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REPORT ON THE TEENAGE OBSTETRICS PROGRAM: SOCIAL SERVICE MODEL FOR PREGNANT ADOLESCENTS

by

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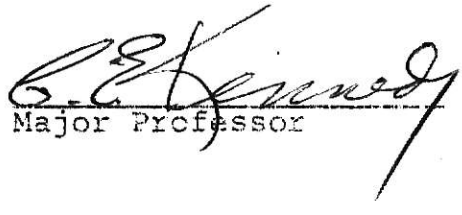

Major Professor

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INTRODUCTION

The great number of teenage pregnancies has become a serious concern in recent years, "experts believe it is a source of both immediate and prolonged family instability" (Furstenberg, 1980b: p. 1). Research indicates that women who become mothers while in their mid- or early teens are more likely than older mothers to have medical, social, and financial problems during pregnancy and while rearing their children (Chilman, 1980).

The purpose of this paper is to describe a program in an inner-city hospital that is directed toward providing assistance to pregnant teenagers 16 years of age and under. It will also consider the perceptions of a small group of girls in the program who were interviewed after they had delivered their babies.

A brief overview of the literature is included to provide a context for considering the information presented in this report. Following the discussion of the program and interview data, the author offers her recommendations concerning ways of strengthening the program.

I. TRENDS FROM THE LITERATURE ON TEENAGE PREGNANCY

Public opinion is mistaken in thinking that our nation is experiencing a recent epidemic of births to adolescents. Chilman (1980: p. 794) points out that the "birthrate per thousand women fell markedly for 18- and 19-year olds between 1960 and 1976 and somewhat less so for young women between ages 16 and 17. The rate for 14- and 15-year olds (though much lower than that for older mothers) peaked in 1975 and declined somewhat in 1976 and again in 1977 and 1978. The 1978 birthrate for women ages 18 and 19 was close to the lowest rate ever observed for this age group." (Also see American College of Obstetricians and Gynecologists, 1979)

What HAS changed since the mid-1960's is a rise in the proportion of births to unmarried adolescents and, until fairly recently the birthrate of mothers under the age of 16. The acceptance of premarital sex and unwed parenthood, legalization of abortion, the drop in the onset of puberty, and easier access to contraception have made the psycho-sexual development of contemporary teenagers very different from that of their parents' generation (Kantner, 1977). The economics of our fast-changing society have also placed pressures on families. Early

sexual activity does not necessarily lead to early childbearing, but the potential begins sooner than for those who delay the first sexual encounter. Increasingly, young parents are not marrying early (Sorenson, 1973; Zelnick and Kantner, 1977).

The delay of marriage creates need for family and social support, but in most instances has beneficial effects over the early teenage marriage. The adolescent mother is more likely to receive government assistance if she is single; she is more likely to continue her schooling if she is single, living with an adult, usually from her own family, and if she limits further childbearing.

Furstenberg (1980b), on the basis of a five-year study of 320, mostly black, low-income mothers in Baltimore, makes the case that the teenager's family of origin is a crucial factor in the subsequent well-being of mother and child. This conclusion is supported by the study addressed in the interview and discussion sections reported later in this paper. Furstenberg acknowledged that, for the rare girl who married following pregnancy and the marriage endured, there was little difference between her outcome and that of women who waited until after marriage for pregnancy. However, for most of the pregnant teenagers who married the father of the child or someone else, before or after the child was born, the marriage usually did not survive through the five years of the study, and many of the girls moved back with their families.

Chilman's article for the Decade Review issue of the Journal of Marriage and the Family (1980) is a current review of the literature on adolescent pregnancy. Her summary of correlates of early childbearing for adolescent parents as distilled from her review is reproduced in Figure 1. A summary of correlates of early childbearing for children of adolescent parents is described in Figure 2. One can extrapolate from these data, and Furstenberg (1980a) supports the conclusion, that family support, by way of encouraging school attendance, supplementing the government check, and providing free/low-cost child care and housing, helps the young parent continue to develop his/her personhood.

The Family's Involvement

Normally, the teenage parent is a part of a family, and if positive relations exist, he/she expects the family to help provide for his/her children (Lewis and Lewis, 1980). These same family members are seldom involved in the early months to influence the course of the pregnancy, they may have little say in the adolescent's wedding plans or the other parent's involvement with the child (Furstenberg, 1980a, b). The adolescent may expect the head of the house to fulfill obligations to him/her and accept whatever he/she presents, even a baby.

In the instance of the adolescent mother keeping the child and remaining at home, the family must readjust

Figure 1. CORRELATES OF EARLY CHILDBEARING FOR ADOLESCENT PARENTS

- Educational--Adolescent pregnancy and/or parenthood was one factor in dropping out of high school.
  An early marriage was closely associated with dropping out of school; the crucial factor was early marriage rather than pregnancy or parenthood.
  Adolescent mothers tended to have done poorly in school and to have had low school interests and goals before pregnancy occurred.
  Adverse educational effects for white, but not black, teenagers were found especially if they became adolescent mothers when they were younger than 17.
  Half or more of early school dropouts returned to school in later life, often in early middle age.
  Availability of child care, especially by family members, was an important aid in school return of young mothers.

- Later family size--Larger family size was likely, especially if first birth occurred before mother was age 15 or 17, particularly if she was black and especially if she married.
  There was a slight tendency for adolescent parents to want larger families than was true for older parents.

- Marriage and marriage disruption--The majority of unmarried adolescent parents married within a few years of the first child's birth. Early first marriages with or without adolescent pregnancy were more likely than later marriages to dissolve in later life. Early marriage rather than the timing of the birth appeared to be the key variable in later marital disruption.
  Perhaps very early childbearing is associated with later marital disruption.
  Adolescent mothers were more likely to return to school if they failed to marry.

- Labor force participation--Later occupational status, hours worked, and waged earned were not directly associated with maternal age at first birth.
  Timing of first pregnancy appeared to have no effect on occupational status of male partners.
  Young married men and women expressed somewhat more job satisfaction than singles.
  Young married women with children were slightly less satisfied with their career prospects than young married women without children. No differences were found between single parents and single nonparents. Adolescents parents, by age 30, were somewhat more dissatisfied with jobs (30 percent dissatisfied) than young people who postponed parenthood.

- Effects on welfare assistance--Adolescent single mothers were slightly more apt than adolescent marrieds or nonmothers of similar backgrounds to be dependent on AFDC when the children were very young, but this higher dependency rate was short-lived.
  In later years, women who had been adolescent mothers were especially apt to be welfare dependent, compared to the general population.
  Availability of welfare assistance made it possible for a sizable proportion of adolescent mothers to return to school.
  Black adolescent mothers were more apt than those who were older at first birth to have grown up in a family that received public assistance. Dependence on public assistance after a child's birth was most apt to occur for very young adolescent mothers.

- Maternal behavior and attitudes with firstborn children--Majority appeared to he as competent and caring as older but otherwise comparable mothers (by race and socio-economic status).
  Majority of mother-infant interactive behaviors were rated as appropriate, but significantly more mothers with first births before age 18 were rated as overly protective or too inattentive at child's four-month old testing: rating improved somewhat at eight-month observations.
  No significant differances were found between adolescent and postadolescent mothers in respect to accidents occurring to their children.
  No significant differences were found in measured childrearing attitudes or maternal perceptions of the temperaments of their infants. Adolescent mothers were observed to be high on maternal warmth and physical interaction; they were lower than older mothers on verbal interaction.

From Catherine S. Chilman, "Social and Psychological Research Concerning Adolescent Childbearing: 1970-1980," Journal of Marriage and the Family 42 (November 1980): 800-801.

Figure 2. CORRELATES OF EARLY CHILDBEARING FOR THE CHILDREN OF ADOLESCENT PARENTS

Physical health--There appear to be no adverse effects associated with young maternal age if high quality prenatal and later health care are available.

The health of the child tends to be better if two adults, rather than one are in the home.

Cognitive development--Significantly lower scores for children of adolescent mothers tend to become minimal when appropriate controls are instituted for adverse effects of poverty, racism, and family headship. Sons of adolescent parents may be more adversely affected than daughters in respect to cognitive development and educational achievement.

The presence of another adult in the household appears to reduce adverse cognitive development effects seemingly associated with single adolescent parent families.

Socioemotional adjustments and personal characteristics--No significant differences were found during infancy, early childhood or by age 12 or so, if appropriate controls were employed for effects of poverty, racism, and family headship.

A small, but statisically significant, proportion of children of adolescent mothers were rated as having behavior problems (especially sons).

Overall behavioral development--A somewhat larger proportion (about 9 percent) of children of adolescent mothers compared to about 4 percent of other children were rated slow in overall development; boys seemed to be particularly affected.

Infant sons of adolescent black mothers, compared to those of older black mothers, had higher ratings of slow responses to their mothers.

Educational achievement of children--No significant differences were found in some studies; in others, slight differneces were larely explained by somewhat lower levels of cognitive development.

At age 7, children of adolescent mothers are more apt to repeat a grade; sons had somewhat lower reading achievement scores; a larger proportion of sons of very young adolescent mothers were rated as having learning disturbances.

A greater tendency for school adjustment problems in first grade was likely to increase over the years, with severe behavioral school problems more likely to be present by adolescence.

Family composition and structure--There was a greater tendency for marital disruption, single-parent households, and remarriage, so that a child had a stepfather or was cared for by a grandparent or other relative.

There was a slight tendency for children, as teenagers, to repeat the parental pattern of early childbearing and/or marriage, as well as to have large families. This tendency remained even after the effects of racism, poverty, and family headship were statistically controlled.

om Catherine S. Chilman, "Social and Psychological Research Concerning Adolescent ildbearing: 1970-1980," Journal of Marriage and the Family 42 (November 1980): 802.

its lifestyle to incorporate a new helpless person (Furstenberg, 1980a, b; Russell, 1980). Unplanned as the teenage pregnancy might be, a "spirit of cooperation in the household" occurs after baby's arrival. The successful family finds ways to reorganize household chores, redistribute the household income, rearrange living space, revamp schedules, and remove barriers to communication. This adaptability is not simple and the family must find a workable point between chaos and rigidity. Such restructuring might mean a higher level of functioning for the family unit.

The teenager is physically pregnant by herself, but the condition affects everyone in the family. Parents may become grandparents at a too early age. Often they must handle the disdain or pity from relatives and friends who make them feel ashamed of their teenager's condition (Lewis and Lewis, 1980) and cause them to question their own parenting abilities. In most cases, the grandparents continue to parent their child and the grandchild, also. In trying to help the young mother retain her youth and not jump into more premature adult decision-making, the parents may take over the teenager's mothering responsibilities (Furstenberg, 1980a, b). Her dependency and immaturity are prolonged. She may feel that the baby is awarded the attention she had desired. In those instances where the family may offer free room and board, financial assistance,

childcare, transportation to school, church, and medical facilities, emotional support, and parental consent for birth control counseling (a requirement for minors in some states), the teenage mother may do well to stay at home. If the family looks upon the first pregnancy as a mistake that is forgiveable, they may "rescue" the girl. Successive births by the same child, a multiple pregnancy (twins or triplets), a handicapped baby, or another child's early entry into parenthood makes it harder to cope and excuse the event once considered an "accident."

Not only do the parents respond differently to the teenager involved in premature parenthood by either allowing him/her adult privileges or by hindering maturity (Furstenberg, 1980a, b; Russell, 1980; Lewis and Lewis, 1980), but also the other children in the family now have a baby with whom to compete for attention. There is someone else younger and less powerful as far as decision-making and authority are concerned, but the baby wields much power in demanding attention and requiring time, energy, and material sacrifices.

If the young mother has been "picked on" before, that distinction may be passed to a sibling (Lewis and Lewis, 1980), the new "Identified Patient." Usually aunts and uncles are much older than their nieces and nephews, but teenage pregnancy may merely introduce a new playmate or brother- or sister-type into the house.

The crisis in the teenager's life can spell disruption in his/her parents' marriage. Their marital relationship greatly determines the cohesion of the family, how autonomous the teenage parent and the other children are, how the members are able to achieve individuality (Russell, 1980). One can predict how devastating the pregnancy will be on each person, including the parents, by noting how "enmeshed" or "disengaged" he/she is in relation to the family.

