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Health Effects of Adolescent Pregnancy: Implications for Social Workers

Terri Combs-Orme

ABSTRACT: *Adolescent pregnancy carries significant risks to the health of the pregnant adolescent and her child. These risks, which include pregnancy complications, low birth weight, and infant mortality, are due in large part to the behavior of the adolescent and her socioeconomic circumstances. Early and consistent use of health care can minimize risks by permitting the detection and management of serious problems. Human service professionals should use every opportunity to encourage good prenatal care, while keeping in mind the developmental and personal needs of the pregnant adolescent.*

BOTH PROFESSIONALS and the public agree that pregnancy is undesirable for adolescents. This consensus holds true even when adolescents are married, although the issue takes on additional controversy when the adolescent mother is not married, because of the public costs.

Adolescent pregnancy carries many negative consequences, such as reduced educational achievement and earnings potential for adolescent parents. The risk of adverse health consequences for both mother and baby is another significant negative aspect of adolescent pregnancy. Social workers have been aware of the health consequences of adolescent pregnancy for many years (Wessel, 1963), although some may now believe that improved technology has eliminated many risks for pregnant adolescents. This article discusses health risks and health disadvantages for adolescents as well as the implications of such risks for practitioners. Although pregnancy incurs significant negative health consequences for adolescents, most of these problems can be managed with appropriate health care.

Health Risks

Clearly, adolescent pregnancy involves additional risk for adverse outcomes when compared with outcomes of women in the ideal childbearing age range of 20 to 24 years. The three major indicators of poor pregnancy outcome are pregnancy complications, low birth weight, and infant mortality. All of these risks are higher for second and subsequent-order births than they are for first births (Hardy & Zabin, 1991).

Pregnancy Complications

Pregnant adolescents are at risk for a number of health complications that have serious

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TABLE 1. Rates of medical complications of pregnancy for adolescents and older women, 1989.

Complication	Younger than 20 years ^a	20-24 years ^a	All women
Anemia	30.3	22.9	19.1
Cardiac disease	2.3	2.9	3.6
Lung disease	3.5	2.9	3.0
Diabetes	7.4	13.6	21.1
Genital herpes	5.3	6.8	8.1
Pregnancy-related hypertension	35.4	29.4	28.2
Renal disease	4.1	3.2	2.7
Eclampsia	7.3	4.6	4.4
Uterine bleeding	6.7	8.1	9.1

^aNumber of births with complication per 1,000 live births.

Adapted from National Center for Health Statistics. (1992). *Monthly Vital Statistics Report*, 40(12-S), 11.

consequences if left untreated. Table 1 shows rates of selected complications for live births in 1989 (the most recent year available) among adolescents younger than 20, women ages 20-24, and all women. As Table 1 indicates, although adolescents are at higher risk for some serious complications, they also have a reduced risk for certain others.

Renal conditions for which adolescents are at excess risk include urinary tract infections, acute pyelonephritis, and preeclampsia (Repke, 1991). Urinary tract infections and pyelonephritis relate to changes in kidney functioning during pregnancy. These conditions are responsible for a significant amount of maternal morbidity during pregnancy and can be associated with intrauterine growth retardation and even fetal death (Samuels & Landon, 1991).

Preeclampsia is a serious hypertensive disorder of pregnancy that affects the functioning of the kidneys, liver, and blood; this condition constitutes a medical emergency (Anderson &

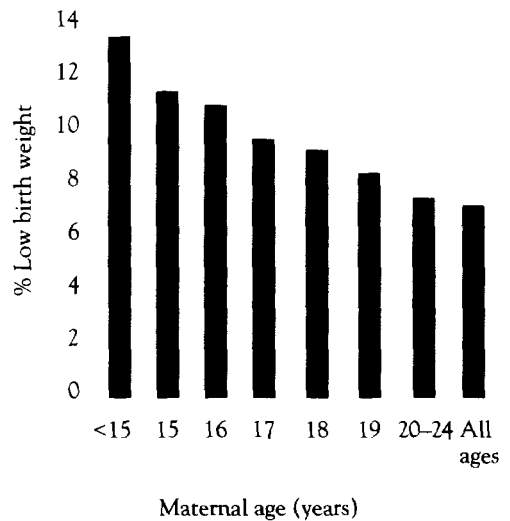
Sibai, 1991). Full eclampsia, which is marked by seizures, is often fatal. When it is possible to do so, preeclamptic women are delivered immediately; in other cases, hospitalization and intravenous medication are indicated until the fetus is mature enough for delivery.

