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Teenage Pregnancy: Correlates of Sexual Behavior and Overview of Prevention, Intervention, and Local Programs

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Overview

It is doubtful that any woman who has become pregnant and delivered a child did not experience some level of anxiety or frustration. It is also not likely that these women did not have anything else occurring simultaneously in their lives, such as work, social, and family commitments. Pregnancy and the expectancy of bringing a new life into the world inherently carry a certain amount of stress and uncertainty. Finding oneself in this situation has an incredible impact when a young woman has perhaps not even fully developed herself, and is faced with the challenge of raising a child.

Sexual behavior in adolescence has always been a controversial subject in this country. As will be discussed later, societal changes have contributed in part to mixed views on the topic. According to the 1988 National Survey of Family Growth (as cited in Miller & Moore, 1990), by age 14, approximately 25 percent of girls and 33 percent of boys have had sex. By age 19, this percentage has increased to 80 percent of girls and 87 percent of boys. Although this rate is not reportedly significantly higher than in other industrialized countries, the United States does report the highest rate of teen pregnancy (Alan Guttmacher Institute, 1994; Miller & Moore; Moore et al., 1997; Voydanoff & Donnelly, 1990). One reason for this seemingly surprising discrepancy may be the fact that information regarding birth control is more readily available to adolescents abroad than in this country. Information is accessible through the schools as well as the mass media, and the social stigma often attached to sexual activity in the United States is not expressed in these other societies (Chilman, 1989; Ladner, 1988).

Some studies have focused on teenage pregnancy within racial minority groups. For example, Miller and Moore (1990) found in the 1980s that black teenagers reported having intercourse earlier in adolescence than whites. A study of
teenage girls' resolutions of their pregnancies, which will be discussed later, focused exclusively on the Hispanic population (Berger et al., 1991). Although some studies have concentrated on teen pregnancy in association with a particular minority group (Miller & Moore, 1990; Ladner, 1988; Berger et al., 1991; Pete & DeSantis, 1990;), Desmond (1994) reminded us that teenage pregnancy is indeed an issue of adolescence, not race. Although it can be helpful to define the population of teens who become pregnant in terms of race, socioeconomic status, and family constellations, no adolescent female can be ruled out as absolutely immune to this occurrence.

Although schools seem to be the most likely setting in which to address this problem, there are several issues that arise when discussion of sexuality is combined with public education. The coordination of community services is often a difficult aspect of developing and implementing a successful program. School psychologists are in an ideal position to implement programs in schools, as well as join students, parents, and the community in sharing in the effort.

There is not only one factor that affects the rate of teen pregnancy in this country. Social views, education, peer pressure, family structure, socioeconomic status (SES), personal values and opinions, and characteristics of adolescence in general all play a role in influencing teenagers' behavior. This paper will review the social changes that have occurred in the United States in recent decades in order to view adolescent pregnancy within a temporal realm. It will also examine some of the research that has explored specific correlates to early sexual activity and pregnancy. Types of prevention and intervention programs will be defined, as well as examples of such programs in place around the country. Finally, local programs within Las Vegas and the Clark County School District will be described.
Social Influences

One factor affecting rates of teenage pregnancy and childbirth in the United States has been the dramatic changes in the views of the dominant culture since the 1950s. There has been decreased negative social stigma for unwed mothers and for premarital sexual intercourse (Ladner, 1988). In 1950, less than 15 percent of adolescent births were illegitimate; now over fifty percent occur outside of marriage (Davis, 1989). In fact, the proportion of births occurring outside of marriage to mothers under the age of 20 increased from 30% in 1970 to 64% in 1987. This is contributed to, in part, by the trend to postpone marriage (Ladner; Smith, 1994; Ventura, Clarke, & Mathews, 1996), and the incidence of marriage in pregnant teens continued to decrease through the 1980s (Farber, 1991; Moore et al., 1997; Smith).

Of course, all pregnancies have not always resulted in the adolescent taking on the role of mother. In the white population in the 1960s, adoption was encouraged because illegitimacy in the white community was looked down upon. In 1973, the Roe v. Wade Supreme Court decision legalized a woman’s choice to abort a pregnancy (Weatherley, Levine, Perlman & Klerman, 1987). Not surprisingly, abortion rates for adolescents increased after this ruling (Farber, 1991). In 1975, several bills were proposed within Congress to offer pregnant adolescents alternatives to abortion, such as more accessible social and health services. Unfortunately, these proposals were not passed at that time (Weatherley et al.). These types of services now seem to be more readily available to young women, and will be examined later in this paper.

Adolescence as a period of life

By definition, adolescence is the period of life that lies between childhood and adulthood, where neither set of social rules that are appropriate for these groups applies specifically to teens. Adolescence is a time of redefining oneself and forming one’s own identity (Freeman, 1989). In order to become self-sufficient adults, Pittman
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(1989) indicated that people need to develop in five distinct areas. One of these areas, education, includes not only academics, but also decision-making and problem solving skills. Another area, personal growth, includes attitudes, beliefs, and views of oneself and others. Other areas of development include health, work preparation, and development of a social responsibility and awareness. It is the responsibility of the family, the schools, and the community to ensure that today's youth grow and develop in all of these areas to become self-sufficient adults.

Pregnancy is not a condition that can always be looked upon as negative. Again, it is when it occurs during adolescence that it is viewed as "bad". At other stages of life, it is a condition that is usually celebrated. Messages that society tends to send teens about crime, smoking, and drug abuse can be extended to include adults as well. These are activities that are generally viewed as negative across the lifespan. In the case of sexuality and pregnancy, however, these are viewed negatively because of timing, not because the condition of pregnancy is inherently wrong. Because of these mixed messages being sent, teenagers need reasons to believe that delaying pregnancy is truly in their best interest (Pittman, 1989; Scott-Jones, 1991).

Not only is delaying pregnancy generally in the best interest of the adolescent(s) involved, but perhaps in the interest of their future children, as well. Sommer et al. (1993) found that adolescent mothers were less knowledgeable about child development than were adults. They also found that teenage mothers had a more undesirable attitude toward their role as a parent than did adult mothers. The cognitive readiness of adolescents to assume the roles and changes in responsibility that come with parenthood was found to be related to these more negative outlooks. Adolescent mothers may still be establishing their own identity, and may not be able to fully commit to or understand the needs and demands of a developing baby. Cognitive readiness for parenthood was found to be related to the developmental
stage of adolescence in general, rather than to the individual situations of teenage parents. With the current trend to delay marriage and childbirth, the “delayed transition to adulthood has meant an extension of the adolescent period” (Rosenheim & Testa, 1992, pg. 35).

Adolescence is a time of life in which individuals are forging their own identities and discovering their own individuality. So much must be given to a developing infant, both physically and emotionally, that it may seem more of a burden when the mother is an adolescent. Throughout the 1980s, studies showed that even when variables such as lower educational level and income were controlled for, the quality of mother-infant interactions was lower when the mother was a teen (Miller & Moore, 1990). This was exemplified by a lower frequency of verbalization, a poor quality of play, less knowledge of developmental milestones, and a less positive attitude toward the infant. Miller and Moore also found that adolescent mothers were more likely than older mothers to rate their infant as having a difficult to moderately difficult temperament. This could be significant because studies have found that a parent’s view of a child as “difficult” was correlated with an increased risk for behavior problems later on, even when these views were not consistent with those of independent raters (Bates, Maslin, & Frankel, Chess & Thomas, as cited in Miller & Moore, 1990).

As is evident by the history and wide scope of this matter, adolescent sexuality perhaps should not be looked upon as problematic in and of itself. Instead, these young adults need to have education regarding “the human condition” because, after all, sexuality will find its’ way to everybody, whether they are ready for it or not. Perhaps sexuality and information about it should be looked at as a part of the development of an individual (Chilman, 1989). Chilman also suggested that a family systems approach be applied to the complex developmental process that molds the way a person comes to learn about the world. These complex individual values,
Teenage pregnancy attitudes, and beliefs from a young age help individuals make choices about who they are and who they see themselves becoming in the future. If adolescents can be given the power of knowledge, options for their futures can be opened, and hopefully will lead to more educated choices.