Often one parent blames the other for "letting the child get pregnant" or for "letting him get that girl in trouble." However, teenage pregnancy is usually not one parent's fault, the adolescent does make some decisions on his/her own. Unexpected pregnancy may be a reaction to a family pattern, or system, in which every family member has taken part. This is especially evident when a loved one has died or all the children are growing up and moving away (Furstenberg, 1980a, b). Unconscious signals may be given for a son/daughter to have a baby to replace the deceased or to delay the "emptying of the nest."

Although the pregnancy may be unwanted, the infant is, more times than not, wanted and welcomed. The baby serves as the family's centerpiece of pride. But there are times when shame, guilt, money problems, and anger override joy. Some parents cannot and do not accept the teenager's situation and want nothing to do with their child or the grandchild. In those instances the young

person's plight is exacerbated, he/she must draw on all the personal strength available and do a great deal of growing up in a short amount of time. Placing two children (teenager and baby) out on the street either forces the teen into a trial-and-error adulthood, a marriage of convenience, or both children into becoming wards of the state. The healthy family's guidance and support are vital to the adolescent's positive self-esteem. Without these means of assurance, the adolescent may doubt him/herself and tend toward early pregnancy (Litton-Fox and Inazu, 1980) or other acting out, rebellious behavior.

The teenage years should be a time of identity development, further sexuality education, and value structuring (Litton-Fox and Inazu, 1980), but "expecting a child" shifts the teenager into new roles if he/she takes on the responsibilities of parenthood. Since the young mother keeps the child over 90% of the time (American College of Obstetricians and Gynecologists, 1979) her family situation is highly important. Her marital status affects how much money flows into the household for how many people, whether or not she is totally dependent on public assistance, and if she completes her education. If she were married, the couple would probably have little income, but they probably would not qualify for state aid, and therefore the girl might drop out of high school. The girl's emotional stability is linked to her coordination

of various resources such as family members, crisis agencies, day care centers, hospital clinics, the school system, etc. The professional advice and family support she receives during pregnancy and afterwards is of primary importance to her health and to that of the child (Chilman, 1980). The family, whether it is the girl's family of origin or her husband and in-laws, provides broader access to the world than the single adolescent mother would usually have. The family supplies transportation for the girl who does not drive, other people to help raise the baby, advocates in dealing with unfamiliar institutions, and the basics of food, clothing, and shelter. When the outside world rejects her, home, though not perfect, may be the only refuge that tolerates and takes care of the young mother and her offspring.

The teenager's relationship to the family of origin is a central factor in the lives of most teenage parents. Programs of education and support for both the teenagers and their families of origin are important for the well-being of all concerned.

Physical Health

Medically speaking, the young pregnant female is at risk for a number of reasons. She is notorious for eating high calorie-low nutrient food stuffs which hamper the baby's development as well as her own growth. Her general hormonal activity has not reached mature levels. She has

few means of survival independent of her parent(s), she does not usually know how to hunt for resources because she has not yet finished the developmental tasks of adolescence. Low birth weight babies (less than 5 1/2 pounds) and premature births are typical of young mothers under 16 years of age. Thus, the possibilities of disease, infant and maternal mortality are great. These are more likely with successive births before age 20 and with short intervals between births (Lowe, 1977). Many young girls (and some older women) erroneously believe that breastfeeding prevents pregnancy, or that they will not engage in sex soon, or that one cannot become pregnant again very soon after delivery, or that contraception is sacrilegious or unsafe at any time, and another pregnancy results within months or a few years. The body needs at least twelve months to fully recuperate after each pregnancy, and the young girl requires several years for her body to mature after it has expended so much energy toward the development of another life.

Young mothers are more prone to anemia, hypertension, vaginal infection, hemorrhage, toxemia, miscarriage, poor nutrition, and premature or prolonged labor. The maternal death rate for teens is 60% higher among teen mothers than among women aged 20-24 (Lincoln, 1977; Lowe, 1977; American College of Obstetricians and Gynecologists, 1979).

Birth Control

Why is it that teens who relate intercourse to having babies--all teens are not knowledgeable in this area--do not make better use of birth control methods? Why do one million girls wait until they have experienced pregnancy before seeking reliable contraception (Furstenberg, 1976)? Of the 10.2 million sexually active girls in 1976, ages 15-19, 25% did not consistently practice birth control (American College of Obstetricians and Gynecologists, 1979).

One espoused theory (Furstenberg, 1976) suggests that the adolescent often decides there is no need to delay the inevitable. Her mother admonishes her 'to be careful,' but does not elaborate on what she means or HOW to be careful. Both women expect the adolescent to become pregnant "anyway" and she does just that, the self-fulfilling prophecy at work perhaps.

> [T]he more negative and anxious individuals are about sex, the more likely they are to risk an unwanted pregnancy . . . . Negative feelings about sex are rarely strong enough to inhibit sexual behavior completely, but they do inhibit the use of contraceptives by affecting each of four steps needed for contraception.
>
> (Byrne, 1978: p. 81)

Byrne identifies these steps as: the assumption that sex will occur; acquiring the contraceptive; communication between partners that at least one is planning to use the contraceptive; the actual implementation.

Teenagers do report reverberations of their use of birth control (Clinkscales and Gallo, 1977; Lincoln, 1977; Bolton, 1980) as related to Byrne's steps. It is difficult to admit sexual activity to oneself, especially if the incidents of intercourse are occasional. The partner may be unaware that the other wants to engage in sex and/or use birth control. The other may think that revealing that information could cause the partner to think of him/her in an unfavorable light.

Young people crave excitement and sensation; they often feel that birth control will interfere with these for the following reasons: Planning to have sex is made too evident by the package of condoms in the wallet, the daily Pill, or the interruption of foreplay to "protect oneself." Teens may view birth control as protection against the partner rather than an avoidance of pregnancy and that attitude is unacceptable in a caring relationship. So they offer themselves without restriction. Another factor in choosing not to use birth control is the conviction that one way to discover the partner's true interest is to risk pregnancy: "Does he love me enough to marry me?," "Does she love me enough to have my baby?"

Procuring contraceptives is no simple matter for teenagers. Pharmacists, medical personnel, and other adults give those disapproving looks and moralizing orations to make them feel guilty. Many teens cannot ask money from

their parents without explaing why it is needed, and the parents usually do not want confirmation that that child is sexually active, although they might suspect it.

A further motivation to becoming pregnant is the teen's perception that the status of parent commands more respect and power than "teenager" alone. Some teenagers want to be pregnant in order to assume a more equitable relationship with their parents, such as the older sister(s) has now that she has had a baby (Furstenberg, 1980a). Or the girl may be attracted to a "privileged" group of young mothers.

Lindemann (1974: pp. 13-75) describes three stages adolescents wander through in the process of seeking birth control. The "do nothing" or Natural Stage accounts for sex without protection. The unpredictable occurrence of sex, the infrequency, the desire for spontaneity and naturalness spawns intercourse without birth control. The Peer Prescription Stage usually occurs later after the teenager has had several sexual encounters and begins to think of the consequences. Friends give advice through their own experiences, but these recommendations are too often inaccurate, incomplete, and not presented with the scientific facts. Knowledge of non-pregnant friends' sexual activities and personal "luck" increases the risks taken, especially when sex is not commonplace (Furstenberg, 1976). Most teenagers do eventually get

instruction from professionals in school or the doctor's office. This Expert Stage provides education, discussion and material, hopefully deterring another unwanted pregnancy.

In summary, the obstacles to teenagers' use of birth control include the defensive attitudes of adults and teens. These barriers result in lack of awareness and/or planning by the teenager. Furstenberg proposes a thought which this author has been most inclined to support. "[M]ost women who become unwed mothers do not set out to have a child out of wedlock," there is no "advance commitment," therefore, no need for birth control. "Such sentiment may develop after pregnancy, or it may never develop. In short, rather than being directed or drawn to it, most women 'drift' into adolescent parenthood" (1976, p. 39). The decision not to do anything results in a continued pregnancy, an easier choice than making a "real" decision to abort or make concrete plans for raising a child (Fosburgh, 1977).

II. THE TEENAGE OBSTETRICS PROGRAM

History

The Mayor's Task Force on Teenage Pregnancy formed of medical, social service, education, religious and other community leaders prepared a summary paper in 1979 entitled "A Few Facts About Teen Pregnancy in Kansas City." It included the following data: In 1976 approximately 5,300 teenagers were pregnant in Kansas City; 3,000 babies were born; 1,600 mothers chose to abort, and 700 miscarried. The Missouri Center for Health Statistics (1980) reported that Jackson County, Missouri, had 2,042 live births and 1,160 out-of-wedlock births to teenagers in 1978.

The Department of Obstetrics and Gynecology at Truman Medical Center (TMC) has acknowledged the growing problems of adolescent pregnancy and infant mortality for several years, and has responded to these issues by implementing several programs designed to intervene during the prenatal and postpartum period of care. In 1980, 890 or 41% of the 2,155 deliveries at TMC were to teenage mothers. Teen deliveries at TMC accounted for approximately 45% of all teen deliveries in Kansas City. (See Appendix A for 1978 and 1979 statistics.)

Since 1974, the Kansas City Chapter of the March of Dimes Foundation has awarded TMC an annual Health Education Grant providing supplies, educational resources, continuing staff education funds, travel reimbursement, and salaries for the Teenage Obstetrics Program (TOP). The program is designed to address many of the adverse health and social effects of an early pregnancy on both the young mother and child as mentioned in the first part of this report. TOP's objectives have been to provide the adolescents receiving prenatal care at TMC a strong working knowledge of pregnancy, health and nutrition, labor and childbirth, child development, parenting skills and infant care, personal development, and family planning. The purpose is to lessen the crisis atmosphere which accompanies teenage pregnancy and make the transition from adolescence to motherhood as healthy and smooth as possible. Through an ongoing support network, individual and family counseling and referral, many needs are handled, such as continued education and infant medical care. The family has an informed and wider choice of resources. Of course, the infant's welfare is also of great importance, and when it is discharged, hospital staff is satisfied with the plans made for taking care of the child, which will be mentioned later.

Monies from the federal government have recently helped institute a system of free pregnancy testing that is available for all adolescents coming to TMC. This may be

the occasion for the first contact between the adolescent and the health care system and, in turn, with TOP. Many of the families cannot afford or do not value medical attention unless there is an emergency. The concept of routine monthly check-ups is quite new and must be encouraged.

The target population for 1980-81 was narrowed to adolescents 16-years old and under.* The intent behind eliminating the 17- to 19-year olds was to limit the case-load. In 1978, there were 801 teen deliveries at TMC, in 1979, 902, and in 1980, 890 (see Appendix A). Since there is but one TOP worker, the smaller numbers have improved the level of involvement with every client and her family. The age limitation also recognizes the differences in needs at various developmental stages. Older teenagers usually have other specialized concerns as they approach the end of schooling and independence. Younger girls are typically more dependent on their parent(s), more idealistic in their expectations of the boyfriend, and less likely to have ever worked outside of home. They have been exposed to fewer years of education. However, it may be well to comment that many of the teens, regardless of age, have cared for small children before, their relatives' children or those of friends and neighbors. The idea of being responsible for a little one was introduced to them early in life.

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* Three patients enrolled were older than 16; they continued contact with TOP after the primary clinic interview.

Participants of Teenage Obstetrics Program (TOP)

During the period considered in this paper, August 1980 to March 1981, TOP had enrolled 93 teens, 46 of whom had completed pregnancy by March when this report was prepared. Thirty-six babies are living with their young mothers and the situations of the remaining 10 are detailed below:

adoptions	1	baby in foster care	1
miscarriages	4	baby living w/mother	36
abortions	1	baby living w/father	1
		client not pregnant	1
		client ceased contact with TOP	1

The above chart characterized the postpartum file. Of the 47 girls in the prenatal file, 27 live with their mothers and 9 have two parents in the home. The others live with other relatives or a friend. Thirty-seven girls are experiencing their first pregnancy and the other 6 have been pregnant once before. (TOP has no record of how many pregnancies the remaining girls have had.) Less than half of the fathers of these expected children are actively involved with the girls during pregnancy.