McAnarney and Greydanus (1989) emphasize that adolescents' increased risk for such complications is likely due not to their age, but to their primiparity (these illnesses are more common in primiparous women) and their poor use of health care resources. This latter factor is especially important with regard to the pregnancy complications discussed above, because such complications can be detected early and managed successfully through regular prenatal care (Ryan & Schneider, 1978). Moreover, observation and monitoring during prenatal care can prepare the health care team for complications of labor and delivery.

Low Birth Weight

There are two reasons for infants being born at low birth weight (LBW), that is, below 2500 grams (approximately five and one-half pounds): (1) prematurity, which is conventionally defined as delivery before 37 weeks of gestation, and (2) intrauterine growth retardation,

Fig. 1. Low birth weight by maternal age.



Adapted from National Center for Health Statistics. (1991). *Monthly Vital Statistics Report*, 40(8-S), 28.

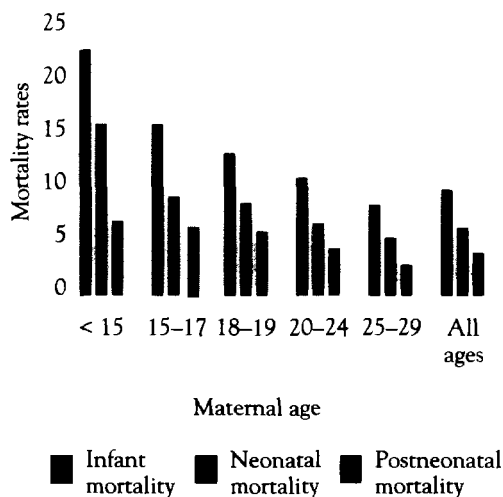
which is indicated by a low birth weight for gestational age. Adolescents are at excess risk for LBW infants due to both causes (Makinson, 1985). In 1989, approximately 7% of all (5.7% of white and 13.5% of African American) live births in the United State were LBW. The distribution of LBW babies by mothers' age indicates increased risk for adolescents (Figure 1). The risk is particularly high for very young adolescents (younger than 15); the relative risk of LBW associated with very young ages of mothers is especially high for white women (data on race not shown).

Low birth weight increases risk of cognitive deficit, morbidity, and death during the first year of life (McCormick, 1985). Although survival rates have improved with neonatal intensive care technologies, infants who weigh less than 1500 grams at birth (referred to as very low birth weight [VLBW]) are particularly at risk. These infants often have lengthy hospital stays in neonatal intensive care units (NICUs), and hospital charges may reach hundreds of thousands of dollars (Rudolph & Borker, 1987).

Infant Mortality

Two components of infant mortality are neonatal (death within the first 28 days of life)

Fig. 2. Infant mortality by maternal age, 1987.



Unpublished data adapted from the Centers for Disease Control, Public Health Service, U.S. Department of Health and Human Services, Washington, DC.

and postneonatal (deaths occurring between 29 days and 12 months of life). Neonatal mortality generally results from perinatal conditions such as LBW, whereas postneonatal mortality is correlated with socioeconomic factors.

McCormick, Shapiro, and Starfield (1984) demonstrated with a large sample of births in the period 1975-1978 that the increased risk of neonatal mortality for adolescents' infants could be accounted for by their higher rates of LBW. This factor was not relevant for postneonatal mortality. However, even after controlling for LBW, the infants of adolescents died at higher rates than did the infants of older mothers. Moreover, whereas neonatal mortality fell for all groups during the study period, postneonatal rates increased significantly.