**Male behavior**

Mixed messages are often sent by way of the media and society in general with regard to acceptable ways of behaving and certain societal roles. Physiologically, biologically, and hormonally, teenagers are able and often willing participants in the process of continuing the species. However, society dictates that individuals wait until they acquire an education, employment, and appropriate financial status before procreating (Scott-Jones, 1991). If teens are shown why these factors are important before beginning a family, rather than just being told “no” by their elders, they may understand it more readily. Scott-Jones found that 73% of boys and 40% of girls who had not yet had intercourse predicted that they would become sexually active before marriage. With teenagers not equating sexual intercourse with a marital relationship, even years in the future, chances of unwed girls becoming pregnant are increased.

Double standards for males and females have existed in society throughout history, and they still exist today. Adolescent and preadolescent females are often encouraged to emphasize looks, social skills, and pleasing others rather than focusing on education or developing their own identity (U.S. Department of Health and Human Services, 1997). It is exactly the opposite view, however, that should be encouraged in order to develop the five areas mentioned by Pittman (1989) to reach self-sufficiency in adulthood. A girl’s internal worth, rather than external qualities, must be emphasized if she is to develop lasting self-esteem as a person. Realizing the control a girl has over her life is important so that she can make positive decisions regarding her future. Although many children born to adolescent mothers were fathered by boys
who were also teenagers, research has shown that this is not always the case (Hardy & Zabin, 1991). In 1993, Kiselica reported that adolescent males fathered only 29-30% of adolescent pregnancies in young girls. In four separate studies, the rate of pregnancy of adolescents by young men aged 20 or older ranged from 39% to 70% (Alan Guttmacher Institute, 1994; Moore et al., 1997; Weinstein & Rosen, 1994). In one study, approximately 15% were fathered by men older than 25 (Weinstein & Rosen). This seems to indicate that the behavior of men may be more in need of adjustment than that of adolescents.

When looking at adolescent pregnancy as a problem that needs to be addressed, evidence has shown that male sexual behavior is more problematic and more in need of change than female behavior (Meyer, 1991). Sexual behavior in males, especially in adolescence, is driven physiologically as well as socially. Sexual experience and knowledge can be seen as a social or status marker in certain peer groups. As noted by Freeman (1989), "sexual expression is one area over which [males] have control and can use to influence the peer network" (pg. 116). In many school or community based programs, decisions regarding sexual activity are seen as just a part of being responsible. However, adolescent males and fathers have not traditionally been involved in these programs (Freeman). Female-oriented programs have helped to perpetuate the sexual bias that teenage pregnancy and its prevention are the sole responsibility of the females. The fact that the behavior and attitudes of males is underemphasized and that of females is emphasized, in fact, contributes to the continuation of the adolescent pregnancy problem (Meyer).

Kiselica (1995) offered a multicultural approach to counseling with teenage fathers that was focused on the universal, human aspects of fatherhood that are common to every man in this situation. As mentioned earlier, some authors have focused on culture-specific views of dealing with the issue of teenage pregnancy.
Although there are times when this can be most appropriate, Kiselica suggested helping young males with the universal emotions and confusion of being thrown into fatherhood as an adolescent.

In programs that focused on teaching males to be more responsible regarding sexuality, the following elements were found. The programs emphasized abstinence, as well as providing information on birth control methods. They involved male leaders in the community and topics that were directed by teen concerns, and they also made teens aware of media and peer influences on their behavior. Finally, they utilized peer networks and schools and career planning in looking towards the future (Freeman, 1989). On a national level, programs funded by the Department of Health and Human Services focused on young men and effective decision making skills by promoting abstinence in association with the Administrations Fatherhood Initiative (U.S. Department of Health and Human Services, 1996).

It is also important to look toward the education of males with regard to what should be expected of fatherhood, whether it is planned or not. Weinstein and Rosen (1994) found that young adult males often do not have realistic expectations regarding infants and their behavior, and often possess inadequate knowledge regarding child development.

**Correlates of Early Sexual Activity**

Several factors that contribute to a teenager being at-risk for early pregnancy have been noted over years of research. Not surprisingly, early sexual intercourse and inconsistent use of contraceptives both were found to place teens at-risk (Chilman, 1989). Teens who live in households with low socioeconomic status are also more at-risk for pregnancy (Voydanoff & Donnelly, 1990, Legislative Commission, 1990). Miller and Moore (1990) examined several general characteristics of adolescence that may contribute to early sexual behavior. These included general
feelings of invulnerability, inability to associate consequences to their actions, and
tendencies to be more socially critical and more tolerant of deviance. Miller and
Moore also reported that a high percentage of males who became teenage fathers
had a history of rebellion such as having conduct problems or having been involved in
some criminal activity.

Use of Birth Control. These characteristics of adolescence are common in
many teenagers. When they are combined with a lack of knowledge about sexuality
and a limited number of options for the future, the result can be children having
children. In one study (Berger et al., 1991), almost 60% of girls who became pregnant
did not use contraception, even though the majority of their pregnancies were
unwanted. Chilman (1989) identified some of the contributing factors to non-use of
birth control. They were alcoholism of parents, family violence or conflict, authoritarian
or punitive parenting, low family communication, neglecting or rejecting parents, and
ambiguous boundary setting. On the other hand, teens were found to be more
likely to use contraception if they were able to recognize their sexual activity without
guilt, when they had more information regarding types and availability of birth control
(this factor was found to increase with age), and when they were in a steady
relationship (Miller & Moore, 1990). The cognitive maturity of an individual
determines to a great extent the choices that they make. It requires a certain level of
cognition to be able to foresee the consequences of present behavior on the future.
Younger adolescents, who are biologically able to procreate, may not yet possess the
ability to realize the impact that unprotected sexual activity could have. Voydanoff and
Donnelly (1990) found that the age of first intercourse is a factor when examining
contraceptive use.

Education. Other characteristics that have been correlated with students at-risk
for pregnancy were low academic achievement and low educational expectations
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(Chilman, 1989; Desmond, 1994; Farber, 1991; Ladner, 1988; Legislative Commission, 1990; Miller & Moore, 1990; Paget, 1988; Voydanoff & Donnelly, 1990). School psychologists often deal with students who have experienced academic difficulties and failure. This is a population that may respond effectively to a prevention program implemented in a school.

If a teen has no hope that she will succeed academically, then parenthood may seem like an area where she feels she could be successful. As reported by Desmond, motherhood is considered to be an achievement within the black community, and “if the adolescent is unsuccessful in school, pregnancy may be a way out of an environment that reinforces a negative sense of the self” (pg. 327). A study of black adolescent females noted that “the combination of responses from peers, male partners, and families gave the girls the impression that their pregnancy was routine behavior for their age group” (Pete & DeSantis, 1990, pg. 152).

Family. Pete and DeSantis (1990) also found numerous familial correlates to early sexual behavior that involve the interaction of family members and the perceptions by teens of these exchanges. One of these was an inability or reluctance on the teen’s part to discuss sex with a parent. It was found, also, that there was often a lack of supervision or structured activities during after school hours. This was found by Moore et al. (1997) to be common in single parent families, which in itself is also a correlating factor to early sexual activity (Voydanoff & Donnelly, 1990; Legislative Commission, 1990). The Alan Guttmacher Institute (1994) reported that alcohol consumption by teens is correlated to sexual activity, including unprotected sex. Also noted by teens, in the study by Pete and DeSantis, was a perception of inconsistency between what parents said and what was actually permitted. Overall, these homes often shared the characteristic of having an ineffective authority figure as head of household. Also, a relationship with religion in the home was found; as the religiosity
of the family decreased, the likelihood of early sexual activity by teens increased (Voydanoff & Donnelly).

