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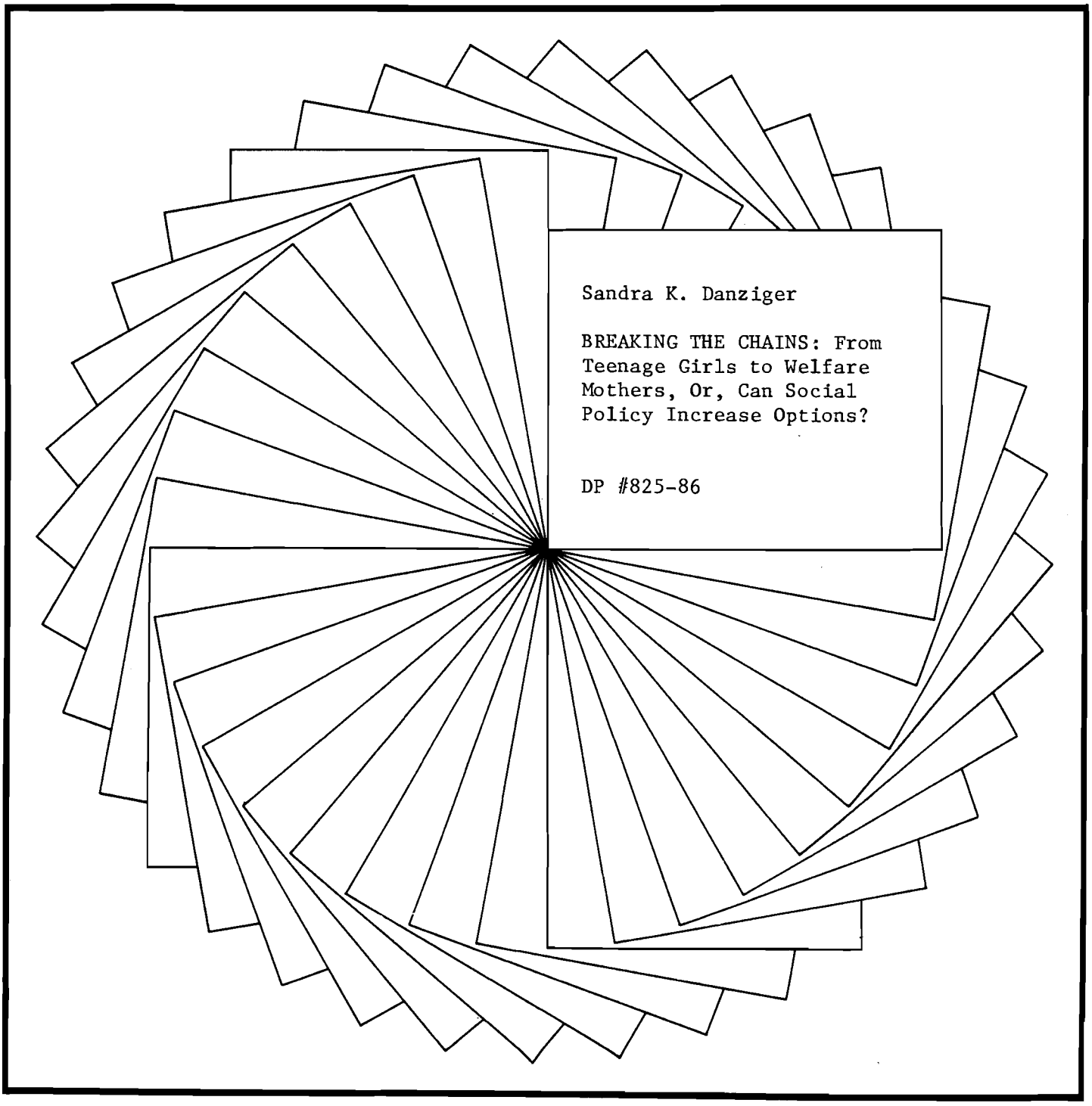

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# Breaking the Chains: From Teenage Girls to Welfare Mothers, Or, Can Social Policy Increase Options?

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## Abstract

This paper examines the decision pathway to becoming a teen welfare mother. In each of four stages, I review the incidence and prevalence of different possible choices and the role of government policies and programs as a determinant of these choices. Statistics currently indicate that one in five sexually active young women becomes pregnant; close to half of these give birth. One-third of all teen mothers aged 16-19 received welfare in 1984. Policies recommended to promote alternatives to welfare recipiency include better employment and education opportunities for teen parents and youth in general, more comprehensive sex education, and contraceptive services, and more father involvement through paternity adjudication and child support.