Figure 2 shows total rates of infant mortality and rates for neonatal and postneonatal mortality by maternal age for 1987. The effects of maternal age are most dramatic for total mortality and for neonatal mortality; the elevation for postneonatal mortality is less dramatic and may be due to variables that are not controlled here.

Data on the causes of death for infants by maternal age are not readily available, so it is difficult to explain fully these differences in mortality by maternal age. Certainly much of the excess risk for neonatal mortality is due to high rates of LBW among young mothers. With regard to postneonatal mortality, rates of both injury (McCormick, Shapiro, & Starfield, 1981) and rehospitalization (McCormick, Shapiro, & Starfield, 1980) during the first year of life are elevated among infants of adolescent mothers.

Other Risks

In addition to the risks posed to the index pregnancy, adolescent pregnancy negatively affects lifetime reproduction and mental health of mothers. Women whose first pregnancy occurs in adolescence bear more children over their lifetimes than do women whose first births occur later (Card & Wise, 1978). Because higher-order babies generally are not as healthy as are lower-order babies, early childbearing results indirectly in poorer pregnancy outcomes among these women.

Second, little attention has been focused on the potential of mental health problems resulting from adolescent pregnancy. Hardy and

Zabin (1991) interviewed a random sample of 389 adolescent mothers who had given birth in Baltimore in 1983. They reported high levels of depression among their sample of pregnant adolescents: 54% overall, with higher rates among adolescents with second or subsequent pregnancies. Moreover, because many adolescent mothers become socially isolated from peers, help may be unavailable. Although 69% of Hardy and Zabin's sample reported having someone to talk to about their feelings, only 14% received professional counseling. Twenty-eight percent—39% with a second or higher-order birth—said they received no help from any source.

Other than higher-order births, research has not clarified the risk factors for depression or other mental health problems among pregnant adolescents. Currently 25% to 50% of juvenile psychiatric patients in many clinics are considered to be at least moderately depressed, whereas in general adolescent samples, 20% of females report depressed mood (Hodgman, 1989). The proportion is likely to be as high or higher for pregnant adolescents, who are faced with considerable personal stress and interpersonal problems as a result of the pregnancy. Zuckerman, Amaro, and Beardslee (1987) also suggested that hormonal changes experienced during pregnancy might exacerbate depression among adolescent females.

Reasons for Additional Risks

Except for the very youngest adolescents (younger than 15 years, perhaps), it is unlikely that the poor pregnancy outcomes experienced by adolescents are caused by physiological factors. At one time, it was believed that the competition between the adolescent mother's own growth and developmental needs and the needs of the fetus was responsible for poor outcomes, but Makinson's (1985) extensive review of data from five developed countries did not support this association.

Evidence suggests that the disadvantages suffered by adolescents and their infants are more closely related to adolescents' behavior and the circumstances in which they live. Recent studies that have controlled for background factors, including education, marital

status, and other indicators of socioeconomic status, find little or no independent effect for maternal age on poor outcome. Strobino, Ensminger, Nanda, and Kim (1992) note that the choice to bear a child during adolescence distinguishes these young women from their older counterparts in a number of important ways. Strobino et al. emphasize that none of the studies that has controlled for these factors has demonstrated a significant independent effect on birth outcomes for maternal age. They caution, however, that these studies generally have not measured maternal biological maturity.

Socioeconomic Circumstances

The primary risk for infants of adolescent parents is the poor socioeconomic prospects for the family. Adolescent mothers and their infants (and fathers who live with their families) have lower incomes than do older families, and they thus suffer the consequent disadvantages of low income: poor and unsafe housing, fewer cultural and social advantages, poorer quality nutrition, and fewer goods and services of all kinds. In many cases, the young family lives with extended family in large, crowded dwellings.

