons for the increased out-of-wedlock birth rates have received little attention in policy debates, however. A major factor has been the declining rate of marriage (Hayes, 1987, p. 77).

After a sharp rise in the adolescent marriage rate following World War II and continuing through the 1950's, the rate has since been steadily declining, as it has for older women. In 1960, only a third of the women between 20 and 24 had not married; by 1978, almost a half in this age group were unmarried, although in general, the declining marriage rate has been accompanied by a commensurate increase in cohabitation (Bell, 1983). Three structural factors are associated with the postponement of marriage since the 1960's: youth unemployment, prolonged high school and college education, and a skewed sex ratio reflecting a shortage of males, especially between ages 15-35. The impact of unemployment and the declining pool of available males has been particularly severe for blacks.

The percentage of men who have ever married varies directly with their income at every age and educational level. The employment picture for young people has been especially bleak since the 1960's. This is due to economic stagnation compounded by the entry of the baby boom cohort and an increasing percentage of women into the labor market. Youth unemployment rates have remained consistently high, especially for black males, even in periods of recovery.

Since men, on the average, marry women about four years younger, one effect of the baby boom was to create a 5 to 10 percent surplus of women at the age when most first marriages occur. This marriage gap was exacerbated by a higher male mortality rate. Males between the ages of 15 and 35 are especially prone to death from accidents, murder and suicide, and a substantial percentage are incarcerated. Violent death and incarceration take an especially high toll

among black males, and with the high rate of unemployment, there is a dearth of potential marriage candidates, especially among blacks (Bell, 1983).

Premarital Sexual Activity, Contraception, and Abortion

During the 1970's, there was a substantial increase in the percentage of unmarried adolescents who were sexually active. The proportion of unmarried girls 15-19 who had ever had intercourse increased from 28 percent in 1971 to 46 percent in 1979, and then declined to 42 percent in 1982. The proportions of black girls who were sexually active during this period ranged from 13 to 31 percentage points higher than white girls (Hayes, 1987, p. 40).

Socioeconomic status is strongly associated with age at first intercourse, contraceptive use, abortion and childbearing. Using the mother's educational attainment as a measure of socioeconomic status, the lower her level of schooling, the more likely her adolescent child would become sexually active. An analysis of the National Longitudinal Survey of Youth data found that 53.7 percent of those girls whose mothers had not completed high school were sexually active by age 18, compared with 34.1 percent whose mothers continued beyond high school (Hayes, 1987, p. 45).

The causes of adolescent childbearing are complex, and no single explanation can account for the variety of behaviors and circumstances involved. Middle and upper-class adolescents become pregnant as do those from impoverished backgrounds. Yet a number of studies have pointed to the associations between poverty, the early initiation of sexual activity and the failure to use contraception. As summarized in a review of the research, the following factors appear to be central:

> . . . poverty, living in a one-parent family, minority group membership, low education and occupation of parents, low economic achievement and low educational-occupational goals of the young person (Chilman, forthcoming, p. 7).

The linkages between one's life circumstances and sexual and contraceptive behavior remain unclear. However, there is evidence that adolescents who perceive some benefit in

avoiding pregnancy and childbearing are more likely to do so. They tend to be those who have high aspirations and see some likelihood of achieving their life goals. Conversely, those who have low self-esteem, fatalistic attitudes and a lack of efficacy are more likely to bear children (Chilman, forthcoming; Furstenberg, 1976; Moore, et al., 1986).

Contraception

Despite the major strides in the availability of contraception during the past twenty-five years, problems remain. Federally funded family planning services first became available under the Economic Opportunity Act in 1964, and services expanded rapidly in the early 1970's with the 1970 enactment of the Family Planning Services and Population Research Act, Title X of the Public Health Services Act. Title X initially drew support from a coalition of women's rights and population control advocates, many of whom were concerned about growing AFDC enrollment. However, Title X has since been opposed by conservatives who contend that it fosters promiscuity and erodes parental authority. With the passage of Title X, there developed a two-tier system of service delivery, with government sponsored family planning services targeted to the poor, the young and minorities, while white, middle-class women relied more on private physicians. However, with limited funding for Title X, there remains a substantial gap in available services.

An Alan Guttmacher Institute study in the mid-1970's estimated that a minimum of 1.6 million adolescents at risk were unserved by either a private physician or an organized program (Dryfoos & Heisler, 1978). There is little reason to believe this situation has improved since then. A national survey of adolescent girls confirmed this picture of family planning availability and utilization:

> If we add together those who never use contraception and those who have never used medical methods, we have around 70 percent of the sexually active who are not being reached through organized services. In addition, there is the large group of young women who ultimately use medical methods,

> but whose acceptance of these methods comes after an extended period of nonuse, which in many cases involves an unintended pregnancy. *In terms of their penetration of the market for teenage contraception, the nation's physicians and clinical services can reasonably be regarded as marginal suppliers* (Zelnik, Kanter and Ford, 1981, pp. 129-130, emphasis added).