The ages of the TOP clients range from 12-17 years of age, the mode is 16. Years completed in school range from fifth to eleventh grade, the mode is tenth grade. Most of TOP's clients are Black, less than one-third are White, and one Hispanic is in the current caseload. Nineteen girls have visited or enrolled in the school for pregnant adolescents. The statistics of the postpartum file closely parallel these prenatal file figures, except more girls had completed the ninth grade than any other grade. (See Appendices B and C for details on prenatal and postpartum demographics, respectively.)

These are the girls for whom TOP exists. The next section discusses what TOP does for them.

Procedures of TOP

The teenager's introduction to TOP commonly occurs at the first obstetrics interview when they meet the TOP Health Educator/Social Worker (HE/SW). They are also individually introduced to other support staff in the OB/GYN clinic. These include a nurse, financial counselor, and the Women, Infants, and Children (WIC) secretary. The clients complete an intake form which deals with the living situation, school status, and pregnancy status (Appendix D). They also take a written test on child care and development which allows the HE/SW and a nurse practitioner to assess their knowledge of childrearing (Appendix E). The papers

are placed in the individuals' folders in the TOP center located in the offices of the Obstetrics and Gynecology Clinic.

As contact with the adolescent continues (via telephone conversations, home visits, subsequent appointments), the HE/SW often interacts with other members of the client's family. These families play key roles in the success of the pregnancy. The number of contacts with the teenager and her family varies depending on how early in her pregnancy she entered the program, how receptive the family is, and how critical the situation. If the girl does not accept herself and the pregnancy, she is not going to voluntarily come to the hospital or to TOP and discuss it. The average number of contacts made by the HE/SW directly to the adolescent or in her behalf is few (five to ten) or many (thirty to forty) in number. This is in addition to the contacts of other support and medical staff. Some cases require much or a little work, there is not much middle ground.

Referrals are frequently made to the hospital dieticians, a nurse practitioner, Division of Family Services, Visiting Nurses Association, and local social service agencies as the needs become evident. The intent is to help the adolescent maintain a feeling of responsibility, while providing her with necessary information to make the needed contacts.

A Social Services package (Appendix F) is distributed and scanned with the client at the first TOP interview. These quick reference packets contain concise information on: pregnancy development, food for the pregnant teenager, help in coping with a new baby and with self, and post-partum exercises, some of the most important issues surrounding pregnancy. The pregnant girl receives several small booklets related to pregnancy from the nurse, so many, perhaps, that she is overwhelmed and reads none. The TOP packet provides a quick, all-in-one, easy-to-read option which may peak her interest to read or inquire further.

Nurses on the Nursery and Maternal Care Units alert the HE/SW when a girl 16 or younger is admitted onto the ward. There are some patients who receive prenatal care elsewhere and come to TMC only for delivery. There are occasionally some patients who receive no prenatal care until the time of delivery. If the girl is not registered with TOP, the HE/SW introduces herself and enrolls her into TOP, beginning at that point to provide whatever assistance is needed.

One volunteer educator comes every Thursday morning for one and one-half hours giving lectures and showing films on pregnancy and delivery to patients in the clinic waiting area. She is a very helpful and appreciated example of motherhood. She brings her 2-year-old daughter

with her and she models good parenting. This woman happens to be pregnant again and the other pregnant women can directly identify with her.

TOP works closely with the Teenage Parent Center (TPC), Kansas City district school for pregnant girls, and the HE/SW describes the school's procedures to every patient. The adolescents are invited to explore this educational option which may include vocational training. The HE/SW often takes them to the school for their first visit.

TOP presents films upon invitation to high school and junior high classes. Films are also used in other public presentations, in private sessions, and at the Saturday morning support group.* Pamphlets on birth control, sex education, and other family matters are distributed to clients and/or their parents and boyfriends as the need arises. Books may be checked out on a library-type system. (See Appendix G for listings of these materials.)

Frequently, the client-HE/SW rapport is positive enough that the adolescent comes to the TOP office without appointment during prenatal medical visits. She may need reminding of an appointment and the HE/SW gives her a call.

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* TOP is a part of the steering committee of a community-based support group for teenage parents. TMC clients are encouraged to attend these weekly meetings. At present, the group is preparing radio and television public service announcements to inform the public of the program and to introduce thought-provoking messages to teenagers.

The family may have concerns regarding school, financial, or family matters and contact is made over the phone, or they make a special visit to the office. The HE/SW sees the mother daily after delivery while she is in the hospital. Planning is done at this time about the child's care and the mother's care. This includes such crucial questions as: Where will each live? Is there an adequate supply of diapers, milk, and baby clothes? Who will help the mother with the child? Check-up appointments and WIC appointments are made for mother and child before they leave the hospital.

The pediatric hospital located within a short walking distance of TMC, Children's Mercy Hospital, follows about one-half of the teen mothers' children in the Intensive Care Clinic (ICC) after birth. The young age of the mother and the baby's usually low birth weight or precarious health condition indicate some social and/or medical risk factors, thus the need for a special care unit. The nurse practitioners and HE/SW from this clinic introduce themselves to the new mothers on the postpartum ward. They visit the ward daily so that, if the young mother chooses to use Children's Mercy's services, she will be able to identify faces and feel more comfortable. ICC staff contacts the TOP HE/SW for information gathered prenatally on the adolescent's situation. General follow-up after delivery is shared between the two hospitals.

After the baby's appointment at Children's Mercy the young mother can come right over to TMC for her personal needs. Non-ICC babies are seen at other clinics. The follow-through in those situations is less systematic.

The Clients' Situations

The mature young lady who enters the TOP office alone sometimes transforms into a confused, rebellious, distracted person in the presence of other family members. Hostility or dependency is shown in their interactions. If the girl's mother is present, the girl may lash out at her because she feels she has an ally in the HE/SW or she knows her mother will not retaliate in public as she would at home. Or she may allow mom to ask the questions and do most of the talking, beginning to relinquish herself of responsibility. Such abdicating of responsibility may continue also after delivery. The majority of TOP's clients come from single female parent homes (see Appendices B and C). The girls' natural fathers make only occasional and distant contact.

The relationship between mother (or mother-figure) and daughter is often heavily damaged even before the early pregnancy (Bolton, 1980). Discovering that her young daughter is expecting, the mother usually becomes distressed and furious. Frequently, the mother, herself, bore her first child during her school-age years and she predicts that in fifteen years or so her daughter will be as

dissatisfied with her life as she is (Chilman, 1980). Her own life is being complicated with this addition, not less harried as she had hoped at this stage of her life. By the time the teenager returns home with her baby, grandmother is calmer, at least on the surface, and she works toward the best possible rearing of her grandbaby.

Most of TOP's clients plan to finish high school, but very few of them have mentioned college. To some extent their young age limits such futuristic vision but the circumstances of many of these girls will limit their pursuing higher degrees. Most of the responsible ones want to work part-time and continue their schooling. However, a 14- to 15-year old can only obtain a menial type of job with menial pay. This leaves little time for childrearing, attending school and doing homework, performing household chores, and sleeping!

TOP clients usually are not interested in the alternatives of abortion or adoption. Although they say that they did not think "it" would happen to them, they soon begin to accept pregnancy. Time and again the girls give these almost standard explanations about keeping the child:

1) "My mother didn't give me up or get rid of me, so why should I do that to my child?!"
2) "I don't believe in abortion."
3) "I figure I did it [became pregnant] so I should take on the responsibility."
4) "I can't give up my baby after carrying it for nine months and going through all that [labor and delivery]."

In some cases, the girl is using an often-heard excuse because she cannot voice what she really feels due to a lack of verbal skills; or she does not know why she wants a baby; or she is afraid of the consequences if she tells the truth. She feels that the baby is reward due her after carrying the pregnancy full term, or it is a punishment she deserves for having wrongly indulged in sex. Not keeping the child is usually not an alternative in the young person's sub-culture and peer pressure is always an issue. Adolescents turn from the family to friends for approval. The teenager may be under pressure from other teenagers to prove him/herself as a man/woman, to dare to be a part of the "right" crowd.

TOP interviews have not yet revealed that these teenagers are keeping their babies because they "wanted someone to love and someone to love them" as many popular sources report. Deeper probing might uncover such rationalizations, but this is not a typical reaction of these girls.

The young pregnant girl has major decisions to make, but she does not have the maturity to see beyond her immediate situation. Her mother's example of early and frequent pregnancy was more significant than her threats and warnings opposing premarital sex or pregnancy. Once pregnant, the teenager resigns herself to the fate of motherhood.

III. POSTPARTUM INTERVIEWS WITH TOP CLIENTS

The above overview of TOP provides background for the following responses from interviews conducted for this study with approximately one-third of the currently enrolled TOP clients regarding their personal development after having children. These girls were chosen on the basis of the HE/SW's involvement with each girl and knowledge of her family situation. The HE/SW had had at least three pre- and/or postnatal contacts with each of the young mothers. Six of the interviews were conducted at the clients' homes, 4 in an office setting, 3 in a hospital clinic room. Each girl's situation is, of course, unique. However, it was the interviewer's impression that these 13 were rather typical of the TOP population at large, although they were perhaps more positively oriented to the project and feeling more secure in their life circumstances than some. Their agreement to participate in this study could denote a more open and cooperative segment of the TOP population than those who refused participation or did not keep their appointments.

The demographic data for these clients at the time they registered in TOP are described below*:

Client lives with:	Two parents 3		Grandparent(s) 2		
	Mother 6		Guardian/		
	Husband 1		Foster home 1		
Number of this pregnancy: N =	First 11		Second 1		Third 1
Father of child involved and contributing:	7				
Age of TOP Client:	12	13	14	15	16
N =	1	1	2	2	7
Last grade completed:	6	7	8	9	10
N =	1	1	4	4	3
Race:	Black		White		Hispanic
N =	10		2		1
TPC visited or enrolled: 8					

* Based on information supplied by the client or from her medical chart.

Interview Procedure

The HE/SW read each item to the respondent from her copy of the interview form (Appendix H). The HE/SW instructed the girl to check every answer on her copy that applied to her. In case none of the answers offered were applicable, the girl was encouraged to write her own response next to "Other." She was encouraged to ask questions at any time. Appendix H lists the frequency of responses to each question. The following paragraphs present the findings from the interviews along with a discussion of their significance and the author's subjective impressions concerning some of the situations encountered.

Findings and Impressions

In March, 1981, when the interviews were conducted, the ages of the clients ranged from 12 to 16 years, the ages of their babies ranged from 18 days to 4 months. All but one of the adolescents were single and most (12) lived with their infants. The family situation was satisfactory to 9 of the girls; 1 indicated parental interference, and 2 suggested that they received much help from their families. Unsurprisingly, five noted that their family relationships had improved since they had delivered. Furstenberg (1980a) suggests that tensions are resolved and the grandparent(s) becomes more "solicitous and protective" at the time of teen pregnancy. Six TOP young mothers felt relationships within the family had remained the same.

The girl's relationship with her mother is altered when the girl becomes pregnant. It may change in one of two ways: she may be treated more as a woman or more as a little girl who needs her mother's help. Both situations result in more concerned attention and communication. If other siblings have enjoyed such a change in status upon becoming parents, this girl may pattern their steps and force the family to reevaluate itself. The unexpected pregnancy is not necessarily tragic, it may benefit the family members if they allow themselves to learn and grow from the experience (Russell, 1980).

In terms of self-concept, motherhood was noted as the most important role for 9 of the teens; teenager was the identity chosen by 1, daughter by 2, one respondent wrote "niece." When commenting on their feelings about being a mother, some girls chose more than one response to express their feelings. Eight identified with the response "It is more exciting than I thought it would be." Two said they did not feel much different, and only two said they wished they were not a mother right now. Four chose the response "Life is hard, but I will pull through." One wrote, "It's not as bad as I thought. I think I can survive with my baby."