Hardy and Zabin's (1991) three-month follow-up of adolescent mothers and their infants in Baltimore confirmed these disadvantages. In their study, 80% of African American and 57% of white adolescent mothers lived in female-headed households. Six percent of the total (1% of African Americans and 25% of whites) were married and living with their husbands, and 6% of white and 12% of African American adolescent mothers lived with their boyfriends. Many of these mothers had moved several times, often living in large households ($M = 6.3$ for African American and 5.0 for whites). Most of these adolescents lived in poverty (45% of whites and 58% of African Americans had a total income below \$10,000). After 15 to 18 months, little change had occurred.

It has been well documented that children in poor families are less healthy than are more advantaged children; they have higher mortality rates and more disability days (Starfield & Budetti, 1985). Although part of this health disadvantage results from less optimal use of primary health care by poor children (Newacheck & Halfon, 1986), most of it probably results from

conditions resulting from socioeconomic status. The overall quality of life for poor children, who are overrepresented among adolescent parents, makes these children vulnerable to poor health (see Combs-Orme, 1990).

Use of Health Care

A major difference between women who bear children during adolescence and those who delay childbearing is their use of health care resources. Pregnant adolescents, for example, are less likely to seek early and consistent prenatal care. The American College of Obstetricians and Gynecologists (1983) recommends that all pregnant women see a health care provider at least once during the first trimester, monthly through the second trimester, and more frequently thereafter. Women who have medical problems or other identified risks are advised to follow a more intensive schedule.

As Table 2 shows, adolescents initiate prenatal care later in pregnancy than do older women; the youngest adolescents, who are at highest risk of poor outcomes, are least likely to seek care during the critical first trimester. As a result of their late start in receiving health care, adolescents are less likely to have the recommended total number of medical care visits over the course of the entire pregnancy (data not shown).

Why do adolescents delay that important first prenatal visit? In Hardy and Zabin's Balti-

more sample, only 44% of the young women initiated prenatal care in the first trimester. These young women reported delaying seeking care for several reasons, including denial of pregnancy (see Rosenthal & O'Grady, 1992), the wish to conceal it from their parents and others, and indecision about how they should resolve the pregnancy. Other commonly cited reasons included clinics' hours conflicting with school hours, transportation problems, and fear of medical tests and procedures.

Young, McMahon, Bowman, and Thompson (1990) interviewed 201 pregnant women who delayed prenatal care until the third trimester. Nearly 25% of the women were younger than 18; unfortunately, the authors did not present their findings by maternal age. It should be kept in mind that asking women why they did not enter prenatal care may create a social response bias that is hard to assess. Nevertheless, Young and colleagues' (1990) results help explain why women may delay prenatal care. These young women reported a number of reasons, including failure to recognize the pregnancy (which may be a particular problem among younger adolescents, whose menstrual periods are irregular), ambivalence about the pregnancy and how to resolve it, and fear of family's and the baby's father's reaction to the pregnancy. Other reasons cited included depression and family crises that absorbed all their attention. Nearly 12% of the entire sample felt fine or had had no problems in previous pregnancies and thus saw no reason to seek early care. This and other studies clearly suggest that both lack of knowledge and mental health problems may play a significant role in adolescents' seeking health care when they are pregnant.

Adolescents' poor use of health care resources, however, is not confined to obstetrical care; many adolescents do not use health care services after childbirth. Hardy and Zabin (1991) found that 11% of adolescent mothers had no regular source of health care at 15 to 18 months after childbirth. These young mothers were more conscientious about health care for their babies than they were for themselves, although other researchers have shown poor use of well-child care by adolescent mothers as well.

Strobino and colleagues used the National Longitudinal Survey of Youth to examine ado-

TABLE 2. Initiation of prenatal care by adolescents and older women, in percent for each trimester, 1989 births.