Other familial factors that have been reported to have an important impact on sexual behavior of teens are the mother's early sexual experience and the presence of older siblings who are sexually active. A positive correlation was shown between mothers' early sexual experience and adolescent sexual experience in their children (Miller & Moore, 1990). Berger et al. (1991) reported in their study that 77% of pregnant adolescents had mothers who were also pregnant as adolescents. Similarly, a separate study found that 77% of the mothers of teenage fathers were teenage parents themselves (Freeman, 1989). This indicates that the occurrence of early sexuality, and thus pregnancy, may be the result of the family values or way of life in which a child is raised. Within the home environment, early sexual behavior, which may result in pregnancy, may not be viewed as negative. Other reasons given by teens for becoming sexually active included curiosity, peer pressure, the inability to say "no", drug and/or alcohol use, and, usually more common in younger teens, falling in "love" (McCullough & Scherman, 1991).

Resolution

According to Berger et al. (1991), every year approximately ten percent of adolescent females experience pregnancy. Of this estimated 1 million pregnancies, approximately one-half delivered their baby, 40-45% aborted the pregnancy, and almost ten percent were either spontaneously aborted or stillborn (Alan Guttmacher Institute, 1994; Berger et al.; Davis, 1989). Realization of a pregnancy and decisions regarding its resolution are rarely regarded as simplistic. Farber (1991) found that teens' initial reactions to the news was either negative or neutral. Some of the unfavorable emotions were due in part to anticipated negative reactions from parents. Farber also found that the reactions from parents and other family members ran the
gamut from disapproval, anger, and upset to surprised, embarrassed, and understanding. Several factors contributed to the decision of how to resolve a pregnancy including values, beliefs, and attitudes of the adolescent and her family members, religion, and amount of family support. Berger et al. found that the primary decision-making factor regarding resolution was the teen's own feelings and opinions. Secondary were the desires and feelings of the baby's father, followed by the girl's mother. Berger et al. also found that almost all of the pregnant teenagers in their study expected changes in the relationship with their boyfriends and with their mothers as a result of the pregnancy.

Adoption as a resolution was chosen by less than five percent of pregnant adolescents (Davis, 1989). Adoption was found to be more likely as a solution when the adolescent's parent or parents were in favor of it (Herr, 1989). Findings regarding the income of the teen's family and adoption showed that higher income families favored adoption more often than lower income families, and that minority students (black and Hispanic) were less likely to utilize adoption services as a resolution (Farber, 1991; Warren & Johnson, 1989). One explanation for this may be that it is more "socially acceptable" for people with lower incomes to have a child out of wedlock than those in higher income brackets.

The decision to keep and raise a child as a single adolescent mother requires much strength of the individual and support of family and friends. Important factors that were found to be involved in this decision include the fact that both the adolescents and parents were against abortion and adoption, the male partner did not abandon the teen and were either financially supportive or supportive in the physical care of the baby, the adolescents had single friends or peers raising children, and the presence of a supportive family (Herr, 1989; Pete & DeSantis, 1990).
Types of Programs

There exists a multitude of programs in which the primary goal, and sometimes secondary goal, is to reduce the teenage pregnancy rate. Although these programs share this goal, the means by which they undertake it may differ greatly. There are several levels of intervention on which programs can focus, from prevention in elementary school to serving adolescents who are already mothers. According to the following research, the level of intervention varies from a one-on-one service delivery, to a more widespread community based effort. Also, the location and availability of the services offered varies from school campuses to community agencies.

Levels of Programs

Ravoira & Cherry (1992) outlined three major types of programs aimed at the issue of teenage pregnancy. Level one, or primary prevention, is an effort to intervene at the earliest point possible. The aim at this level is to educate and inform young people about decision making and sexuality before they begin to be sexually active. Its goal is to delay sexual activity, and therefore pregnancy, and teach adolescents why this is truly in their best interest. The next level of prevention, secondary prevention, is used when teens are already sexually active. The main objective at this level is to prevent pregnancy by increasing life options and self-esteem and encouraging the use of contraception through the use of health clinics and comprehensive sexual education programs. According to Voydanoff and Donnelly (1990), the two main goals of pregnancy prevention are usually (a) delaying or reducing sexual activity and (b) increasing the use of contraception. The third level indicated by Ravoira and Cherry is primary intervention. This occurs after an adolescent has already experienced a pregnancy or birth of a child. Goals at this level are the prevention of more pregnancies and increasing the well-being of both the mother and child.
Levels of Focus

Several levels of investigation into the problem of adolescent pregnancy have been outlined in recent years. Franklin (as cited in Desmond, 1994) recommended that teenage pregnancy be looked at from a four level approach. The first is an individual level, including early sexual activity and the use or non-use of birth control. The family level investigates family structure and the primary values in the family. From the socio-cultural level, the effects of low income and low education are examined. Finally, the social-structural level looks at the role that institutions play in decision making.

Levels of Implementation

Also, levels of implementation of prevention and intervention differ in their target population as well as intensity. According to Smith (1994), there are three levels at which messages to delay sexuality and pregnancy can be communicated: (a) The Universal level, (b) the Selected level, and (c) the Indicated level. The Universal level is the most general, and is of the lowest intensity. It includes school based sexual education classes, public service announcements, and access to contraception. The Selected level focuses on teens in high risk or at-risk groups for pregnancy. Programs that target these groups include after-school activities that promote self-esteem and decision making skills. The Indicated level is the most intense level, and it targets teen parents and teens who demonstrate "risky" behaviors. These programs involve explicit sexual education and distribution of contraception. They also may include individual, family, or group counseling. Mentor programs are implemented at this level, and are based on the idea that sexual behavior is influenced heavily by peers. The mentors are trained to talk about sex, pregnancy, and general information, and become a source of support for the teen (Teen Connection, personal communication, May 12, 1997; Voydanoff & Donnelly, 1990).
School Based Sex Education

Adolescents do not enter the school environment already knowing everything about history, art, mathematics and English. It cannot be expected that they enter the social world of adolescence and innately understand the complex situations and changes that are going on around them. As Davis (1989) stated “If...we want teenagers to behave more responsibly in sexual matters, we must provide them with the means and knowledge to do so” (pg. 24). This quote does not isolate female adolescents as the only responsible party; the needs of both males and females must be addressed, as well as male responsibility issues in the area of teenage pregnancy (Ladner, 1988).

Who is to teach today’s youth these valuable lessons? This has been a question of morality, legality, family and personal values, and social responsibility for decades. There has been much controversy regarding what to teach in a “sex-ed” or sexual awareness curriculum, and whether such education should include information on birth control, abortion, decision making, population issues (Ladner, 1988), or morality and religion. In one study (Weatherley et al., 1987) it was found that although the majority of parents in certain communities were in agreement with sexual education in the classroom, particularly vocal minorities were often successful in preventing the introduction of sex education curricula.

Zady and Duckworth (1991) outlined a scenario from a Jefferson County school district in Kentucky. In 1979, Kentucky approved and passed mandated sex education in schools. Parents in Jefferson County went to court and eventually had the mandates lifted. The following were arguments made against sex education. “Bodies and souls can be destroyed through sex-not through history or math... I’d rather my kids get [information about sex] from the gutter than from a teacher - an authority figure they look up to” (pg. 25). So in 1981, the state of Kentucky allowed sex education to
be voluntary (as opposed to mandated) in the schools. Therefore, Jefferson County dropped this course as a requirement, and the parents dropped their lawsuit. Without district support, however, teachers were now the ones who were at risk if they chose to teach sex education. The results of this were that teachers were afraid to teach this sort of curriculum, it was not taught, and eventually, some teachers believed that it was actually against the law to teach sex education. This is just one example of a community unable to work together and the obstruction in education that grew from fear and miscommunication.

**School Based Health Clinics**

School based health clinics are usually operated by outside agencies and offer a range of health services, but mixed results have been found with regard to contraception use and pregnancy (Voydanoff & Donnelly, 1990). In 1984, Kirby found that the most successful and effective sex education programs were affiliated with a school based health clinic that attempted to facilitate communication of information between parents and students. As illustrated in the Jefferson County situation, schools can be caught in the middle between community and parental obligation, between community benefit and individual parents' desires for their children. After the home environment, where parents have the most influence, the school environment is the next logical step of implementation of programing due to mandatory attendance. Community resources are needed so that, subsequent to the home environment, schools do not have to undertake the entire burden of prevention and intervention. Also, school-based programs alone do not address the needs of the 50% of adolescents who get pregnant after they drop out of school (Weatherley et al., 1987). Whether programs exist within the schools or out in the community, every effort should be made to work with teens from their perspective, focusing on their individual needs and situations (Chilman, 1989). The most important factor is giving adolescents the
power and life options to make it to adulthood with all of the skills necessary to succeed.