# Breaking the Chains: From Teenage Girls to Welfare Mothers, Or, Can Social Policy Increase Options?

## INTRODUCTION

This paper examines the chain of events that begins with early teenage sexual activity and results in single mother families who rely heavily on Aid to Families with Dependent Children (AFDC). The process can be conceptualized as a series of decision points that lead to alternative paths, some of which result in higher chances of welfare dependency than others. In describing what is known about the fertility and family structure choices of these young women, I will assess the role of government in terms of public welfare programs and programs other than AFDC that might increase options for young people.

In presenting the research evidence and developing policy proposals, I first describe the chain of events. Four "decision points" along the pathway are presented with summaries of what is known about the incidence and prevalence of the different possible choices. Next, for each of the four stages, the determining factors associated with each choice and the possible role of government programs are examined. Finally, the major social programs that could reduce the number of young women who follow the path to welfare are assessed; a number of policies are suggested to attack the problem at each link in the chain.

## PATHWAYS TO ADOLESCENT MOTHERHOOD AND AFDC DEPENDENCY

### Decision Points

The behavior that leads to a teenaged girl becoming a single mother AFDC recipient results from a series of "decision points" in which the young woman makes choices, whether or not she perceives them as such or has any awareness of other options. The model in Figure 1 is adapted from other reviews of the problem, all of which conceptualize it as a multi-stage sequence of events (see also Flick, 1986; Moore and Burt, 1982). Figure 1 illustrates the current prevalence of choices that lead to welfare dependency in each of the four stages and presents data on the number of women at each stage.

--First, the young person confronts the decision of whether to begin and continue sexual activity, specifically premarital heterosexual intercourse.

--Second, once the young person has become sexually active, she or he may use some form of contraception never, sometimes, or regularly. Choices here involve whether to use, how often to use, and what types of methods to use to prevent conception.

--Third, once a young girl becomes pregnant as a result of poor contraceptive practice, she faces the issue of how to resolve the pregnancy:

  Will she have an abortion?

  Have the baby and have it adopted?

  Have the baby and marry the father?

  Have the baby and become a single mother?

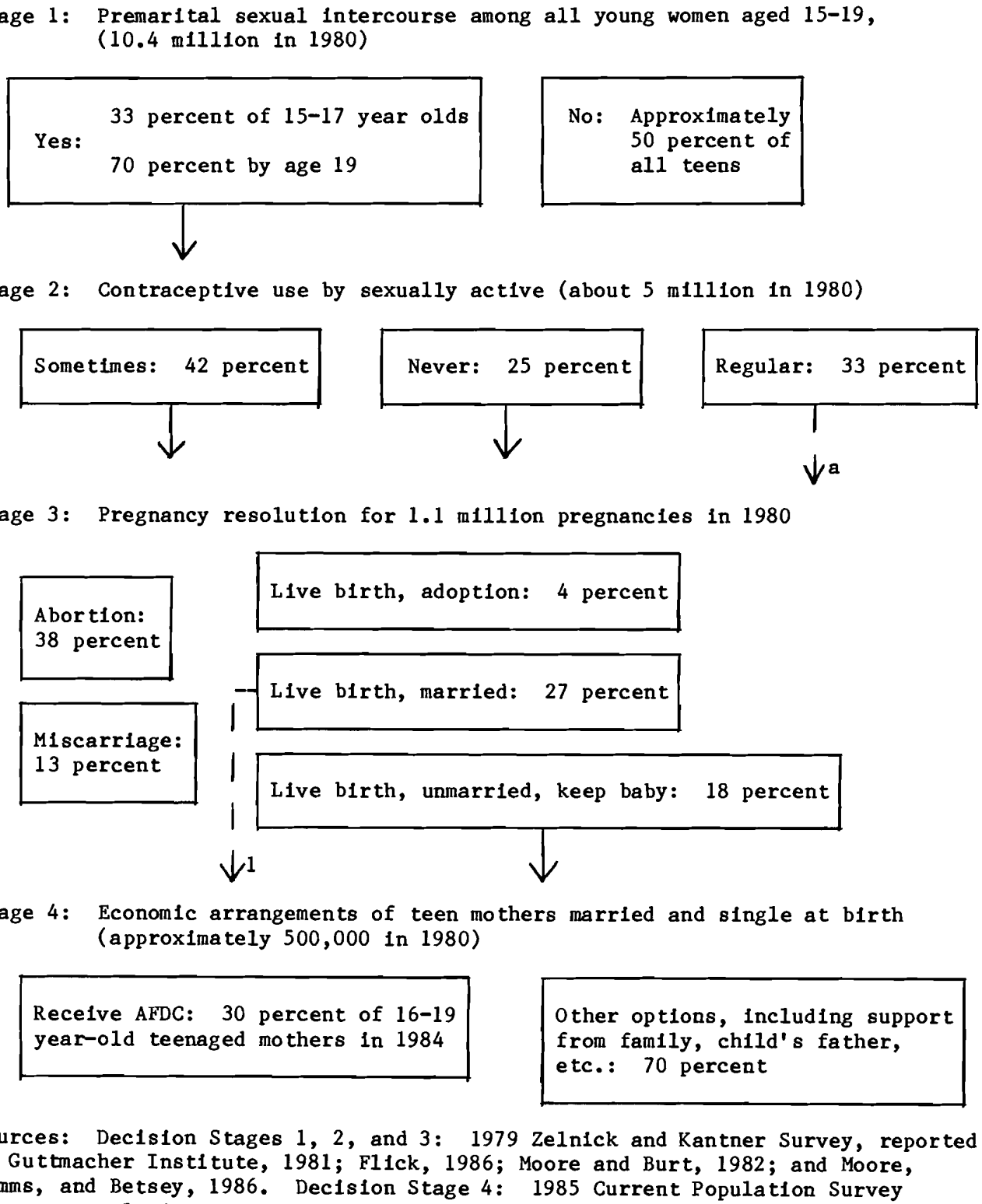
--Finally, fourth, once the young girl decides to have the baby and to become a single mother, she confronts the issue of how to provide for her child and herself.