Age group (years)	1	2	3	None
<15	37.3	41.7	14.2	6.8
15-16	46.5	38.4	10.4	4.7
17-19	55.3	32.6	8.4	3.7
20-24	68.9	22.7	5.6	2.8
All women	75.5	18.1	4.3	2.2

Adapted from National Center for Health Statistics. (1991). *Monthly Vital Statistics Report*, 40(8-S), 43.

lescent mothers' initiation of well-child care for their infants (Strobino, Ensminger, Nanda, & Kim, 1990) and to compare adolescent mothers' infants' health with the health of infants born to older mothers (Strobino et al., 1992). Their sample included 3,130 infants of mothers aged 14 to 25 years. The authors found that adolescent mothers delayed initiating well-child care for their infants in the first two months after giving birth (Strobino et al., 1990). This delay was associated with social and economic characteristics of the young mothers and their own delayed use of prenatal care. On the other hand, the youngest mothers scheduled more health care visits for their infants during the second six months of life. Despite this increased number of visits during the second six months, younger mothers' infants received fewer than the recommended number of well-child visits during the first year of life.

Strobino et al. (1990) also examined infant hospitalization (a measure of poor health) during the first year of life and found that infants of younger mothers were more likely to be hospitalized during the first year of life. Increased hospitalization was independent of eth-

nicity, infant birth weight, length of nursery stay after birth, well-child care, smoking during pregnancy, and several measures of socioeconomic status.

Other studies, however, have emphasized that differences in health status between babies of adolescent and older mothers are minimal when socioeconomic variables are controlled (Rothenberg & Varga, 1981). Smith, Spiers, and Freedse (1987) reported on a program designed to provide primary health care to infants of adolescent mothers; the study was designed to ascertain predictors of poor appointment-keeping behaviors. Findings indicated that young mothers who had negative attitudes toward their infants, who lived in unstable home environments, and who relied on public transportation were less likely to keep nonroutine appointments. Nevertheless, these authors emphasized that continued efforts to engage the young mother can be successful, particularly if program staff deal directly with young parents' personal and immediate needs.

Other Health Behaviors

Adolescents display various health-related behaviors that contribute to poor pregnancy outcomes. Many of these behaviors (such as smoking) have been conclusively established as risk factors for poor pregnancy outcome, whereas other behaviors present less conclusive evidence.

Smoking. Evidence shows that smoking during pregnancy is associated with LBW (Kleinman & Madans, 1985). Table 3 compares the smoking status of adolescents with that of women ages 20 to 24. Although few younger teenagers (younger than age 15) are smokers, those who do smoke have elevated risks of bearing a LBW baby. Greater numbers of older adolescents and women in their twenties smoke; they, too, risk bearing LBW infants.

Alcohol. The use of alcohol during pregnancy has been associated with a number of poor outcomes, including fetal alcohol syndrome and birth defects (Pietrantonio & Knuppel, 1991). Table 4 shows drinking status for births in 1989. Although the data show small percentages of young women who drink during pregnancy, two factors should be kept in mind. First, the proportion of women who drink during pregnancy increases with age. Such increas-

TABLE 3. Smoking during pregnancy by adolescents and birth weight, 1989 births.

Age group (years)	Smoking status	(%)	Low birth weight
<15	Smokers	7.8	15.6
	Nonsmokers	92.2	13.8
15-17	Smokers	19.0	11.6
	Nonsmokers	81.0	10.1
18-19	Smokers	23.9	10.7
	Nonsmokers	76.1	8.3
20-24	Smokers	23.5	10.6
	Nonsmokers	76.5	6.3
All women	Smokers	19.5	11.4
	Nonsmokers	80.5	6.0

Adapted from National Center for Health Statistics. (1992). *Monthly Vital Statistics Report*, 40(12-S), 16.

TABLE 4. Drinking during pregnancy by adolescents and older women, 1989 births.

Age group (years)	Drinkers (%)
<15	1.2
15-17	1.8
18-19	2.5
20-24	3.4
All women	4.1

Adapted from National Center for Health Statistics. (1992). *Monthly Vital Statistics Report*, 40(12-S), 17.

es are probably due to normal maturational processes and the fact that older adolescents have less supervision, more opportunities to drink, and more money with which to purchase alcohol. Thus, older adolescents are presumably more at risk of poor outcomes as a result of drinking behaviors. Second, these data most likely reflect underreported proportions of young pregnant women who drink (National Center for Health Statistics, 1992).