Comprehensive Programming

Farber (1991) agreed with comprehensive pregnancy counseling and that it should be sought at the earliest possible time to ensure maximum choices, including abortion options. A comprehensive approach to pregnancy, whether it is at the prevention or intervention stage, is one where "specific program components including health, educational, and social services must be assembled and linked through some coordinating mechanism" (Weatherley et al., 1987, pg. 79). A comprehensive approach ensures that the entire adolescent is treated, not just the situational circumstance of pregnancy. At the preventative level, self esteem, life options, education, and career are emphasized. These are also addressed at the stage if a girl is already pregnant. At this point, health and nutrition of both the child and the mother are addressed, in addition to child development and information the new mother will need.

Three phases of policy development dealing with teenage pregnancy in school were outlined in Zady and Duckworth (1991). The first is an institutional commitment which requires goals and policy descriptions that take into account possible challenges, parental views, and community organizations that could lend services to the program. Second, the implementation of the program must be looked at, and specific methods of presenting information and allowing for discussion within the classroom must be identified. Finally, the public and overall perception of the program must be anticipated.

"The most effective strategies are those which gain the support of not only schools but also the communities and other groups" (Legislative Commission, 1990, pg. 13). The cooperation of parents, the media, and other community organizations is
important in order to ensure continuing support and further development of the program and related efforts. If these groups are involved from the beginning, the likelihood of continuing support is increased. It is ideal to bring the view to the community that everyone needs to be involved in education for it to work (Paget, 1988). A variety of groups need to have input including parents, students, schools, businesses, and religious and cultural groups. If the benefits of investing time, energy, and resources in today's youth are realized, the result will be an increase in volunteers and mentors from the community, as well as materials and overall enrichment for the classroom (Edwards, 1988). This idea can be applied to education in general, in addition to its benefits for particular groups such as those implemented to deal with teenage pregnancy. Communities and society as a whole send messages as far as expectations of behavior in a multitude of situations. If parents, schools, churches, media, and community organizations came together and maintained consistent expectations, this could serve as a powerful influence on adolescent sexual behavior (Hardebeck, 1987).

Stevenson (1990) suggested that the following elements should be present in a successful sexual education program based within a school. Parents should be involved from the beginning, and information given to students during the course of the program should also be given to their parents. This will let parents know what their child is learning, as well as facilitate communication between students and their parents. A general decision-making curriculum should be presented in order to let students see the control they have over their lives. This can be applied to areas of sexuality as well as other social situations. Finally, it was suggested that teen parents in the community and / or the school become involved and serve as a source of information for other students. Miller, Card, Paikoff, and Peterson (1992) add that program goals must be clear, specific, and long term. Also, the program would need
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to be intensive in content and duration, and the target population should be relatively young.

Direct sex education is not the only option open to the field of education in preventing the occurrence of teenage pregnancy. Direct knowledge about reproduction is important, but so are self esteem, self-worth, and a caring adult in a teen's life. These are things that girls who are at-risk for pregnancy often do not possess. An emphasis on the future and skills to allow adolescents to reach adulthood safely are just as vital in education. The director of a program for at-risk middle school students described the importance in emphasizing choices and outlining opportunities that are available because "once they see a purpose in school, the other problems tend to fall away" (Lee, 1990, pg. 12). Pittman (1989) suggested that schools can help increase students' ability to delay sexual activity in three ways. First, the teaching of sexual education, family life, and decision making should be expanded. Second, increasing the availability of individual and small group counseling may allow students to feel more comfortable discussing difficult topics. Finally, the quality and range of school health programs could be extended. In her investigation, Scott-Jones (1991) concluded that there was no real difference in reproductive knowledge between teens who had been exposed to formal sexual instruction and those who had not. There was, however, a greater knowledge of contraception in those who had had a formal program, and knowledge of contraception was correlated with the use of effective methods. Despite this, as of 1991, the only federal program for adolescent pregnancy prevention (The Adolescent Family Life Act) would not support programs that focused on contraception. The only exception to that rule includes programs aimed to work with adolescent mothers to prevent subsequent pregnancies (Scott-Jones).

"The single focus view of premarital pregnancy and childbearing does not
provide for the range of services that are crucial in effective prevention and intervention efforts" (Ravoira & Cherry, 1992, pg. 101). Comprehensive school-based sexual education programs need to combine the school, community, and home environments. Of primary focus should be basic education, educational expectations and achievement, and dropout prevention. Access to information regarding sexuality, counseling, and community health services options can all help delay sexual activity and avoid pregnancy (Pittman, 1989; Scott-Jones, 1991; Theriot & Bruce, 1988). Accurate information about sexuality should be delivered to children and adolescents by all agencies. “Children need basic information” (Pittman, pg. 63) and they need to feel safe to question information and discuss feelings, emotions, and personal concerns.

Regardless of the location of any initiative aimed at reducing teenage pregnancy, a comprehensive, committed perspective is necessary. In 1996, the National Campaign to Prevent Teenage Pregnancy was founded and announced a goal of reducing teen pregnancy rate in the United States by one-third by the year 2005 (Alan Guttmacher Institute, 1994). The U.S. Department of Health and Human Services has suggested the presence of five key principles in a national strategy to reduce adolescent pregnancy (1996). The first is that the involvement of parents and adults is required. Also, an abstinence-based message and personal responsibility are emphasized. Third, young people need to have clear strategies for the future, and understand the impact that education will have on their lives. Fourth, community organizations such as schools, businesses, media, and other groups should become involved and develop strategies to increase the likelihood of staying in school and decrease the probability of early pregnancy. Finally, in order to see a real impact of this initiative, sustained commitment by all of those involved would be required.
Prevention Programs

The two most prominent types of programs are abstinence-only and abstinence-based programs. Abstinence-only programs promote that abstinence is the only acceptable method for the prevention of pregnancy and disease. Abstinence-based programs are described as promoting abstinence as the best choice for preventing pregnancy and the transmission of sexually transmitted diseases (STDs). The latter programs also present accurate factual information regarding contraceptive use and prevention of disease (Nevada State Health Division, 1996).

It is important to provide a range of services aimed at preventing, at any age, problems of unplanned, unwanted parenthood if possible (especially a range of birth control and related services) and at providing needed assistance to those parents who are problem-laden. (Chilman, 1989, pg. 20)

Groups such as Girls' Club, Boys' Club and other community organizations offer counseling services. Some have linked with schools to develop programs to address the needs of children and adolescents (Pittman, 1989; C. Urrea, personal communication, May 12, 1997). Teen Choice in New York City is one example. It is a program that offers a wide range of information, counseling, health concerns, referrals on sexuality, including family planning and pregnancy. Teen Choice encourages postponement of sexual activity as well as accurate information on contraception. It encourages adolescents to make informed, non-pressured decisions about life in general. School-based health clinics allow access to general health services, and are especially needed and utilized in low income neighborhoods where access to outside general medical services is limited. The availability of these clinics increases the likelihood that teens will contact an adult before becoming sexually active. These health clinics are utilized by teens with their parents' consent (Pittman, 1989).
Curricula

Within the school environment, sex education does not have to be limited to a one-semester course in high school, when teens have often begun to have sexual encounters. Awareness of family, love, child development and self-worth can and should begin as soon as kindergarten and continue throughout school. This may start the child thinking at an early age of what a responsibility a baby is, as well as opening up options for the future. **Education for Parenting** (Scattergood, 1990) is a curriculum designed to begin in kindergarten and end in third grade. However, it can be adapted to older children in higher grades as well. This program involves mothers, infants, and toddlers and brings to light the demands of raising a child. Academic areas such as reading, writing, and mathematics can revolve around this unit, as well. The curriculum requires a volunteer during her late months of pregnancy to visit a classroom in order to discuss development and answer questions that the children may have. Ideally, the same woman with her infant, then toddler, would continue to participate with the group of children as they progress through the grades, continuing to answer questions and discuss development. Areas to be investigated through the unit would be physical, social, and cognitive development, the mother and child relationship, child care, health, and safety. Finally, the children can apply what they have learned by taking care of a younger child or a small pet such as a hamster. Observing the development of an infant into a toddler allows the children a greater understanding and increases knowledge about child care.