In large measure, the stories of success stem from supportive families, especially the grandmothers. Life is not extremely difficult for many of the girls right now, motherhood is exciting. But, the author questions the long-term effects on the grandmother, or the other family member who is responsible for the adolescent and her baby, as he/she copes with extra sacrifices.

In regard to life outside the home, 6 girls had returned to an academic environment, and all the others planned to complete high school or the General Equivalency program at some time in the future. If these mothers continue their education, it will not be hassle-free, particularly if they marry (Furstenberg, 1976, 1980b; Chilman, 1980). Most of the teens must miss school to keep the baby's routine or emergency appointment. Those

adolescents deferring their education to be at home with their children may feel quite out of place if they return to school after one year and are no longer members of their regular class. They may subsequently drop out.

The respondents had little trouble answering questions about other peer relations. Eight girls were dating; 5 of these were dating the baby's father. Four girls indicated they did not wish to date at this time. One girl agreed with her elders' choice for her not to date. Eight planned to begin using birth control in the near future, and 4 already were using preventive measures. Ten respondents checked that other girls at their age should not have babies, but 4 thought that they were better off than non-mothers.

One young mother told the interviewer that she was "scared, just not ready to date again." Those dating probably receive much support from their families in terms of babysitting, encouragement, and money. Life is not so simple for the 4 girls who have decided to abstain from dating and having sex for a period of time. Having a baby has firmly demanded a change in their lifestyles and attitudes. They are no longer responsibility-free, but tied to their children and the duties therein. It will be interesting to see who, indeed becomes pregnant again before age 20 or marriage, whichever comes first. At the time of the interview 3 respondents already expected to become pregnant before age 20.

The main source of income for 7 respondents was money from the government (Aid to Families with Dependent Children, AFDC) as it is for most teenage mothers (see Chilman, 1980). Most of the other girls were involved in the initial processing stages of their AFDC applications, 3 received help from the father of the child, 5 stated that they could not survive financially without their family's help. Two girls had part-time jobs at the time of the interview.

If funds for Medicaid, AFDC, WIC, youth employment, and child care are removed, possibly more of these mothers will report "I do not know how my child and I are going to survive." Nye and Lamberts (1980) suggest that "the more the stigma is eliminated from school-age childbearing, the more single parenthood is accepted, and the more financial support and other services are provided to school-age parents, the more school-age parents we shall have (other variables constant)." TOP's respondents do indicate that motherhood will not affect their relationships at school or church and most of them are not working. However, if society should choose to attempt to prevent early pregnancies by cutting the budget for these special programs, would not we be sacrificing babies already born and punishing teens who are already mothers? It is not in the compassionate tradition of this country to force starvation, lack of medical attention, and abandonment. It is apparent from the present number of early pregnancies that

that making life a little rougher is not a strong deterrent to teens to avoid pregnancy. Knowledge of the problems of early childbearing and changes in value systems before the first pregnancy would be more effective, yet, more arduous to implement.

Except for the girl whose child was in foster care, the mothers had kept or indicated that they planned to attend their babies' first checkup appointments. They were accepting the responsibility of seeing to the children's medical needs.

One question on the structured interview form asked the girls to check the adjectives which described their emotions since becoming mothers. The five most popular answers were happy (11), loving (10), glad (8), thankful (8), and scared (6). Although many of the mothers have positive feelings, 4-6 checked that they were nervous, confused, worried, or scared. Adolescence is a stormy period and motherhood increases the silent stress for some teenage parents, they have little freedom to be children themselves. There have been minor crises for these new mothers. As they grow alongside their children, the young mothers' ability to cope will be tested as will their families' flexibility. Can the satisfactory home situation last as expenses rise, as patience wears thin, and as disagreements surface between the mothers as to how the infant should be reared?

The persons upon whom these young mothers had most relied during the previous 6 months often were the same persons they would rely upon in the future. Father of the child, aunt, friend, and grandmother were listed, but mother was the most common response. One girl said she did not know who she could lean on for support in the upcoming months. Pregnancy was traumatic for this 12-year old, an incest victim who placed the child in foster care, and for others: the 16-year old having her third child and debating with the idea of adoption, which she rejected; for the 15-year old whose natural mother sent her away when she learned of the pregnancy and has not seen her or the baby since. (See Appendix I for illustrative profiles of certain cases.)

The author does not feel that the full impact of early childbearing has hit some of the girls because they have had cushioning; they do not have total responsibility for themselves or their children. One might conjecture from the statements of older women who were young mothers, that over time the adjustment tasks of motherhood will result in the teens interviewed painting different pictures than now.

IV. SUMMARY AND RECOMMENDATIONS

As complicated a task as comprehensive adolescent pregnancy programs can be, they are nevertheless crucial. They are also few in number around the nation. Included in recommendations for a program are: day care, employment counseling, abortion counseling and assistance, counseling of the teenage father, low cost/free contraception and training in how to acquire and use it, the most rare and most needed services (Lincoln, 1977; Jaffe, 1977). Reycroft and Kessler (1980) recommend that an effective adolescent pregnancy clinic should house "midwives, nurses, physicians, social workers, health educators, psychologists, and nutritionists." They advocate access to a special-care nursery, Lamaze childbirth classes, breatfeeding instruction, pre- and post-delivery, continuing education programs, day care, maternal and paternal education, and vocational technology training.

To house all these services under one roof is a tremendous and costly enterprise. In cooperation with its medical facilities and referral resources, TOP helps the community fulfill most of these requirements. Besides the programs already mentioned, the free childbirth preparation and parenting classes are conducted by the nurse

practitioner in the clinic, breastfeeding is addressed by the nurses and the volunteer during her presentations. The Teenage Parent Center has recently opened an eight-infant capacity day care center within the school itself with hopes of expansion in the near future. The hospital's pregnancy termination unit staffs a counselor with whom TOP has good relations, the workers refer patients and consult one another easily.

TOP does not actively seek out the teenage father, but is open to him if he contacts the office or accompanies the young mother. Some girls and their families want no further contact with the young man and cannot or will not offer information to help locate him. Neither does the TOP HE/SW have the time to conduct such searches. The fathers might be more relaxed about contacting the TOP office if there were a male staffperson with whom they could communicate and the girls' families were more amenable. But, of course, some males lose interest in the girl who "gets herself" pregnant. (See Haas, 1979.) Sexuality education and socialization for boys is quite lacking.

TOP's employment counseling referrals are few and inadequate, the ideas given to clients or boyfriends are usually for summer or temporary jobs, or those from a basic layman's knowledge. Although TMC is not the setting for employment counseling, it would be a positive move for TOP to build up its list of references outside of the hospital in this area.

Any service provider addressing the socio-psychological needs of teenagers learns that young people have problems or want to talk outside of the regular office hours. For any program providing service to adolescents and their families the author suggests a 24-hour hotline number and adequate staff available every day and night, not only for crises, but for information. One of the limitations of TOP's small staff is that the HE/SW is usually unavailable at night and on weekends. Having time for self is important for the social service professional, but the client may need to hear a familiar voice at any time. A hotline for teen parents could be helpful to the clients and the teens' working parents who cannot contact TOP during the normal business hours. An all-hour service is convenient for almost everyone and it could strengthen the outreach of the sponsoring adolescent pregnancy program. This requires a great deal of commitment from the staff since the hours will be irregular. Money, a supervising system, workers, publicity are age-old matters with which to be reckoned.

Furstenberg (1976; 1977) notes that any type of program promoting birth control needs to be long-term to reduce the threat of another unwanted pregnancy. Continued contact with the hospital, in case of problems or questions, and postpartum discussions on the woman's success with contraception encourages use. TOP and the clinic encourage the use of birth control by having the patient talk to the nurse practitioner, physician (at the postpartum checkup),

and the Health Educator. They supply patients with medically prescribed contraceptives, information, and names and places of where to go for birth control for which no prescription is necessary. The adolescents are free to call or visit at any time for check-ups, refills, or discussion.

Follow-up calls to the home after hospital release are fruitful as they detect problems in the transition from TMC to home; but a home visit within one week postpartum, after the four-week check-up, and at six months would continue that support and educational system even longer. A person(s) with some nurse's training and social services background would be the best contact(s) at this time to answer medical, infant care, and readjustment questions. If TOP does not make the follow-up contact, too often the adolescent does not avail herself of further TOP help. Possibly the girl sees TOP as a hospital facility fulfilling her needs as long as she is a client; once she is basically out from under the doctor's periodic care, she may not feel that she has the right to contact TOP. This hesitation is the reason why outreach and meeting the girl in her own territory is so important. She must believe that TOP is available to her even when she is not pregnant.

Educating and counseling the client is basic to TOP. However, work with the family is also considered important. The office schedule and routines of the adolescent and family frequently clash leaving little time for extended

family involvement except over the telephone and that gives the HE/SW only a one-dimensional view, without the non-verbal cues that tell so much. All the help given to the client may be undermined at home where she spends much more time. The adolescent hears and reads many half-true tales regarding the dangers of contraceptives or the devastating pain of delivery. It takes a long time to convince her of the positive effects of birth control and the differences in each pregnancy and delivery for every woman. As shown in the interviews, the girls perceive home as more helpful than the professionals. This is why TOP tries to teach the family how to be self-sustaining. The family should be the long-term support system for the young mother and child. Teenage parenthood can certainly be a time of pleasant anticipation and pulling together for the family (Russell, 1980). A comprehensive TOP should include interviews with the family or interviews with the parent(s) and adolescent at least once during each trimester of pregnancy to monitor the family adjustments. If the family has not truly recognized the girl's condition in the early months and what changes a baby will bring, by the seventh month there is little opportunity for denying that she is visibly pregnant and the situation must be dealt with openly. Many hours are needed from staff, adolescent, and family in addition to the regular clinic visits. Another in-house counselor is needed in some cases for extended work with individuals, families, or

several families together. Having the person as an intrinsic part of the program instead of referring the reluctant, frightened, and time-limited family to what it might call a "shrink," would increase the chances of regular sessions. The family may reject someone new in another location and they would reject the image of the "crazy" or "sick" family. Therapy and education, as a part of TOP, could more easily address such subjects as parenting, reactions to divorce, intrauterine and infant death, discipline, and value-teaching for teenage parents and their parents, who have a very complex time struggling with early pregnancy and childbearing.

General family life education classes will soon begin in the OB/GYN clinic waiting room on a twice weekly schedule using audio-visuals and presentations. Teenagers, their parents, and the fathers of the children will be included in the audience.

It is the author's contention, based on these interviews and experiences with TOP, that a decrease in adolescent pregnancy in the 1980's is possible if:

1) the number of adolescents continues to decline
2) there is improved contraception technology and consistent use before one year or more of sexual activity has occurred
3) stigma-free sexuality education is taught in the school systems and supported by parents
4) there is less media attention to sex related advertising and presentations
5) the nation and its families were able to find economic stability at a functional level

6) parents and professionals (legislators, medical staff, social workers, pharmacists, teachers, etc.) were more attuned to teenagers needs and were well-informed, easily available, and not condescending or belittling; this may require increased funding for family life education for the community and professionals.

Society may disapprove of the act of premarital sex among adolescents, but it should not condemn and shut out the persons who do engage themselves sexually. Nurturance of the young ones now means a more positive outcome for everyone in the future, including the adults who will have aged and possibly become dependent on a humanitarian power structure. Society's task in curbing the feared "epidemic" of teen pregnancy begins with the offering of viable alternatives--meaningful and decent paying jobs, other means of sexual release without full intercourse, emphasis on school activities that appeal to more students. One of the best methods of controlling unwanted parenthood is through developing proper role models in the family and at the community level to aid the teenager's maturation process, especially if he/she is already dealing with pregnancy before being physically, emotionally, or financially prepared.