While reproductive processes are "natural," they are also shaped by material and social conditions. The introduction of the birth control pill and IUD in the early 1960's shifted primary contraceptive responsibility from males to females. For young, unmarried women, the use of contraception, especially the pill, diaphragm and IUD, conflicts with strong social sanctions against being sexually assertive.

Kristin Luker (1975) put it this way: ". . . our present contraceptive technology has increasingly created an ideology that says un unwanted pregnancy is the woman's fault." She argued that the failure of many young unmarried women to contracept represents a kind of rational risk-taking where women "weigh the actual costs of contraception against a discounted risk of pregnancy" (p. 41). The costs of contraception for young unmarried women include the flaunting of taboos by planning to have sex, being sexually available and experienced.

Despite the technological shift to female contraceptive methods, Zelnik, Kanter and Ford (1981) found that 40 percent of adolescent girls who used birth control relied on male methods, the condom or withdrawal. However, adolescent males remain insufficiently concerned about their contraceptive responsibility (Chilman, forthcoming, p. 10).

Abortion

Abortion also has played a central role in limiting the number of births to teenagers during the past fifteen years. From 1973 to 1982, the proportion of teen pregnancies terminated by abortion rose from 24 to 39 percent (Levine and Adams, 1985). The abortion rate might be even higher were it not for the 1976 Hyde amendment prohibiting federal funding for abortions (Steiner, 1981).

When one considers the differences in the availability and utilization of contraception and abortion, along with the availability of the marriage option, the class dimensions of teenage pregnancy stand out. Low income and minority girls become sexually active earlier and are much less likely to use contraception or rely on abortion than white, middle class adolescents. Zelnick, Kanter and Ford (1980) found little difference in contraceptive use between black and white teenagers when controlling for age, socioeconomic and family status, and age at first intercourse. Even before passage of the Hyde amendment, abortion was used mainly by the middle classes. The poor pregnant teenage girl is about two-fifths as likely to abort irrespective of race. Considering the effects of both marriage and abortion, Zelnik, Kanter and Ford (1981) found:

> ". . . those in the lowest SES category were 9 times as likely to deliver illegitimate births as those in the highest category; among whites the differences are even more extreme, in that none of the women in the highest [SES] category delivered an illegitimate birth, all of their illegitimate pregnancies having been 'resolved' either by abortion or by marriage" (p. 158).

Summary and Conclusion

As a social problem, early unintended pregnancy and childbearing can be defined in different ways. It may be seen as resulting from impoverishment, restricted educational, vocational and marriage options, inadequate preparation for sexuality, lack of information and access to contraception and abortion, and social prohibitions against female birth control initiatives. The adverse consequences associated with early childbearing may also be seen as manifestations of poverty, an inadequate health care system, and the lack of public child development supports. Such interpretations call attention to the structural components of the issue and reveal ways in which individual behavior and social policy are constrained by economic inequality and racial and gender bias. They suggest the need for basic re-

forms to reduce poverty and inequality and improve access to health care, family planning and other essential services.

Historically, however, the dominant problem definitions have focused on the individual girl rather than the social context of childbearing. It has been her immorality, neurosis, or ignorance, or the lure of public support that caused her to become pregnant. Her immaturity was itself the cause of poor pregnancy and developmental outcomes. Her behavior threatened the social fabric by perpetuating the culture of poverty and spawning a host of costly social ills.

The predominance of individualistic definitions of the problem is not accidental. The prime arbiters in defining adolescent pregnancy have been the service providers, helping professionals, academics, bureaucrats and politicians who have some vested interest in the issue. Given the constraints of the political system, the policy options they promote must be acceptable to dominant interests if they are to receive serious consideration. This rules out universalistic health care, income support, and full employment policies that might alter the social context of early childbearing, especially among minorities and the poor.

Policies to promote early sexuality education, birth control information and access, and contraceptive responsibility would benefit adolescents at all income levels. While such policies are not as costly as basic welfare state reforms, they threaten patriarchal family values by appearing to sanction adolescent sexuality. A National Academy of Sciences panel concluded, "The problems of adolescent pregnancy and childbearing are solidly rooted in many of the forces and principles that shape our society—individualism, family autonomy, and free enterprise" (Hayes, 1987, p. 293).

Changing circumstances, most notably concerns about the spread of AIDS, and the efforts of both new and established advocacy groups have opened the national policy agenda to a somewhat wider range of options. There is increasing recognition of the role of poverty, racial discrimination, and sexism in early childbearing. However, many of

the more recent proposals continue to focus on individual change. Remedial education, employability training, values clarification, assertiveness training, life skills planning, and mentoring programs may be of limited benefit unless adolescents perceive that there are meaningful life options available to them. Even incremental efforts to strengthen existing family planning, income maintenance, nutritional and maternal and child health programs are most welcome, as are campaigns promoting sex education and contraception. It is not likely, however, that the rate of adolescent childbearing or the incidence of adverse health and social consequences will be significantly altered without major changes in income distribution, employment opportunities, gender roles, and health and welfare services.

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