A more detailed and extensive curriculum for grades kindergarten through 12 was outlined by Weinstein and Rosen (1994). The suggested topics for grades kindergarten through three emphasized ideas such as how babies change a family structure, that healthy babies come from healthy lifestyles, that both parents should be
involved in caring for a baby, and that babies require a lot of time and energy. In these grades, guest speakers, including a nurse or the parents of an infant, can be effectively utilized. In grades four through six, issues such as maternal health and personal choice were emphasized. The idea that getting pregnant and creating a new life is in the control of the individual was highlighted. Other topics included family planning, effects of alcohol, smoking, and drugs on fetuses, and a father's participation in prenatal care and delivery. Also, other viewpoints were explored such as family structure in other countries and challenging stereotypical roles. In middle school, seventh through ninth grades, children who have been exposed to this curriculum already have basic ideas regarding child development and the importance of a family on that developing child. In these formative social years, basic genetics and fetus development are explored, as well as criteria used in making decisions to become parents, pregnancy prevention, and the impact of pregnancy on an individual's future. Finally, in grades ten through twelve, the curriculum expanded on prior knowledge and allows the teens to explore personal values, as well as decision making and problem solving skills. This can be accomplished by having the students role-play as couples with an infant, involving community resources, encouraging adolescents to volunteer in the community, and encouraging positive choices regarding their futures.

Other Prevention Programs

The following programs and ideas were collected from numerous sources and are in place in limited settings around the United States. Each has proposed to have reduced the incidence of teenage pregnancy in their specific populations. Several undertook this by attempting to increase self-esteem, decision making and problem solving strategies in young girls.

In 1996, the Department of Health and Human Services launched an educational campaign called Girl Power! aimed at girls aged nine to fourteen. This
The Teenage Pregnancy campaign encompasses organizations at the national, state, and local levels. The effort of this initiative is to encourage preteen and early adolescent girls to make positive decisions about a wide range of issues, including health, education, and social issues. This effort is driven by the ideas that while all adolescents, both males and females, need encouragement for the future, girls also need information and messages geared exclusively towards them. Also, studies have shown that girls, especially in early adolescence, tend to lose self confidence and perform less well in school as a result. Posters, public service announcements, and a website are a few of the ways this effort has reached young girls (U.S. Department of Health and Human Services, 1997).

The I Have a Future campaign is in place in Nashville, Tennessee's public housing projects and targets primarily African American males and females ages ten to seventeen. It is a community based program that promotes a decrease in teenage pregnancy by increasing and expanding life options. Other goals include an increase in sexual knowledge which is proposed to lead to more responsible sexual behavior of adolescents. A more general goal, to which reduced teenage pregnancy is included, is the ability to overcome environmental barriers by introducing the seven basic principles of Kwanzaa. Briefly, these principles which can be applied to almost any situation in life are Purpose, Unity, Self-determination, Collective work and responsibility, Cooperative economics, Creativity, and Faith (Peters et al., 1991; U.S. Department of Health and Human Services, 1996).

A program designed for small groups of at-risk early adolescent females was initiated by the University of Southern Mississippi (LeBlanc, Snell, & Cowart, 1997). Because the setting for this program is the school environment, proper administrative, parent, and student consent was obtained for participation. This program consisted of six sessions in which the girls participated in activities such as distinguishing facts
from myths regarding teenage pregnancy and sexually transmitted diseases, independent research and presentations by the girls about STDs including AIDS, discussions about pregnancy and birth control, and role playing exercises dealing with social situations. Throughout these sessions, question and answer periods were encouraged, as was confidentiality regarding personal topics that were discussed in group. The girls took a pretest before the group began, and a post test on the final day. Scores showed that the girls' knowledge about sexuality, pregnancy, and STDs increased.

The Baby? Think it Over! program is one that originated in Alaska, and is currently being utilized in high schools throughout the country, including some in Las Vegas. It involves an infant simulator which cries at random intervals and must be tended to for varying amounts of time throughout the day. The simulator looks like a doll with a battery-operated mechanism in its back and is the charge of a lucky adolescent for a determined amount of time, often overnight or over a weekend. A tamper-resistant probe is worn by the "mother" and/or "father" which allows only those individuals to tend to the needy infant. The crying of the doll is realistic, and the simulator is able to keep track of the total minutes the child was allowed to cry without being tended to, as well as any instances of abuse such as dropping, hitting, or shaking. This simulator is used as a teenage pregnancy deterrent in high school child development and similar classes, as well as in programs for teen parents and at-risk students (S. Grinnell, personal communication, May 5, 1997).

Postponing Sexual Involvement is a program aimed at thirteen to fourteen year old adolescents. The primary foci of this initiative were to emphasize abstinence and delayed sexual initiation, but information on contraception was also introduced. The program focused on skill-building exercises, basic factual information, and resistance to peer pressure in relation to sexual involvement. Early findings indicated delayed
sexual involvement for both genders, but especially for females. Also, higher contraceptive use was found with those who became sexually active (U.S. Department of Health and Human Services, 1996).

A Teenage Pregnancy Awareness Project was developed in Bowling Green, Kentucky for sixth, seventh and eighth graders in association with the health department. The curriculum emphasized anatomy and physiology, responsible sexual behavior, and the importance of self-confidence and self-esteem. Abstinence is stressed, but parental consent is required to participate in the program. Parents are actively encouraged to participate in the program and view what their children will be learning. Also, a workshop for parents is held to allow parents to examine their views on the topics as well as learn to communicate with their children effectively on difficult topics (Theriot & Bruce, 1988).

The Teen Outreach Program emphasizes increasing life options and is based primarily in schools. Its goal is to prevent early pregnancy and promote academic achievement with students ages eleven to nineteen. In this initiative, curriculum based discussion groups are emphasized in combination with volunteering in the community (U.S. Department of Health and Human Services, 1996).

Project Taking Charge is an abstinence-based program that combines sexual and vocational education for junior high and high school students and parents in low income areas. It promotes self-development and self-esteem for at-risk teens through the involvement of students, parents, and the community (Jorgensen, 1991; Pittman, 1989).

The Children's Aid Society's Adolescent Pregnancy Prevention Programs target girls ages ten through twenty and are comprehensive programs aimed at avoiding unintended pregnancy through responsible sexual decision making. Also emphasized are career awareness, family and sexual education, medical and health
services, mental health services, self-esteem through the performing arts, academic assessment, and participation in individual sports. Compared to national levels, adolescents participating in these programs had lower alcohol use, were less sexually active, and were more likely to use contraception if they are sexually active (U.S. Department of Health and Human Services, 1996).

The Teenage Pregnancy Prevention Initiative put forth by the California Wellness Foundation was founded in 1992, and its primary message is that the attitudes and behaviors of adults need to be improved on the issue of teenage pregnancy. The overall emphases in education are responsible decision making and healthy sexual development. This is approached by increasing the awareness of the effectiveness of contraception, an increase of respect for adolescents who regularly use effective contraception, and the development of public policies regarding the issue of teenage pregnancy (California Wellness Foundation, 1997).