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APPENDICES

Appendix A

Truman Medical Center
Teenage Delivery Statistics

Age		12	13	14	15	16	17	18	19	Total
1978	N =	1	5	15	57	128	151	225	219	801
1979	N =	0	6	17	90	99	190	253	277	902

Total Deliveries 1978 N = 2,149 Teens N = 801

1979 N = 2,108 Teens N = 902

Births with Medical Complications at Delivery 1978 N = 183 Teens N = 131

1979 N = 224 Teens N = 131

Appendix B

Client Demographics -- Prenatal File*
Total -- 47

Client lives with:	Two parents	9	Grandparent(s)	2
	Mother	27	Other relative	5
	Husband	3	Friend	1

Number of this pregnancy:		First	Second
	N =	37	6

Father of child involved and contributing: 21

Age of TOP client:	12	13	14	15	16	17
N =	1	1	8	13	23	1

Last grade completed:	5	6	7	8	9	10	11
N =	1	1	1	12	12	18	1

Race:	Black	White	Hispanic
N =	35	11	1

TPC visited or enrolled: 19

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* Lack of available information in some categories for some clients accounts for the difference in totals.

Appendix C

Client Demographics -- Postpartum File*
Total -- 46

Client lives with:	Two parents	11	Grandparent(s)	1
	Mother	25	Other relative	4
	Husband	2	Guardian/ Foster home	2

Number of this pregnancy:	First	Second	Third
N =	39	4	1

Father of child involved and contributing: 22

Age of TOP client:	12	13	14	15	16	17	18
N =	1	1	7	14	20	1	1

Last grade completed:	6	7	8	9	10	11
N =	1	1	10	17	8	2

Race:	Black	White	Hispanic
N =	32	10	2

TPC visited or enrolled: 19

---

* Lack of available information in some categories for some clients accounts for the differences in totals.

Appendix D

TOP Intake Form

Name_____ Hosp. #_____ 1st Visit____

Address_____ Zip Code_____ Phone#_____

Birthdate_____ Age____ GR____ P____ AB____ LMP____ EDC_____

Referred From_____ Self____

Educational Level_____ Grade: / Last School Attended_____

School Referral YES____ NO____ Where_____

Previous Prenatal Care YES____ NO____ Where_____

Living Situation: Both Parents____ Mother/Father ONLY____ Grandparents____ Child's Father

Relative/Who_____ Other____ **NEEDS HOUSING REFERRAL: YES____ NO____ Action_____

W.I.C. Referral: YES____ NO____ Action:_____

INITIAL INTERVIEW_____ PRENATAL CARE_____ NUTRITION_____ HEALTH EDUCATION____

BIRTH CONTROL_____ BRINGING BABY HOME_____ LABOR & DELIVERY TOUR_____

POST PARTUM_____ OTHER INSTRUCTIONS_____

PROGRESS NOTES *Dated

:tual Delivery Date_____ A.D.C. Referral: YES____ NO_____

.OSING NOTES:_____

Appendix E

Pregnancy and Child Care Test

PLEASE CIRCLE THE ONE ANSWER THAT YOU CONSIDER TO BE MOST CORRECT FOR EACH QUESTION.

1. When a young infant cries, mother should:
   A) let him cry so as not to spoil him
   B) spank him
   C) attend to him as soon as possible

2. How much does a mother need to gain during her pregnancy?
   A) 5 pounds
   B) 10 pounds
   C) 25 pounds

3. A baby knows the meaning of the word "no" by the age of:
   A) 2 months
   B) 6 months
   C) 12 months

4. The part of the body where the baby grows for 9 months, inside the mother, is called the:
   A) ovary
   B) uterus
   C) vagina
   D) fallopian tube

5. Choose the following answer that is <u>not</u> a sign of labor:
   A) strong, regular contractions
   B) ruptured bag of waters
   C) braxton-hicks contractions
   C) bloody show

6. Sexual activity can be continued throughout pregnancy unless:
   A) there is vaginal bleeding
   B) threatened premature labor
   C) if bag of waters has ruptured
   D) it becomes uncomfortable for the woman or if the doctor instructs no sexual intercourse
   E) all of the above

7. What else is needed to make a baby besides a woman's egg and a place in the woman for the baby to grow?

A) a happy marriage
B) an IUD
C) a sperm
D) menstruation

8. A child learns to walk around the age of:
   A) 1/2 year
   B) 1 year
   C) 1-1/2 years

9. A baby's temperature is taken with a rectal thermometer. A normal temperature is:
   A) 97.6 degrees
   B) 98.6 degrees
   C) 99.6 degrees

10. A monitor is placed around a woman's tummy while in the Labor Room to record contractions and the baby's heart beat:
   A) for all women
   B) only in emergencies
   C) if the labor has gone for more than 10 hours

11. Smoking, drugs and alcohol used during pregnancy:
   A) has no effects on the baby if not used heavily
   B) should not be used at all during pregnancy to assure the best health for mother and baby
   C) is okay to use if the mother is eating a well-balanced diet

12. While in labor during a contraction it is helpful to:
   A) squeeze the handles on the table and hold your breath until the contraction is over
   B) relax and practice a special way of breathing
   C) drink plenty of fluids

13. The pregnant mother needs some of these foods every day:
   A) milk, vegetables, breads, and cereal
   B) milk, vegetables, breads, and sugar
   C) milk, vegetables, breads, and oil

14. Which type of birth control method does not require a doctor's prescription?
   A) the pill
   B) IUD
   C) diaphragm
   D) condom

15. It doesn't matter what the mother eats because the baby will be born the way it was meant to be.
   A) True
   B) False

16. A child learns to talk:
    A) when his mother responds to his sounds by smiling, talking, and being affectionate
    B) once he begins preschool
    C) automatically, whether his mother speaks to him or not

17. After a woman has a baby:
    A) she can get pregnant any time
    B) she cannot get pregnant until she has at least one period
    C) she can get pregnant unless she is breastfeeding

18. A newborn baby:
    A) does not need to be talked to because he cannot understand language
    B) does not need to be held much because this leads to spoiling
    C) cannot be spoiled before it is 6 months old

19. A danger sign of pregnancy that should be reported immediately to the doctor is:
    A) vaginal bleeding
    B) ruptured bag of waters
    C) infection, fever, or chills
    D) all of the above

20. Pregnant women should:
    A) avoid much exercise two months before delivery
    B) remain inactive throughout pregnancy to avoid miscarriage
    C) practice special exercises to prepare for labor

21. Most children are fully potty-trained:
    A) by 1 year
    B) by 1-1/2 years
    C) when they are 2 years or older

22. A child should begin to have his shots:
    A) at 2 or 3 months
    B) when he's ready to go to school
    C) only when he is sick

23. To avoid gaining too much weight during pregnancy a mother should:
    A) skip meals during the day
    B) not eat bread
    C) try to eat balanced meals and avoid sweets

24. A baby should be:
    A) dressed with less clothes than adults
    B) dressed with the same amount of clothes as adults
    C) dressed with more clothes than adults

25. A baby recognizes his mother:
    A) within one week
    B) by 3 or 4 months
    C) not until one year

26. At what time of the month can a woman become pregnant?
    A) during ovulation
    B) any time of the month
    C) when she feels horny

27. Breast feeding:
    A) does not require any special preparation before the baby is born
    B) is not as good for mother and baby as bottle feeding
    C) is healthy for mother and baby

28. Following a proper diet during pregnancy is:
    A) too hard to do
    B) not important
    C) important for both baby and mother

29. When coming to TMC to have a baby:
    A) you are not allowed to bring anyone with you
    B) you are encouraged to bring a close friend or relative to coach
    C) you can have as many as four friends with you at one time

30. Some birth control methods are safer than others. Which of these is the safest?
    A) pill
    B) IUD
    C) abstinence
    D) condom & foam

THIS BOOK CONTAINS NUMEROUS PAGES WITH THE ORIGINAL PRINTING ON THE PAGE BEING CROOKED.

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Section II: Nine Months Of Pregnancy

James Dingfelder, M.D.*

Counselors may be asked questions by the pregnant woman concerning the actual size and physical characteristics of the unborn baby. A brief month-by-month outline of pregnancy is provided below for the counselor's guidance and reference in dealing with these questions.

First Month

Following the union of the egg and sperm in the midportion of the fallopian tube, the fertilized egg moves into the womb (uterus) and begins to grow and divide into cells. A portion of these cells develop into the membranes that make up the amniotic fluid sac surrounding and protecting the growing embryo. Another portion of cells invades the receptive soft lining of the womb and forms the vital placenta (or afterbirth) which is connected by the umbilical cord to the enlarging embryo. Through this narrow life-line, the embryo is able to extract the vital nutrients from the woman's blood stream that are essential to its growth, as well as to exchange oxygen and return waste products to the maternal circulation.

As prenatal development continues, a third and smallest portion of cells in the fertilized ovum (egg) become the center of attention as these cells subdivide into three layers of body tissue. The inner (endoderm) layer soon forms the gastro-intestinal system, the urinary tract, and many of the glands for internal secretion such as liver, gallbladder, pancreas, and thyroid. The middle (mesoderm) layer forms the muscolo-skeletal system, the kidneys, the blood circulation and the connective tissues. The outer (ectoderm) layer will become the brain and nervous system, the eyes, and the skin and its subdivisions of nails, tooth coverings, sweat glands, and hair.

After one month's growth, the embryo measures about one-quarter inch from head to a temporary tail. A primitive urinary tract and digestive tract have formed and growth is being promoted through a rudimentary blood vessal circulation supported by pulsations from a tubular group of muscle cells which will eventually form the adult heart. Sprouts of tissue which mark the site of future arms and legs can be recognized at this stage.

Second Month

At the end of eight weeks, the growing embryo has achieved a trunk length of nearly an inch. The prominence of the head emphasizes the maturation of the nervous system at this stage of growth. The growing blood vascular system is now providing continued nutrition to the recognizable finger and toe buds on the arms and legs. The external sex organs are still in an indifferent stage of development, and the sex of the embryo is not recognizable, but other characteristic features such as the eyes, ears, nose, and mouth can be appreciated.

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Third Month

The rapidly growing fetus has achieved a weight of nearly an ounce at the conclusion of the third month and is now around three inches in length. The nervous system begins to coordinate movements of the growing muscle tissues which are able to provide the fetus with active movements in its fluid surroundings. It now is able to react to changes of light, sound, and temperature as well as to skin sensation. The heart beat can be recorded by sensitive sound-amplifying devices or by refined electrocardiographic apparatus. The first baby teeth begin to form at this stage and nails appear on fingers and toes. Fetal sex is still somewhat ambiguous, but can be recognized by an expert.

Although the fetus is now capable of swallowing amniotic fluid, it still derives its nutrition through the umbilical cord life-line and the all-essential placenta which has continued to grow on the side wall of the enlarging uterus.

Fourth Month

At the end of the fourth month, the fetus is six inches in length and nearly a quarter of a pound in weight. It moves quite freely within the amniotic sac with enough activity that some women may be aware of these movements. The emphasis of fetal growth throughout the remainder of pregnancy is increasingly one of size and specialization since the appearance of nearly all of the organs in an adult has now occurred and can be found in the fetus. The most critical stages of growth and development, those most sensitive to the destructive outside influences of drugs, irradiation, infections and maternal disease, have been passed. The fetal bone skeleton is clearly visible on X-ray (should one be ordered inadvertently). Diagnostic studies on the amniotic fluid from around the fetus can be done at this stage to detect diseases or conditions such as the Rh negative blood disorders.

Fifth Month

The uterus has enlarged to a level above the navel of the mother by the end of this month, and most pregnant women can feel the movements of the one pound, ten inch fetus quite readily. The external sex is now easily ascertained and the appearance of the body hair, nails, and eyebrows resemble closely those of a full-term infant. The lungs have been formed for some time and the fetus moves quantities of amniotic fluid to and fro in the respiratory system. Oxygen-breathing capacity at this stage is too meager to permit independent outside existence for more than a few minutes.

Sixth Month

An additional month of maturity provides nearly a doubling in weight for the twelve inch fetus, although lung development has still not progressed far enough to permit continued outside existence for more than a few rare infants born at this stage of pregnancy. The fetus is now sufficiently developed, for one of the first external efforts to change its environment in order to permit continued life—a blood transfusion—can now be made into the abdomen of a fetus that is affected by Rh negative sensitization disease.