Other drugs. Drug use during pregnancy presents clear risks to the health of the fetus (Hutchins & Alexander, 1990). The specific effects of prenatal exposure to drugs vary according to the drug used, its timing and dosage, and other factors such as the mother's nutritional status (General Accounting Office, 1990). Ill effects that have been documented for different drugs include LBW, pregnancy-induced hypertension, third-trimester bleeding, malpresentation, puerperal morbidity, fetal distress, and meconium aspiration (Dattel, 1990). Cocaine use in general and during pregnancy appears to have been increasing steadily in recent years; the effects of cocaine use during pregnancy are believed to be serious and long-lasting (Chasnoff, 1989).

Little information exists regarding the extent of drug use among pregnant and parenting adolescents. Amaro, Zuckerman, and Cabral (1989) theorize that sexual activity and the stresses of early motherhood place these adolescents at high risk for drug use. Their study of 253 pregnant women aged 19 years and younger revealed that 52.2% admitted drinking alcohol,

31.6% admitted using marijuana, and 13.8% admitted using cocaine during their pregnancies. Drug users were older and more likely to be married and living with the baby's father. Use of drugs by the adolescent girl's partner was a significant risk for her own drug use.

Nutrition. In 1989, 18% of women whose pregnancies lasted 40 weeks or longer gained less weight than the currently recommended 21 pounds (National Center for Health Statistics, 1992). Adolescent women were much more likely to gain less than the recommended amount of weight, as were unmarried women and women with less than a high school education. Repke (1991) noted that eating patterns common to teens, such as skipping meals, eating junk and fast foods, and poor compliance with iron and vitamin recommendations, may place them at risk of gaining too little weight or being malnourished during pregnancy.

Inability to purchase adequate amounts of healthy foods is another nutritional risk faced by adolescents. Repke (1991) noted that many inner-city and poor rural adolescents cannot get enough food during pregnancy, particularly if they live in large households. In Hardy and Zabin's (1991) sample of 389 adolescent mothers, 11% reported difficulty getting enough food during pregnancy, and 14% reported having difficulty getting enough food for themselves and their infants in the first year after delivery.

Despite their low incomes and obvious needs, these young women did not take advantage of public nutrition resources. Only 45% of African American and 40% of white adolescent mothers reported that they were recipients of food stamps; only 74% of African American and 60% of white adolescent mothers received WIC (Supplemental Nutrition Program for Women, Infants, and Children, which provides coupons for specific nutritious foods for at-risk pregnant and lactating women and young children). Use of WIC increased during the first year of the baby's life (94% of African Americans and 86% of whites accessed the program).

Immaturity and Lack of Knowledge

Finally, adolescents and their infants suffer with regard to various factors that are more difficult to measure precisely but are nevertheless likely to contribute to poor health. Primary

among these factors are immaturity and lack of knowledge, both of which are likely to contribute to adolescents' failure to seek both prenatal and well-child care for their infants, and adolescents' engaging in behaviors that have negative health consequences.

Very young adolescents (age 10–14), who also may be the most vulnerable medically due to rapid musculoskeletal and sexual growth, are obviously not capable of thinking like adults. At this age, adolescents tend to be egocentric and obsessed with their own bodies and selves. Their cognitive thinking is concrete and existential, with little sense of the future or ability to perceive long-range consequences of their actions (McAnarney & Greydanus, 1989). Even older adolescents may find it difficult to defer gratification by changing their eating and drinking patterns and investing time in pursuing consistent health care. Indeed, adolescents' (especially younger adolescents') cognitive development is not consistent with planning for the future or connecting personal actions with their consequences; thus, prenatal care and regular well-child care in the absence of illness may not be a high priority for these young mothers.

In addition to their immaturity, adolescents lack basic information about health habits, signs and symptoms of early illness in themselves or their infants, and the advisability of early treatment when their infants become sick. Indeed, the adolescent parent may lack general knowledge about infant care. All of these deficits would be expected to increase the risk of death for infants of adolescent parents.