These programs are just a few of the numerous prevention initiatives that are being implemented by communities across the country. It appears that the majority have chosen to address the topic of adolescent pregnancy through the broader issues of self-esteem, responsible decision making, life options, and future opportunities. By giving teens valid and tangible reasons for abstaining from or postponing sexual relationships, they may be more likely to realize that these choices are truly in their best interest. Adolescents are trapped between childhood and adulthood. By treating them as children and "forbidding" or "condemning" sexual activity, communities are in essence treating them as children. By teaching teenagers responsible decision making in all aspects of life, including sexuality, then adult thinking will be reinforced so that they will be more likely to consider all options when faced with difficulties throughout their lives.
Despite the aforementioned programs and countless others across the country to prevent teenage pregnancy, adolescent girls continue to get pregnant. No program designed to prevent this occurrence can take into account all of the variables that are present in all of the lives of young girls that contribute to their situations. Also, there is no way to guarantee reaching all of America's teens. Even with programs in place within the schools, every teenager is not contacted. Often, sex education curriculum and programs are offered in classes such as Home Economics or Child Development which are usually elective classes. So, when teenage girls are faced with the life-changing reality that they are pregnant, every effort must be made to make the most of their situation and increase their options from that moment forward. "Adolescent child birth...appears to place women at a substantial long-term disadvantage with respect to education" (Teti & Lamb, 1989, pg. 209). Research has shown that a girl's education level is more indicative of her future financial situation and economic level than is the incidence of early pregnancy (Scott-Jones & Turner as cited in Scott-Jones, 1991). Therefore, the education of these girls is of utmost importance if they are expected to hold a productive and contributive place in society. Also, limiting the financial, educational, and employment options available to a young mother, undoubtedly will bring negative affects onto the new family environment she is creating (Zabin, Wong, Weinick, & Emerson, 1992).

"Though federal law protects pregnant students from being excluded or expelled from school, it has not mandated programs to help them" (Scholl & Johnson, 1988, pg. 42). As with programs designed to discourage and decrease teen pregnancy, those to help pregnant girls and teen mothers cannot originate exclusively from one source. Agencies from around the community must come together to provide the support that many pregnant teens need. Child development, nutrition, health,
financial and employment needs are just a few of the areas that need to be addressed by a comprehensive program.

Needs of Teenage Mothers

Adolescent mothers have a variety of needs that must be met, especially if they are to complete their education. The availability of child care is a concern for every mother who is not able to spend a full day with her child. In order for an adolescent mother to complete her education, adequate child care must be secured. "Whether the expectant teen mother will remain in school usually depends on the availability of child care, a service most teen parents cannot afford" (Ladner, 1988, pg. 241). Even if child care is secured, often transportation to and from school and daycare can be a huge barrier. It was found that child care facilities associated with high schools were a major inducement for teen mothers to attend and finish school (Berger et al., 1991; Ladner, 1988; Pittman, 1989; Scott-Jones, 1991). A survey of teen mothers revealed that resources that were most beneficial were transportation, a support group, and clothing that could be provided (McCullough & Scherman, 1991). Berger et al. found that approximately 80% of pregnant adolescents who were in school with plans to graduate chose to deliver and keep the baby. The availability of in-school day care may have influenced their decision. This eliminates the need for transportation to a secondary child care facility and allows the mother access to her child during the day. On-site daycare centers serve other purposes, including keeping young mothers in school, helping with and monitoring the development of the child, and facilitating both parents' interactions with the child (Scott-Jones, 1991). These efforts to keep young mothers in school are essential to their educational and financial future.

Skills Training

Local universities can assist in providing services in the community and in high schools. A university-based program in Southern Louisiana offers assistance to
economically disadvantaged and/or handicapped young mothers ages 15 to 21. Girls must qualify for the program by demonstrating low job-seeking skills, and the 6-week or 9-week sessions, with child care provided, offer an opportunity to look towards the future. Goals of this program are similar to other intervention programs in that it aims to improve self-esteem, personal development, goal setting, and employment options (Theriot, Pecoraro, & Ross-Reynolds, 1991).

**Alternative Schools**

In 1977, the Lawrence G. Paquin school, a separate campus for pregnant teens in junior and senior high school, was begun in Baltimore's inner city. Girls went to this campus during pregnancy and shortly afterwards, then were expected to return to their home school campus. On-site daycare was provided, as well as access to school nurses, counselors, and social workers. Instruction was given in general curriculum, as well as sexual education, health and hygiene, life planning, and job-training. In 1985, approximately one-third of the 3,000 girls who got pregnant in the Baltimore area attended Paquin. It was found that these girls' babies had lower rates of infant mortality and pre-term births, as well as higher birth weights when compared to girls in the area who did not attend this school. In three- and five-year follow up studies, parenting education was shown to have had a positive effect on education, employment, and family planning. This program is one example of how intervention can result in positive outcomes despite the disadvantaged background of the participants (Amin, Stith, Mariam, & Welcher, 1988).

**Curricula**

Within a regular school environment, much can be done to assist young mothers. A one-semester course in place at the high-school level for pregnant and parenting teens entitled "Children and Books" attempted to get young mothers to see the importance of reading to their children.
Most of my students have been willing to do for their children things that they would not do for themselves - like reading. Their desire to understand what is going on with their children is a natural conduit for introducing reading materials about child development. (Doneson, 1991, pg. 22)

The three goals of the program were (a) to get low-readers into reading high interest materials (e.g., children’s books) that address their particular situation, (b) to introduce new parents to literature that was pertinent to them (e.g., parenting magazines on child development, and (c) to introduce mothers to developmentally appropriate books for children at various ages and investigate themes present in these books (Doneson, 1991). Not only did the program accomplish these goals, but also some unforeseen ones. The themes, pictures, and familiar books brought out very personal stories about the girls’ pasts and families that they were able to discuss openly with each other. The class became an unexpected support group for one another. The young mothers were able to grasp the value of reading and the potential and power of books in their children’s lives.

Programs that include or are based on individual mentors or one-on-one supporters can assist young mothers in numerous ways (Clinchy, 1991; Teen Connection, personal communication, May 12, 1997, Voydanoff & Donnelly, 1990). Mentors can serve as sources of information on several topics including nutrition, sexually transmitted diseases, and pregnancy in general, as well as help young girls with general life skills they may be lacking. Goal-setting, problem solving and general social knowledge are just a few of the areas in which mentors can provide support. With a one-on-one relationship being established, the importance of mentor training is essential. Caution must be taken in establishing trust with a girl, learning to listen, emphasizing the positive aspect, and learning how not to take things personally. The
Teenage Pregnancy

mentor can assist the girl in setting goals, determining values, and problem solving, and can guide the young mother through techniques such as self-management and self-appreciation (Kanfer, Englund, Lennhoff, & Rhodes, 1995).

Other Intervention Programs

School districts across the country are discovering the positive effects of intervention for teenage mothers can have. Comprehensive programs through the school can utilize community agencies to offer students health care, child care, and counseling, as well as an education (Clinchy, 1991; Daria, 1988; Kelly, 1988; LaRue & Miller, 1988; Young Mothers Educational Development program, personal communication, May 12, 1997). They offer services through a number of sources including counselors, nurses, social workers, school psychologists, and teachers. The primary goals of these programs are to keep the adolescent in school and reduce the dropout rate, and allow them to graduate with a high school diploma or GED. In addition to this foremost goal of education, many districts have attempted to tailor a plan in order to address the individual needs of its students.

In Virginia, the Norfolk Adolescent Pregnancy Prevention and Services Demonstration Project has combined public schools with the Norfolk State University and community agencies to prevent initial and repeat pregnancies in young girls and ensure prenatal care during pregnancy. Promotion of self-esteem, job skills, responsible decision making and responsible sexual behavior are emphasized, and on-the-job training and job placement opportunities are available (Kelly, 1988).

A school district in New Jersey identifies pregnant girls within the school and offers counseling and advice on how to talk to the girls' parents if they have not yet discussed the pregnancy with them. The nurse provides basic information regarding health, infant care, and child development, and helps to involve the father if he is also a student. The nurse is able to modify the girl's schedule around her pregnancy,
including utilizing after-school programs or alternative education programs. After the baby is born, the girl's scheduled can be modified so that she is best able to meet her own educational needs as well as the needs of her child (Daria, 1988).

The Teen Parent Program in the Reading, Pennsylvania school district combines the district with a community child care agency in an effort to guarantee quality child care while the mother is at school. The district subcontracts 20 spaces in the child care facility for program participants. To be eligible for this program the girl must be a parent, be enrolled full time for a high school diploma, and have a career goal. Formal parenting instruction is offered for high school credit, and one of the goals of this program is that the students graduate from high school with career goals and vocational abilities (LaRue & Miller, 1988).