Seventh Month

A small percentage of infants born at this stage may survive in a modern, intensive care premature nursery. Hyaline membrane disease of the lung afflicts the great majority of them and seldom permits continued outside life for more than a few hours.

Eighth Month

At the end of the eighth month, the average premature newborn weighing around four pounds will have an excellent chance for successful independent outside life. Amnio centesis (sampling the amniotic fluid via a small needle passed through the uterus) may provide information which can predict the probable survival chances of the infant born four weeks prematurely. On occasion, the obstetrician may select an early delivery when the intrauterine environment is shown to be unfavorable, as with problem pregnancies complicated by diabetes, toxemia, and Rh sensitization.

Ninth Month

Fully mature infants usually weigh over six pounds, are 18-20 inches long and generally emerge fully capable of independent physical existence, provided they are given adequate nutrition, warmth and protection.

ILLEGIBLE

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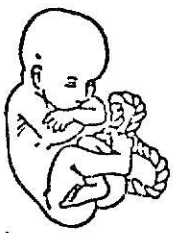
ILLEGIBLE

YOU'RE ON YOUR WAY

Having a baby is a long, exciting "journey." There are turns and changes, guideposts and warning signals to bring you safely to the birth of your baby.

What should you do?

- As soon as you think you're "on the way," ask someone who knows—a doctor.
- Don't be a know-it-all! Even if you've made the same trip before, see the doctor early and often. Every pregnancy is different.



PNC PROTECTS YOU AND BABY

PreNatal Care—before-the-baby-is-born care—is the best way to keep you healthy and to insure that your baby will be as healthy as possible.

The risk of having a baby born before it is due—or a baby that is crippled, or retarded, or born dead—is less if you have early prenatal care.

YOUR BABY IS MADE OUT OF YOU

That's why it's important for you to see a doctor early.

So he can examine samples of your blood and urine to *learn many* things about your health. So he can check your blood pressure, eyes, ears, nose, throat and teeth. So he can examine your chest and breasts, your abdomen and pelvis. It won't be painful, and the doctor must know.

The doctor will also ask about the father's health. He'll want to know about his parents, your parents and about other relatives. Tell him all you know or can find out.

WHAT YOU EAT IS IMPORTANT

Gaining weight is normal when you're pregnant, but be sure to keep it normal. You don't have to "eat for two." The *average normal gain is* 24 to 28 pounds, depending on your weight before pregnancy.

Ask your doctor for advice about diet.

BEWARE OF MEDICINES, TONICS, DRUGS

Don't take anything that has not been prescribed by your doctor, especially for you, during this pregnancy.

Look on any pill, powder, tablet, capsule, liquid medicine or home remedy as a possible danger to your baby—unless the doctor prescribes it.

Check with him early about the safety of any prescription you had before you became pregnant. Never touch medicine prescribed for other members of your family or for friends.

KNOW THIS "NO" LIST

Avoid everything on this list unless your doctor orders one or more to treat a condition you have discussed with him.

MEDICINES • "PEP" PILLS • LAXATIVES • TRANQUILIZERS • ASPIRIN or any other "PAIN RELIEVER" • MINERAL OIL • REDUCING PILLS • BAKING SODA • NERVE TONIC • SLEEPING PILLS • VITAMIN SUPPLEMENTS.

TRAVEL TIPS TOWARD A [illegible] BIRTH...

See a doctor early to protect your health and the baby's. He will type your blood and, in certain cases, your husband's. Protection against Rh blood disease is now possible.

Tell any other doctor you consult that you are, or think you may be, pregnant. He needs to know this to decide whether X-rays or medications are safe for you.

Make sure that your children and all the children in your community are vaccinated against *rubella* (German measles), because when a child spreads rubella to a pregnant woman, her unborn baby may be severely damaged.

Food For The Teenager During Pregnancy

If you are a teenage girl who is going to have a baby, you probably know that your baby takes body-building materials from what you eat during the 9 months of your pregnancy. It's up to you to eat enough food to provide for your baby's growth and development and to meet your own total daily needs.

The earlier you get health care, the better it is for you and your baby. You increase the chances that your pregnancy will go smoothly if you visit a doctor or clinic early in pregnancy, return for regular visits, and follow professional advice about taking care of yourself during this period.

What You Eat is Important

Eating the right kinds and amounts of foods at the right time helps you feel good, look good, and have a lot of energy. Even more important when you are pregnant, eating the right kinds of food will add to your chances of having a normal, healthy baby.

Gain in Weight

Every girl should gain weight during pregnancy. The desirable average gain is 24 pounds, within a range of 20 to 25 pounds. This amount provides for growth of the baby and changes in the mother's body that support and protect the baby.

The way you gain weight is just as important to the healthy development of your baby as the total number of pounds. It is best to gain a small amount of weight each week. You can do this by eating the kinds and amounts of foods listed in the food guide on page 4.

No matter how much or how little you weigh when you get pregnant, you should try to gain about 1 pound a month in early pregnancy—or a total of 3 pounds during the first 3 months. From the fourth month until delivery, you should try to gain about three-fourths of a pound a week.

This means that even if you are overweight, you should not try to lose weight during pregnancy. If you need to reduce after your baby is born, you can get help from a nutritionist or a doctor.

If you are underweight when you get pregnant, gaining weight may not be easy for you, but the effort will be worthwhile for your baby. After delivery, it is likely you will keep some of the weight you have gained.

If you are of normal weight at the beginning of pregnancy, you probably will get back to normal weight within a month or two after your baby is born.

Some Examples Of How Foods Work For A Pregnant Teenager And Her Baby

Foods	Nutrients	How Used
Milk, cheese	*Calcium, phosphorus*	*Build bones and teeth*
	Protein	*Aid growth of new tissue and repair of body cells*
Meat, chicken, fish, eggs, dried peas and beans, nuts, peanut butter	*Protein*	*Aid growth of new tissue and repair of body cells*
	Iron	*Prevent anemia*
Fruits, vegetables	*Minerals, vitamins*	*Make body cells work properly*
Whole-grain or enriched breads, cereals, cereal products	*Carbohydrates*	*Provide energy*
	Minerals, vitamins	*Make body cells work properly*
	Protein	*Aid growth of new tissue and repair of body cells*
Fats, oils	*Calories*	*Provide energy*
Sugars, sweets	*Calories*	*Provide energy*

Food Guide

Nutrients Needed During Pregnancy

Foods give you nutrients and calories that your body needs for good health. Nutrients—proteins, carbohydrates, minerals, vitamins, and fats—are discussed on page 10. You need the same nutrients during pregnancy as before pregnancy. The chart on page 3 shows basic foods, the nutrients they supply, and each nutrient's role in pregnancy.

To get the nutrients you need when you are pregnant, select a variety of foods every day. The food guide can help you in making your choices.

Calories

Energy value of food is measured in calories. Calories are needed for growth and body function as well as for energy. The number of calories you need varies according to your size, age, and activities. When the total energy value of the food you eat is more than the energy you use for exercise and activities, you will gain weight; when the reverse is true, you will lose weight.

When you become pregnant, you will need about 300 more calories each day than you needed before. The extra calories can easily be supplied by such foods as one extra glass of milk plus a sandwich or a pudding. Or you may eat larger amounts of some of the foods that you ordinarily eat. This means you do not need larger amounts of *all* foods when you are pregnant.

It is important, however, to eat the recommended number of servings of meat or meat substitutes, fruits and vegetables, milk and milk products, and bread and cereals—so that you get enough nutrients for your baby's growth and for your own health.

Milk and Milk Products

It takes four to five 8-ounce glasses of milk or milk products daily to give you the calcium you and your baby need while you are pregnant. Choose milk that has vitamin D added. Part or all of the milk may be whole milk, buttermilk, evaporated milk, dry whole milk, dry skim milk, or fluid skim milk. You can also use the milk in beverages such as hot chocolate, in soups, in puddings, and over cereals. Remember to include all forms of milk in your meals as well as all the milk you drink when you count the amount of milk you get each day.

These amounts equal the calcium in one 8-ounce glass of milk:

1 cup of buttermilk
1 cup of liquid skim milk
½ cup of evaporated milk (undiluted)
2 one-inch cubes or 2 slices of cheese
4 tablespoons of powdered skim milk
4 tablespoons of powdered whole milk
1 cup of yogurt

These amounts equal 1/3 cup of milk:

½ cup of cottage cheese
½ cup of ice cream

If you do not like or cannot drink milk, discuss this problem with a nutritionist or your doctor.

Meat, Fish, Poultry, Eggs, Dried Beans

Meat, fish, poultry, eggs, and dried beans and peas, nuts, and peanut butter supply protein. You need two servings of protein foods daily to get enough protein while you are pregnant. When you use dried beans or dried peas or cereals as main dishes, combine them with milk or a small amount of meat to increase the protein value of the meal.

Count as one serving:

2 or 3 ounces of lean meat. Some examples are:

- *1 hamburger*
- *2 thin slices of beef, pork, or lamb*
- *1 lean pork chop*
- *2 slices of luncheon meat*
- *2 hot dogs*

2 or 3 ounces of fish. Some examples are:

- *1 whole small fish*
- *1 small fillet*
- *1/3 can (6½ ounces) of tuna fish*

2 to 3 ounces of chicken, turkey, or other poultry. Some examples are:

- *2 slices of light or dark meat*
- *1 chicken leg*
- *½ chicken breast*

Count as one-half serving:

- *½ to ¾ cup of cooked dried beans or peas*
- *2 to 3 tablespoons of peanut butter*
- *1 or 2 one-inch cubes of cheese*
- *1 or 2 slices of cheese*
- *¼ to ½ cup of cottage cheese*
- *1 egg*

Fruits and Vegetables

Fruits and vegetables contain vitamins, minerals, and fiber, a natural laxative. During pregnancy, you need to eat four or more servings every day. A serving is about ½ cup of fruit or vegetable or ½ cup of juice. You may use fresh, frozen, canned, or dried fruits and vegetables.

Eat at least one serving of a good source of vitamin A every other day:

- *Apricots*
- *Broccoli*
- *Cantaloupe*
- *Carrots*
- *Dark green leafy vegetables—chard, collards, kale, mustard greens, spinach, turnip greens*
- *Sweet potatoes*
- *Winter squash*

Eat at least one serving of a good source of vitamin C every day:

- *Broccoli*
- *Cantaloupe*
- *Orange or orange juice*
- *Grapefruit or grapefruit juice*
- *Raw cabbage*
- *Green pepper, sweet red pepper*
- *Fruit juice drink with vitamin C added*
- *Fresh tomatoes*
- *Dark green leafy vegetables—chard, collards, kale, leaf lettuce, mustard greens, spinach, turnip greens*
- *Fresh strawberries, blackberries, raspberries*
- *Watermelon*

Select two other servings every day from other vegetables and fruits:

Beets	*Bananas*
Corn	*Grapes*
Lettuce	*Peaches*
Peas	*Pears*
Potatoes	*Pineapple*
Apples	*Other vegetables and fruits*

Breads and Cereals

Breads and cereals give you minerals and vitamins as well as the energy you need. Whole-grain breads and cereals provide fiber, a natural laxative. Check the labels on breads, cereals, and cereal products to make sure that they are either made with whole wheat or whole-grain flour or are enriched with minerals and vitamins.

Eat five or six servings of whole grain or enriched breads, cereals, and cereal products every day during pregnancy.