Despite social concern about adolescent parents, it is important to note that little direct evidence indicates serious parenting problems among adolescents. Whether adolescent parents are more likely to mistreat their children is a controversial issue, but Zuravin (1988) finds little evidence of increased risk of child abuse among adolescent parents when socioeconomic variables are controlled.

Practice Implications

Practitioners work with adolescents who are pregnant or at risk of pregnancy in various arenas: prenatal care clinics, school-based clinics, family-planning clinics, hospitals, adoption

agencies, and so forth. Traditionally, social workers' primary focus has not been health concerns but rather decision making and resolution of the pregnancy or the adolescent parent's economic and social situation. However, given the importance of health risks to young women both during pregnancy and later in their lives, and the potential of such risks affecting two generations, it is essential that practitioners who work with this population attend to health care issues.

Encouraging Prenatal Care

Social workers are likely to come into contact with pregnant adolescents at two points: (1) shortly after pregnancy is suspected or confirmed, as part of the decision-making process, and (2) during the prenatal care process, as part of services offered in clinics for low-income women and children. At each of these points, practitioners have the opportunity to encourage young women to attend to their prenatal care responsibilities. Other opportunities to encourage prenatal care include contacts made through well-child care of older siblings and contacts with disadvantaged pregnant women through other social service programs (Combs-Orme, 1990).

Some young women may delay prenatal care until they are certain that they want to carry the pregnancy to term; these adolescents should be encouraged to obtain care in the interim. Evidence suggests that other young women may not understand the importance of early care or may not know where or how to obtain care. It should never be assumed that young persons, especially younger adolescents, understand the importance of good preventive health care and how to obtain such care.

When it is possible to do so, prenatal care services should be tailored to the needs of pregnant adolescents. Repke (1991) claims that the typical inner-city maternity clinic is inadequate for adolescents and prefers specialized services. For example, the Johns Hopkins University specialized maternity-care program for adolescents recommends a comprehensive programmatic approach whereby medical care is provided by faculty, staff, obstetrical nurses, and a full-time social worker. Individualized care differentiates between the needs of a 13-year-old and a 17-year-old. All adolescents are required to meet

with a social worker to explore their needs; younger teens are encouraged to bring their mothers or other significant persons to the program. Group education includes information on the course of pregnancy and the importance of prenatal care, nutrition, and avoiding all harmful substances. Information about neonatal care and parenting is presented later in pregnancy.

Early and consistent prenatal care can equalize adolescents' chances of a good pregnancy outcome, particularly when care includes attention to nutrition, control of anemia and blood pressure, and other general health concerns (Rosenthal & O'Grady, 1992). Human service professionals should never assume that adolescents are well informed about the effects of alcohol, tobacco, and other drugs on the growing fetus, nor should our desire to prevent adolescent pregnancy and our dismay at its occurrence cause us to neglect the health needs of the adolescent when pregnancy does occur.

Vulnerability to Depression

The mental health needs of the pregnant adolescent may be overlooked in the rush to attend to more obvious issues. However, depression may immobilize the young woman and deter her from seeking prenatal care (Young et al., 1990), consulting with and seeking the support of family or others, or even confirming the pregnancy. Depression may also lead her to increased alcohol or other drug consumption.

Practitioners, when conducting assessments, should remember that depressed adolescents may neither recognize their depression nor communicate it to others. Repke (1991) notes a connection between depression and poor weight gain, recommending that pregnant adolescents who fail to gain weight appropriately should be evaluated by a social worker for depression and unresolved feelings about the pregnancy.

Assessing Concrete Needs

One of the most important tasks in working with pregnant teens is assessing their concrete needs (Bolton, 1980; Combs-Orme, 1990; Bierman, 1991). Pregnant teens have identified assistance with concrete needs as the most important thing anyone can do for them (Kadushin & Martin, 1988). Such work is not necessarily popular among practitioners who wish to do higher

prestige work such as psychotherapy. Nevertheless, the concrete needs of adolescents directly affect their health before, during, and following pregnancy. Adolescents living in poverty are at particular risk for poor health.