Finally, the Teen Parenting Program in Memphis, Tennessee was founded in 1987 as part of the Comprehensive Pupil Services Educational Center. This program was able to combine the school district and public and private agencies "all aimed at first rescuing young people in trouble, and then helping them become winners rather than losers in life," (Clinchy, 1991, pg. 66). This program serves a population of 125 students, predominantly African American girls from low socioeconomic areas. They are able to individualize each girl's curriculum through a computer program that allow students to work at their own pace. The philosophy of the program focuses on individual strengths of the participants, and utilizes mentors and curriculum that will teach the girls to be careful, informed mothers. A study showed that the local dropout rate for minority girls from low SES environments who got pregnant was 80% before the introduction of this program. That rate decreased to 38% after the Teen Parenting Program was in place, which is comparable to the overall dropout rate in the Memphis area of 39%, (Clinchy).

Most intervention programs in place share the same goal of keeping young
mothers in school. The specific services offered, from child care to transportation to employment counseling, may vary in individual programs, but the emphasis on increasing options for the future seems to be a fairly consistent theme.

Clark County and Local Programs

There are many different levels of support that are offered to promote initiatives to reduce teenage pregnancy and its effects. From a national level, to state and local community support, a message must be sent that postponement of pregnancy is in everyone's best interest. National information and programs have been discussed. Statewide, the statistics for Nevada are not good. Within Nevada, 11.6% of all births and 20% of abortions in 1987 were to teenage mothers (Legislative Commission, 1990). In 1990, the Nevada Legislative Council Bureau proposed several recommendations for implementation of programs on state, school, and local levels to improve the level of services provided to teenagers on this issue. In 1992, Nevada ranked second in the country for adolescent pregnancy for teens ages 15 through 19. Despite programs designed to prevents pregnancy such as the ones outlined previously, teenage pregnancy prevention programs were found in 1995 to only reach approximately ten percent of all teens (Nevada State Health Division, 1996).

The populations of Las Vegas and Clark County have grown at a phenomenal rate over the last decades, and with that growth, social problems have become more pronounced. Teenage pregnancy within the state of Nevada is among the highest in the country; it has consistently ranked in the top ten states with regard to the adolescent pregnancy rate (Nevada State Health Division, 1996, Legislative Commission, 1990). There are several resources available within Clark County designed to help prevent teenage pregnancy, as well as provide assistance to pregnant and parenting adolescents. They range from community-based to school-based programs, and some offer comprehensive services to meet many of the
adolescents' needs.

State Level

One of the most well-known programs to increase awareness of child development and prenatal care to all mothers in Nevada is the Baby Your Baby program sponsored by the State of Nevada Health Division, State of Nevada Welfare Division, Sierra Health Services, and Sunrise Children's Hospital. Local television stations also participate in sending public service announcements. This service offers referrals for doctors and insurance, and encourages mothers to receive prenatal care and information at the earliest possible time. Information can be requested and is provided on a number of topics, including breast feeding, child birth classes, financial assistance, nutrition, pregnancy tests and prenatal care. Anyone who is a resident of the state of Nevada is eligible for assistance through Baby Your Baby. (State of Nevada, 1997).

Community Level

A community-based program that targets primarily pregnant and parenting teenagers is the Life Line Pregnancy Assistance Center which is a United Way agency. Life Line functions in cooperation with the Clark County School District (CCSD), social services, the Welfare Department, local hospitals, independent doctors, Economic Opportunity Board, and of course, the United Way. Participants in the Life Line program are either involved voluntarily or are mandated to participate by the court system. Individual and group counseling are offered, as well as educational and employment resources to young mothers and fathers within the community. An on-site daycare center provides child care for group participants, as well as necessary supplies such as formula, diapers, clothing, and furniture at no cost. Life Line provides life skills classes that help prepare adolescents for their roles as parents, and also for those as adults in society. Job readiness and social graces are highlighted in two of
The First Time Fathers program is the only one of its kind in Nevada that targets young fathers and encourages them to be productive both professionally and emotionally. It is a 20-week course that is designed to increase job skills and enhance the participants' relationships with their children. There are currently 21 members of this group, and the majority of them are younger than 20 years old. The class also educates the young men on child development and communication. Lynn Richmond-Scales, the executive director of the Life Line Center, stated that even though some participants of the First Time Fathers program initially become involved as mandated by the court, by the end of the program, they are usually eagerly involved and often continue voluntarily (personal communication, June 2, 1997).

A home mentor program is provided where an employee of Life Line regularly keeps in touch with local parents, giving whatever support, emotional or otherwise, that the young mother may need. The Shepherding Home Program is in place to assist young pregnant girls who have no place to live due to a variety of circumstances. It involves volunteer families taking pregnant girls into their homes for the education of their pregnancy and often a few months afterward.

The Life Line program also provides a variety of educational options for young mothers. They offer a General Equivalency Diploma (GED) program as well as regular high school access in association with CCSD. They also provide instruction in an English as a Second Language (ESL) setting, as well as classes as part of the Horizon Project Partnership in the Alternative Education Division of CCSD. (L. Richmond-Scales, personal communication, June 2, 1997).

**School Based Programs**

Several programs are in place in the traditional and non-traditional high school settings within CCSD to deal with the prevention of pregnancy and the continuing
education of pregnant and parenting teens. All of the high schools in CCSD offer child development classes as electives. The "Baby? Think it Over!" program has been adopted in several high schools including Silverado, Durango, and Chaparral. As mentioned earlier, this program originated in Alaska, and involves an infant simulator (doll) with realistic crying. The student "mother" or "father" is in charge of the baby for a certain amount of time (usually overnight or over a weekend). The baby will "cry" on a variable interval schedule around the clock, and will require "tending to" for anywhere from 5 to 45 minutes. The child is tended to by inserting a probe in his or her back, which stops the crying. Also available is the "drug baby". This simulator is significantly lighter than the regular ones (low birth weight), shakes when it cries, and is not as easily soothed. Also, the crying was recorded from a real "crack-baby", and is more distressed and alarming than is the regular simulators. As mentioned earlier, the simulators record their care as far as neglect and abuse, and the drug baby usually is the victim of more abuse than her easy-to-soothe brothers and sisters. The students are required to keep a log of their time with the baby, how long it cried, what the "parents" were doing at the time, and how it made them feel. Responses ranged from neutral to frustration to anger, including a comment that the mother wanted to throw the baby against a wall to make her be quiet (S. Grinnell, personal communication, May 5, 1997).

Although this is an infant simulator and not a real baby, it gives students an idea of the amount of time an infant or child requires of its parents. When participating in this program, a volunteer found that the baby, Pedro, preoccupied a large part of the "mother"s life. Extra time had to be allotted for everyday activities so that Pedro could be tended to if needed. The schedule for the day often had to be rearranged so that Pedro's needs were met. Overall, it was an interesting experience, but the participant knew she was not yet ready for motherhood. Although the simulator looked like a real
infant, it did not react to positive stimuli such as talking to it, smiling, or touch. The motherhood experience that this program provides focuses on the time and needs that an infant requires, and not the overall experience of taking care of a child (J. Rollins, personal communication, May 1997).

Another program in place at the high school level in CCSD is the Parenteen program. It was developed in Las Vegas by Yvonne Chaves who is currently a nurse at Basic and Green Valley High Schools. The program is designed to be directed by the school nurse, and involves parenting issues for pregnant and parenting teens at the high school level. The group meets approximately one hour per week during school time, and discusses issues that are important to the health of the mother and baby, as well as proper care for an infant, legal issues, and utilizing community resources. Also, the participants act as support for each other, whether it be emotionally or as another point of reference for the young mother. Community agencies and resources such as Cooperative Extension, the district attorney's office, and Nevada State Welfare, and the Clark County Family Support Division have all participated in the program by providing information and giving presentations on issues that impact adolescent mothers' lives (J. Wieberseck, personal communication, Spring, 1997).