Count as one serving:

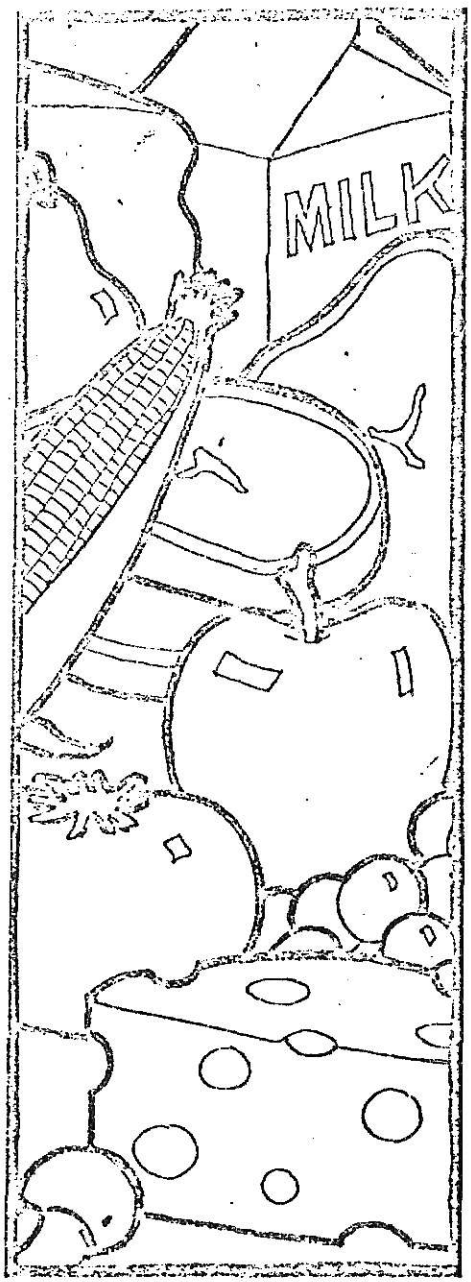
- *1 slice of bread*
- *1 muffin*
- *1 roll, biscuit, hamburger bun, or hot dog roll*
- *1 tortilla*
- *½ to ¾ cup of cooked or ready-to-eat cereal, such as oatmeal, farina, grits, cornflakes, shredded wheat*
- *½ to ¾ cup noodles, spaghetti, rice, or macaroni*

Other Foods

Complete your meals with salad dressings, corn oil or other vegetable oils (used for cooking), margarine made with *unsaturated fat, butter, sugar,* and desserts. Soft drinks, candy, and other sweets should be a once-in-a-while treat. Eating too many sweets may keep you from getting necessary nutrients and cause you to gain too much weight.

Water

People cannot live without water. It helps your body cells work properly and keeps your temperature normal. You need to drink 6 to 8 glasses of water or other fluids each day during your pregnancy—the same amount that is recommended for adults every day.



Meal Plans

Small Meals

You will probably be more comfortable during the last 3 months of pregnancy if you do not overload your stomach at any one meal. You may want to try eating small meals six times a day—at breakfast, midmorning, noon, midafternoon, dinner time, and in the evening. Follow the guide in selecting minimeals to make sure that you include the number of servings of the basic foods needed each day.

Milk and a sandwich made with meat, chicken, fish, eggs, peanut butter, or cheese are excellent minimeals. Other ideas are milk and fresh fruits, fruit juices, cheese and crackers.

Choose the Foods You Like

The following meal plans are samples to show how to get enough nutrients each day during pregnancy. When you plan your meals, choose foods that you like and that fit into your family's eating patterns. Add enough milk, fruits, vegetables, and protein to give you the amounts the food guide recommends. A nutritionist or your doctor can help you fit the plans to your own needs.

If you are not gaining weight at the recommended rate, eat extra servings of breads, cereals, protein, and other foods. If you are very active, you will need to increase the amounts of food suggested in the guide.

Size of Serving:
Bread: *1 slice*
Cereal: *½ to ¾ cup*
Fruits and vegetables: *½ cup or about 4 serving spoons*
Fruit juice: *small glass (4 to 6 ounces)*
Butter or margarine: *1 teaspoon*
Meat, fish, or poultry: *2 to 3 ounces (1 or 2 pieces)*
Milk: *large glass (8 ounces)*

SAMPLE MEAL PLANS

First Day

BREAKFAST
Orange
Scrambled egg
Muffin
Margarine or butter
Milk

MIDMORNING SNACK
Milk

LUNCH
Hamburger with bun
Banana
Cookies
Milk

MIDAFTERNOON SNACK
Ice cream cone

DINNER
Tuna-noodle casserole
Green peas
Jellied fruit salad
Bread
Margarine or butter
Apple cobbler
Milk

EVENING SNACK
Fruit juice
Open-face toasted cheese sandwich

SAMPLE MEAL PLANS
Second Day

BREAKFAST
Grapefruit half
Cereal
Toast
Margarine or butter
Milk

MIDMORNING SNACK
Cheese and crackers
Milk

LUNCH
Ham and cheese sandwich
Celery sticks
Apple
Milk

MIDAFTERNOON SNACK
Pizza

DINNER
Baked chicken
Rice
Spinach
Chocolate pudding
Milk

EVENING SNACK
Hot dog with roll
Lemonade

SAMPLE MEAL PLANS
Third Day

BREAKFAST
Tomato juice
Cottage cheese
Toast
Margarine or butter
Milk

MIDMORNING SNACK
Hot chocolate

LUNCH
Bologna sandwich
Carrot sticks
Grapes
Milk

MIDAFTERNOON SNACK
Peanut butter sandwich
Lemonade

DINNER
Spaghetti with meatballs
Mixed green salad
Bread
Margarine or butter
Canned peaches and cookies
Milk

EVENING SNACK
Orange
Milk

Some Other Concerns

Morning Sickness

Even when you don't care about food because of morning sickness, remember that it is important to eat correctly for your baby's sake. Morning sickness may occur in the early part of pregnancy, and it generally goes away by the end of the third month. Eating small amounts of food throughout the day may help reduce the sick feeling. Many girls find it helpful to eat a cracker or dry toast before they get out of bed, and then to remain flat and still in bed for a short time.

Follow your doctor's recommendations about morning sickness; don't take any medicine for it without your doctor's prescription.

Cravings

If you feel like eating clay, laundry starch, or other things that are not really foods, discuss this with a nutritionist or a doctor.

Vegetarian Diets

A vegetarian diet that includes milk and eggs, cereals, and nuts can be adequate for a pregnant woman. However, a vegetarian diet without eggs and milk may not provide all the nutrients needed during pregnancy. If you are on a vegetarian diet, discuss food choices with your doctor or a nutritionist.

Anemia

Anemia is an illness that develops when there is not enough iron in the body to take care of red blood cells. In the United States anemia is common among teenage girls who do not get enough of the iron they need every day from the foods they eat.

Anemia can usually be treated successfully if it is found before complications develop. This is one of the many reasons that every pregnant girl should see a doctor as soon as she knows she is pregnant.

When a teenage girl becomes pregnant, she needs extra iron for herself and her baby. To make sure pregnant girls get enough iron to prevent anemia, many doctors prescribe both iron tablets and folic acid tablets. Follow your doctor's recommendations about taking iron and folic acid.

Cigarettes, Alcohol, and Drugs

Almost every substance used by a pregnant mother reaches her baby. The safest baby is the one whose mother does not smoke, drink, or use drugs that are not prescribed. Even for girls who smoked or drank or took drugs a lot before they got pregnant, cutting down will help.

Food Assistance

If you don't have enough money to buy the food you need, talk to a staff member of your clinic, city or county health department, or social service (public welfare) department about agencies in your community that may be able to help you.

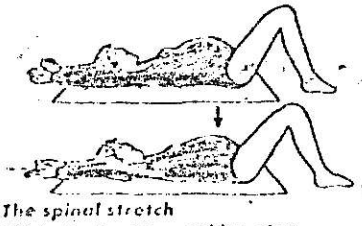
YOUR PREGNANCY

EXERCISES THAT MEET YOUR BODY'S CHANGING NEEDS

Good posture helps your body adapt to pregnancy and may help avoid backaches as well. Here, four exercises from the Nickolaus Technique designed to help align your body and stretch your spine so that your posture will improve. As time goes on, you may want to decrease the number of repetitions or do exercises more slowly. Remember to check these or any other exercises with your doctor.

Deep breathing

Always begin with this. Lie on floor as shown. Draw up knees until you feel your back touching the floor. Turn feet inward; feel a straight line running through each hip, knee and foot. Bring chin down; relax shoulders. Place hands on abdomen, elbows resting on the floor. Relax torso. Inhale for a slow count of two, mouth open, feeling abdominal muscles rise and expanding chest and upper body. Exhale slowly on third count; on fourth count, contract abdominals and press lower back firmly against the floor. Repeat six times.

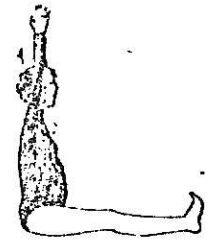


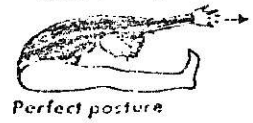
The spinal stretch

Still in the breathing position, place arms overhead on the floor, palms up, arms parallel. Inhale slowly for two counts. This time, as you exhale, pull abdominal muscles toward the lower back and tuck pelvis under slightly, pressing spine against the floor. At the same time, reach behind you, arms against the floor, chin pulled down and neck long. Repeat six times.

The sitting arm and leg stretch

Sit up as shown, legs about hip-width apart. Back should be straight; try to feel your breastbone lifting toward the ceiling. Inhale deeply and reach upward, keeping shoulders relaxed, neck free of tension, abdomen relaxed. As you exhale slowly, contract abdominal muscles and bring head and arms down, chin tucked in. Slowly bend forward until you are reaching past the toes, arms and legs parallel. Keep thighs tight and feet flexed. Inhale again and slowly begin the return. Do this gradually; as the months progress, place your legs farther apart to make the forward reach more comfortable. Stop at whatever point you feel you are forcing. Repeat six times.





Perfect posture

Stand with feet hip-width apart, weight on the balls of your feet, heels resting lightly on the floor, arms resting naturally at your sides. Lift your chest, relax your shoulders and try to get the feeling of a long spine. Inhale deeply, relaxing the abdomen slightly as you expand the chest and back muscles. Exhale as you contract the abdominal muscles and tuck the pelvis under, maintaining a lifted chest and head. Repeat inhaling and exhaling four times.

Getting Back in Shape

Special exercises may not be necessary if you are up and about within a few days after delivery. The exercises recommended to you should be done in moderation to help these parts of your body that expanded during pregnancy return to normal. However, the exercises should not be started without the doctor's recommendation. Remember, it will take time to regain your strength, so don't overdo! Five to ten minutes once or twice a day is adequate in the beginning.

NOTES NOTES NOTES NOTES NOTES NOTES

PARENT DROP-IN CENTER
OLD INDEPENDENCE COURT HOUSE
112 WEST LEXINGTON, SUITE 204
INDEPENDENCE, MISSOURI 64050
(816) 252-2539

Director — Alinda Dennis
Assistant Director — Linda Shadden

Serving parents in Eastern Jackson County, Missouri.

Promoting the positive aspects of parenting.

Helping families cope with the pressure and stress of parenthood.

Helping parents develop skill and confidence in their role as parents.

Children are welcome when parents come to the Center. Child care will be available while parents are involved in Center activities.

A GET-AWAY SPOT FOR PARENTS TO:

- —relax, meet and talk with other parents
- —attend educational programs on a variety of topics around parenting
- —participate in discussions about child development and issues of parenting
- —share concerns and ideas with staff
- —learn new skills
- —find and utilize other community resources
- —have some time apart from the children while they are supervised by experienced caregivers

Initially the Center will be open two days a week. However, as the Center grows we hope to extend the hours.

Hours

Tuesday & Thursday
11:00 a.m. to 4:00 p.m.

Every parent or parent-to-be is welcome to drop in the Center. If you're interested, join in an acitivity or program . . . or just spend your time relaxing with us. We're eager to meet you! Stop by to see us soon.

CAPA SERVICES

CRISIS AND REFERRAL LINE
252-8388

Parents who feel they are losing control or need someone to listen are asked to call this number for confidential counseling. Anyone needing information about child abuse may call for help.

PARENT AIDES

Trained volunteers who work on a one-to-one basis with families who request help.

PARENTS ANONYMOUS GROUP

CAPA sponsors the Independence Chapter of Parents Anonymous. Parents Anonymous is a self-help group for parents who feel they have or might develop a child abuse problem. P.A. meets on a weekly basis at a local church. Babysitting is provided. Call 252-8388 for additional information on the group.