To assist with adolescents' concrete needs, practitioners need extensive knowledge about available services and eligibility requirements. Such services include family-planning services (especially specialized services for adolescents); parent-child support centers; adoption and abortion agencies; income maintenance; Medicaid; nutrition services (including WIC and food stamps); education programs (including high school equivalency programs and special programs for continuing education during pregnancy and beyond); and vocational training and placement programs. Practitioners should be knowledgeable about programs that serve adolescent fathers as well as adolescent mothers.

Important expansions in the Medicaid program since 1986 make health care assistance available to more women. These expansions have eliminated the link between receipt of Aid to Families with Dependent Children (AFDC) and Medicaid; currently, pregnant women with incomes up to 133% (and higher, in some states) of the poverty level are eligible for health care benefits. Other program innovations permit authorized providers to qualify for Medicaid "on the spot" so that the cost of prenatal care is covered immediately. Applications are shorter and have been simplified, and eligibility is guaranteed through 60 days following delivery (Rosenbaum, 1987).

Repke (1991) advises practitioners to put teens in contact with WIC, food stamps, and other resources. All pregnant adolescents should be assessed for eligibility for AFDC.

Finally, home visits may be useful to assess the pregnant adolescent's needs (Combs-Orme, 1990; Combs-Orme, Reis, & Ward, 1985). A home visit is an excellent way to assess the family's readiness for the infant, available resources, and possible needs. Home visits, a traditional social work function (Norris-Shortle & Cohen, 1987; Hancock & Pelton, 1989), may improve pregnancy and early infant outcomes (Olds & Kitzman, 1990).

Pregnant Adolescents Are Children Too

It is easy to forget that pregnant adolescents are still children, subject to the same cog-

nitive and emotional limitations as any child. Despite the temptation to think of and treat pregnant adolescents as adults, practitioners must always consider the developmental stage of the adolescent (Rosenthal & O'Grady, 1992). For example, although respect for privacy is always important, this issue may be especially critical for an adolescent who has never had a pelvic exam and may be unaccustomed to the sensitive issues discussed as a routine part of prenatal care (Smith, 1985).

Bierman (1991) advises social workers to focus on the adolescent herself—her feelings and needs. Attending exclusively to the infant's needs and the adolescent's role as a mother belies her developmental needs and may damage the worker-client relationship. The pregnant adolescent must deal with her own feelings and problems, including her physical health and the changes that occur as a result of pregnancy, before she can focus on the needs of her developing or newborn infant.

The personal needs of adolescent mothers may be quite different from those of older, more mature mothers. The adolescent may fear weight gain and changes in appearance, the pain of labor and childbirth, dying during childbirth, and the life-style changes that her pregnancy demands. Also, service providers may need to be more empathetic toward symptoms that older women endure more stoically,

such as nausea and vomiting. Practitioners' attention to such details may assist the pregnant adolescent in making behavioral changes that will contribute to her health and to a positive pregnancy outcome.

Conclusions

Despite elevated health risks, pregnant adolescents have an excellent opportunity for a healthy pregnancy, particularly if they obtain early and consistent prenatal care. For example, of 11,486 live births in 1989 to adolescents younger than 15, 9,947 infants were normal birth weight. Focusing on interventions that facilitate a healthy pregnancy and birth is more productive than focusing exclusively on risks.

Efforts to reduce the incidence of adolescent pregnancy are worthy and should receive full funding and support. However, when adolescents do become pregnant, it is important to work to assure that the pregnancy is a healthy one. Prenatal care is critical not only for maintaining a healthy pregnancy, but as an important link to other interventions that can improve the young parent's functioning and the family's chances for a healthy and happy life. As part of the prenatal care team, social workers play a vital role in assessing pregnant adolescents' needs and linking them with other available resources.

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