For high school students who are pregnant, CCSD provides daycare at three regular high school campuses: Las Vegas High School, Cimarron, and Rancho (T. Heddon, personal communication, May 5, 1997). Alternative education sites such as Sunset and Horizon were originally established for students who had special needs such as pregnancy or work schedules that conflicted with regulars school hours. Child care is provided at these sites, but no on-site help is available for pregnant or mothering girls who are still in junior high school.

The Homebound program, a division of Alternate Education, provides
educational services to students who cannot attend school, usually due to illness or injury, for 15 consecutive days. The primary goal of the Homebound program is to prevent adolescents from dropping out of school. Pregnancy in and of itself is not a condition for eligibility to this program. However, if the girl is less than 15 years old or has been put under orders of bed rest by her doctor, it is considered a high-risk pregnancy, and the girl is eligible for Homebound services. The Young Adult Center program for middle school girls, ages 14 and younger, is currently at the Sunset East and Horizon West campuses in Las Vegas. The girls participate in five hours of instruction per week, and the majority of work is done outside of school. Two hours a week is spent with a nurse discussing health and nutrition, as well as child development and social issues such as relationships with the fathers of the children. Three hours a week is spent with a classroom teacher and is focused on school work so that the girls do not lose an entire year of academics (T. Heddon, personal communication, May 5, 1997).

As of May 1997, the program at the Sunset East location enrolled six eighth-grade girls, five of whom had children, and one pregnant girl. The children ranged from seven weeks to 11 months old, and all accompanied their mothers to class. The room held three tables for the girls to work, three playpens, one swing, and a small bench that served as a changing table. During an observation, the girls did school work, occasionally tending to children, and answered questions from the observer. All of the girls seemed to have supportive families, and of the five who had children, two of the fathers of the babies were still involved. Two other girls currently had boyfriends who had assumed the role of father. One of the pregnancies was "planned" in that it was not a tragedy that it happened; all others were "accidents" in that birth control was used, but not consistently. At the time of the observation, four of the girls were on Depoprovera, an injectable form of birth control, and one girl had plans to begin this
It is necessary to look at these girls as individuals rather than as a collective group. Each had her own different story and situation. The maturity, and sometimes lack thereof, showed in the faces of these girls. Due to certain choices and circumstances, these girls are mothers and are not yet in high school. They will need support from home, school, and community in order to reach their goal of completing their high school education.

Overall, Clark County provides a number of services to young adolescent mothers, whether it is through the school district or through agencies in the community. Homebound, Horizon, and on-site child care at the high schools are just some of the ways that the school district is attempting to keep young mothers in school so that they will not be doubly burdened with a child and a lack of education. Just as importantly, encouraging adolescents think about the consequences of parenthood before engaging in risky sexual behavior must be emphasized.

Limitations

Lack of Empirical Research

Countless programs have been implemented in an effort to deal with the prevention of teenage pregnancy, as well as those aimed at keeping girls in school once they become pregnant and after the birth of their child. The current research on the topic of prevention and intervention programs, however, is lacking in objective, analytical data. Most of these efforts are undertaken on a small scale because of lack of resources and funding. Large-scale, research-driven, empirical studies to determine statistical effectiveness of techniques, programs, and interventions have not been performed. Therefore, they often lack a scientific plan which reduces the amount of clear statistical outcomes as to the success or effectiveness of the program (Moore et al., 1997; Roosa, 1991). If an evaluation plan could be implemented successfully on
a large scale, this would allow researchers to evaluate components of successful programs, as well as those of unsuccessful ones (Zabin & Hirsch, 1988). Card (1993) gathered a number of evaluation items that had been used in national surveys. Items included in this collection address several areas of sexual activity from sexual knowledge, contraceptive use, and pregnancy issues to antecedents and correlates of sexual behavior and attitudes. This could act as a resource to groups or individuals who evaluate a program, or gather information regarding at-risk teens.

Lack of Uniform Definition of Terms

Another limitation of the research were the terms “teenager” and “adolescent”. These were not consistently defined throughout the research articles. Some sources defined an “adolescent” as being less than 20 years old; others limited their “adolescent” population to data on school-aged teens, or those 18 and under. Therefore, data from different sources referring to teenage or adolescent pregnancy may not be consistent because of varying population definitions.

Lack of Coordination of Services

It is often difficult to connect all agencies in an effort to implement a comprehensive program, even when the organizations involved are essentially serving similar populations. Coordination of services, bureaucratic rules and regulations, and division of services, are considerations to be made if a program is to run smoothly (Clinchy, 1991).

Here in Clark County, in association with the State of Nevada Health Division and other community agencies, community action teams (CAT teams) have been formed to investigate the incidence of teenage pregnancy in an effort to better implement prevention programs. As a member of this team for a short while, it was frustrating to see little being accomplished. It was also obvious that without clear cut ideas of goals that are to be accomplished, and a semi-clear path in mind of how to
accomplish them, little gets completed.

**Lack of Attention to Male Behavior**

Until recently, emphasis on the adolescent males has been missing from literature and programming aimed at reducing teenage pregnancy. Since the majority of attention was aimed at female behavior, pregnancy was often viewed as a female problem that needed to be addressed from that angle. More needs to be done, with regard to both prevention and intervention, in order to encourage male responsibility.

**Conclusion and Future Research**

Adolescence is a time of life when people discover and define their identities and prepare for life as an adult. There are often overwhelmed by changes in their bodies, families, perceptions, and social world. These normal difficulties of adolescence can be compounded when one also must consider fulfilling the role of parent. Adolescents often do not possess the cognitive readiness to assume the responsibility of a parent before they themselves are fully adults.

Although male behavior and fatherhood has become more extensive in the research in the last few years, much still needs to be investigated into the behavior of adult men. Ideally, young men should be taught about responsible sexual behavior in early adolescence so that when they are older and out of school, they at least will have had exposure to the information.

Programs, both prevention and intervention, must be implemented to include a variety of services and outlooks for adolescents. Just as no one variable determines whether a girl gets pregnant, neither does one aspect of programming address the entire issue. Health, school, and community organizations can join successfully to offer complete services to young parents and their children.

It is important that prevention efforts begin early in order to be the most effective. Students must be given viable reasons for understanding why delaying
pregnancy is in their best interest. Programs can begin at home and in elementary school and can teach children problem solving skills and self-esteem. Also, decision making, and how present choices can affect the future, should be emphasized in all aspects of life so that young people can make positive choices regarding their future. By taking this type of approach, students can learn how to handle all aspects of their life responsibly, rather than just focusing on sexuality. Telling adolescents not to have sex may postpone the behavior for external reasons while giving them decision making tools and reasons to postpone this behavior may internalize these reasons. By telling adolescents “no”, it is only the symptom that is being treated, rather than the cause.

With intervention programs aimed at helping young mothers, education of the young woman is generally the primary goal. A formal education in the form of a diploma or GED is necessary for a promising future, and an education regarding the girls' new role as mother is equally important to the life of the baby. After all, education does not end for a girl, just because a girl and a boy made some poor choices. Also, teen mothers could be utilized in programs aimed at prevention of adolescent pregnancy. If teens do not believe that it would be that difficult to be a mother and a student, then these young girls could inform them of all of the added responsibilities of being a teen mother.

Much needs to be done within CCSD to increase communication regarding programs in place in individual high schools. There does not seem to be any centralized effort to increase awareness of this topic across the district and to facilitate communication between schools and personnel.

The field of school psychology is one that lends itself to helping students directly as well as advocating for services in their best interests. It is important that those working with middle school and high school students be aware of school, district, and
community resources available to at-risk students. School psychologists often have the ability to coordinate services and serve as a resource for teens who are at-risk for pregnancy or are already pregnant.

As a liaison between teachers, administrators and parents, a school psychologist is able to address concerns from both areas, as well as bring attention to issues that need to be dealt with within a school. Although most cite-based programs in schools are directed by the school nurse, a school psychologist could assist in coordinating students and services for the program. At the preventative level, programs to improve self-esteem of young girls and open options for the future could be developed. At the intervention level, support groups could be formed to help these young women feel they are not alone and share their different situations and solutions. Although there is little empirical research to verify the effectiveness of most programs, existing programs can be used and implemented within a school environment, and then modified to meet the particular needs of the participants.
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