PUBLIC AWARENESS

The CAPA Director provides ongoing education and training to schools, agencies, hospitals, and other professionals. The CAPA Education Committee has speakers available to present programs for any interested community group. The committee also develops materials to be used to increase public awareness and emphasize preparation for parenthood.

PARENTING DISCUSSION GROUPS

CAPA conducts discussion groups with new parents through our local hospitals. The purpose of the groups are to focus on the realities of parenthood and dispel the myths.

CHILD ABUSE

Child abuse is repeated mistreatment or neglect of a child by his parent or guardian. It may be:

PHYSICAL

beating, shaking, burns, broken bones
over discipline
neglect

EMOTIONAL

no love, support, guidance
constant belittling
verbal attacks

SEXUAL

molestation, incest, rape

Child abuse is an epidemic in the United States today. In Missouri alone in 1979, 48,412 children were reported for child abuse or neglect.

Every parent has the potential to abuse a child at some time. Child abuse occurs every where, with families in all walks of life. Most abusive parents are ordinary people. Relatively few are "criminal" or mentally ill. Many abusive parents were abused themselves. Often they are under stress and unable to cope with their problems. Their child's behavior may trigger the abuse, but it is not the cause.

Most parents who abuse their children want to stop and feel intense guilt about it. Now there is someplace to turn.

WHAT IS BEING DONE?

The Child Abuse Prevention Association (CAPA) is a private, not-for-profit organization established in June 1975, to combat the child abuse problem. CAPA is made up of a professional director and assistant director as well as volunteers from the community who offer their concern and energy to families in need of help. All volunteers receive training and back-up from the CAPA Director. CAPA receives funding through Eastern Jackson County United Way as well as private donations from community groups and individuals. This allows CAPA to provide all services free of charge.

Appendix G

TOP Resource Materials

BOOKS

The Pregnant Adolescent. Frank G. Bolton, Jr., Sage Publications, 1980.

Motherhood and Mourning: Perinatal Death. Larry G. Peppers and Ronald J. Knapp, Praeger Publishers, 1980.

The Parent's Guide to Teenage Sex and Pregnancy. Howard R. & Martha E. Lewis, St. Martin's Press, 1980.

Teenage Pregnancy: The Problem That Hasn't Gone Away. The Alan Guttmacher Institute, 1981.

PAMPHLETS AND BOOKLETS

"Sex and Birth Control for Men," Tom Zorabedian, Emory University Family Planning Program, 1975.

"The Joy of Birth Control," Stephanie Mills, Emory University Family Planning Program, 1980.

"School-Age Parenthood," Ivan Nye and Martha Lamberts, Washington University Cooperative Extension, 1980.

"Not Only for Parents," The American College of Obstetricians and Gynecologists, 1980.

FILMSTRIPS

"Violence in the Family," Human Relations Media, 1978.

"Teenage Pregnancy and Prevention," Human Relations Media, 1980.

"The Gentle Art of Saying No," Sunburst Communications, 1979.

"His Baby, Too: Problems of Teenage Pregnancy," Sunburst Communications, 1980.

"Sexual Values: A Matter of Responsibility," Sunburst Communications, 1978.

Appendix H

Teenage Obstetrics Program Follow-Up Interview

Check all blanks which apply to you

1. How old are you? age N = [12 (1) 13 (1) 14 (2) 15 (2) 16* (7)]

2. How many babies have you had? [# of children 1 (11) 2 (1) 3 (1)]

3. How old is your last baby? [18 days - 4 months]

4. Which statements best describe your present living situation:

   I live alone

   I am married [1] single [12] divorced

   I live with my mother [9] father step-mother step-father grandmother [2] grandfather aunt uncle older sister older brother foster family

   I live with friends

   I live with the child's father's family

   Other [1]

5. Which statements best describe your baby's present living situation?

   The baby usually lives with me 4-7 days out of the week [12]

   The baby usually lives with me less than 4 days out of the week

   The baby lives with my mother father step-mother step-father grandmother grandfather aunt uncle older sister older brother adoptive family foster family [1]

   The baby lives with his/her father

   Other

*Numbers in brackets reflect distribution of responses given to the question.

6. Which statements best describe your feelings about your home?

I am very satisfied [9]

I plan to change the situation within 6 months [1)

I am not happy, but cannot change my living situation right now.

I receive too much [1], much [2[little help in caring for my child

My family and I get along worse better [5] the same [6] since I had a baby

7. Which of the following best describes your most important role: (Check one)

teenager [1] daughter [2] girlfriend wife mother [9] sister granddaughter other [1]

8. Which statements best describe your feelings about being a mother?

It is more exciting than I thought it would be [8]

I really wish I were not a mother right now [2]

I do not feel much different than before I had the baby [2]

It is too much work and worry for me right now

Life is hard, but I will pull through [4]

Other [1]

9. Which statement best describes your present school situation? (Check one)

I go to school almost every day [5]

I will return to school within one week [3] one month one year [2]

I do not plan to return to school

I do not like school, but will return so that I can get a good job [2]

I am working on my GED [1]

I will be working on my GED within one week one month one year

Other [2]

10. Which statements best describe how you think people at school (will) relate to you as a mother?

People accept [4] do not accept me

Being a mother makes no difference [7]

My relationships at school will improve [1] get worse

The school will make special arrangements for me since I have a baby [2]

Other

11. Which statements best describe your feelings about your interest in males?

I am seeing the baby's father more often than any other guy [5]

I am seeing other guys [3]

I have nothing to do with guys right now by my choice [4] by someone else's choice [1]

I want to find someone who will take care of me and my baby [2]

Other

12. Which statements best describe your feelings about other girls your age who do not have babies?

They are jealous of me now that I have had a baby

They get to go out and have fun more than I do [1]

I am better off [4] worse off than other girls who do not have babies

More girls my age should have should not have [10] babies

Other [2]

13. Which statement best describes your present feelings about sex and having another baby?

I have not thought much about having sex or having another baby [5]

I plan to begin using birth control [8]

I will probably have another baby before I am 20 years old by my choice [1] by mistake [2]

I am using birth control now [4]

I do not plan to have sex before I have a husband [2]

I will have sex before marriage, not use birth control, and take my chances

Other

14. Which statements best describe how you think people at church (will) relate to you as a mother?

People accept [5] do not accept [1] me

Being a mother makes no difference [4]

My relationships at church will improve get worse [1]

The church will make special arrangements for me since I have a baby [1]

Other [2]

15. Which statements best describe your present feelings about your baby and the church?

I want [7] do not want my baby to be raised in the church

I do not care one way or the other

I plan to attend another church with my baby [1]

I want [9] do not want my baby baptized/christened/blessed

Other [1]

16. Which statements best describe your present financial situation?

I receive money from the government [7]. the baby's father and/or family [3] my family [3] my job [2]

I do not know how my child and I are going to survive

I can get everything I need [3]

I could not make it without my family's help [5]

Other

17. Which statements best describe your feelings about employment?

I do not need to work right now [2]

I cannot work because there is no one to watch the baby

I do not plan to look for a job for several years [1]

I will be able [4] will not be able to get the kind of job I want when I get ready to work

I can make special arrangements with the job to help with my situation [1]

Other [5]

18. Has the baby had his/her first doctor's appointment?
Yes [10] No [1]

19. Did you or will you go to that appointment? Yes [12]
No [1]

20. Which words best describe your feelings since you have been a mother?

nervous [4]	upset	loving [10]	glad [8]
happy [11]	popular [2]	lonely [2]	confused [5]
tired [5]	worried [4]	scared [6]	thankful [8]
other			

21. Who has been most helpful to you within the last 6 months?

friend [1]	other [3]
mother [9]	aunt [1]
father of child [2]	

22. Who will you most likely turn to for support and direction within the next 6 months?

friend [1] mother [7] father of child [4]
don't know [1]

Appendix I

Case Profile 1

TOP's youngest client was the victim of incest before reaching her twelfth birthday. R. was afraid to tell anyone that her step-father had molested her. When summer came and her mother and aunt went on vacation, R. stayed with her grandmother who noticed her body changing. Abortion was no longer an option by this time, and R. had chosen to place the child for adoption. Her family stuck by her decision and her version of the story.

DFS was notified and following an investigation Mrs. R. and daughter were required to begin counseling after separating R. and the step-father.

With the excuse that her sister's house was closer to TPC, Mrs. R. shipped her daughter off to live with her aunt. Eventually R. began rejecting her appearance, she did not want to be active at all. The aunt stood by her and tried to encourage a more healthy self-concept.

R.'s mother could not give much support. She met with serious emotional problems coping with this tragedy. Mrs. R. was cooperative and acting appropriately after the initial news; she ordered the step-father from the house. Yet, in two weeks she stopped calling or visiting R. regularly. She was gradually being laid off from her job and was suffering financially.

R. became very attached to the male child born. After delivery, he was placed in a temporary foster home. When R. realized that adoption meant that she would never see her son again, she chose to keep him in foster care, enabling her to visit with him once per month.

Mrs. R. basically chose to follow strict DFS demands that R. and the step-father have no contact, but Mrs. R. and the other children moved back in with him, leaving R. with Mrs. R.'s mother. Mrs. R. visits R. frequently.

R. began counseling sessions with a psychiatrist on a periodic basis.

Case Profile 2

B. (15-years old) was obviously a well-behaved, obedient, bright, only child when she and her mother visited TOP on Friday afternoon. She was pregnant by her 22-year old boyfriend. For nine months B. hid the truth from her mother. She permitted the boyfriend to think that she was doing well physically. In actuality, B. had no prenatal care and fortunately, no complications. Her knowledge of human sexuality, growth and development stemmed from reading, classes in school, and previous talks with her mother.

The fear of her strong mother had prevented B. from confiding in Mrs. B. She was afraid of the unknown consequences, but the actual results were traumatic. The week of delivery B. confessed her pregnancy because she realized that she needed to deliver in a hospital. The pediatric hospital examined B. for "stomach cramps," and at this time informed Mrs. B. of her daughter's pregnancy. Needless to say this mother was shocked, and then absolutely furious. All of a sudden she was expected to accept responsibility for a baby she did not carry, plan for, or want.

At this point Mrs. B. had to cease her own denial process. Although she had continuously questioned B.'s menstrual regularity, and although she often asked, "Are you pregnant?" she denied being conscious of her daughter's condition.

With no resources independent of her mother, B. had decided to place the baby for adoption. Mrs. B. refused to raise "a child that was not [hers]." Adoption agencies would have been contacted the following Monday morning if B. had not delivered a female infant that night.

The father of the child offered to keep the baby because he did not want his child to be raised by strangers. He had a job and had mentioned marriage to B., but she knew she was not ready for another major step. His family was supportive and encouraging. B. and her mother had agreed to this as a possible solution at their first visit, but Mother had changed her mind. She did not think this young man should take care of a baby, but the decision was not hers by law. Having proven their concern and capability, the father and his immediate family took the baby to their home, and B. was happy that she had not lost her opportunity to see her own daughter grow.

REPORT ON THE TEENAGE OBSTETRICS PROGRAM: SOCIAL SERVICE MODEL FOR PREGNANT ADOLESCENTS

by

DACIA AMORITA SMALL

B.A., Agnes Scott College, 1979

AN ABSTRACT OF A MASTER'S REPORT

submitted in partial fulfillment of the

requirements for the degree

MASTER OF SCIENCE

Department of Family and Child Development

KANSAS STATE UNIVERSITY
Manhattan, Kansas

1981

ABSTRACT

The dramatic rise of teenage pregnancy in the late 1970s has caused great concern among families, professionals, and, recently, the legislative branches of government. The Teenage Obstetrics Program (TOP), privately funded, has provided counseling and education to hundreds of pregnant teenagers throughout its seven years of existence. Associated with an inner-city hospital in the midwest, clients sixteen-years old and younger receive careful prenatal medical attention, while social needs are addressed. The Health Educator/Social Worker of the program involves several resources to aid the teenager, including family members, a special school for pregnant girls, and various social service agencies. This report offers an overview of national statistics and research regarding teenage pregnancy. It then describes TOP procedures. Results of post-delivery interviews about lifestyle and self-image, conducted with thirteen of TOP's recent young mothers, are included.