  Does she apply for AFDC?

  Get financial assistance from her family?

Figure 1

Decision Pathways to Becoming a Teen Welfare Mother
(Percentage Distribution of U.S. Women Aged 15-19)




Sources: Decision Stages 1, 2, and 3: 1979 Zelnick and Kantner Survey, reported in Guttmacher Institute, 1981; Flick, 1986; Moore and Burt, 1982; and Moore, Simms, and Betsey, 1986. Decision Stage 4: 1985 Current Population Survey Extract, analysis prepared by Institute for Research on Poverty.

[a]These paths also result in the next stage, but less frequently.

Get assistance from the father?

Get some combination of the above 3?

Does she continue her schooling?

Seek employment?

Establish her own household?

By describing these four points as choices of young women, I am not suggesting that the problems of teen pregnancy or welfare recipiency are caused only by the women themselves. The social and economic environments of adolescents, the choices of their parents and those of the fathers of their children also play a role. Teen pregnancy, birth, and welfare rates are affected by what happens in families, in schools, in the health care adolescents obtain, and in employment policies for women, low-income families, and for youth in general. An example of this broader view of the problem is the recent emphasis in the public debate on the behaviors and responsibilities of young men.

Finally, the paths to productive adulthood and responsible parenthood are affected by economic and social inequality between income groups, races, minority groups, and the sexes. The chain of events from teen to welfare mother thus occurs disproportionately among some groups more than others. Policies to reduce these inequities would improve young women's options.

## Prevalence of Decisions

As illustrated in Figure 1, the majority of American young women engage in sex by the time they are 19, and most do not practice contraception regularly and consistently. Even regular users may not use birth

control effectively; thus 1 girl in 10 becomes pregnant while a teenager. Of those who have engaged in premarital sex, the pregnancy rate is 1 in 5. In fact, 29 percent of sexually active whites and 45 percent of experienced blacks aged 15-19 report becoming pregnant before marriage (Moore et al., 1986, p. 24). While just over half of those pregnancies result in abortions or miscarriages, many babies are born to teens.

The number of teen births, as reported in Figure 1, have actually been declining as cohort size has become smaller. By 1983 there were under 489,000 live births to teens, compared to 500,000 in 1980 (Furstenberg and Brooks-Gunn, 1986, p. 309). However, the proportion of births to single mothers is increasing. Of all teen births, 87 percent of those to blacks and 38 percent of those to whites are to unmarried mothers (Moore et al., 1986, p. 13). In addition, very few of these women have their babies adopted, so the number of out-of-wedlock births that result in single teens raising children has increased.

Whether or not they are married when they give birth, many young mothers spend some time as single mothers. Several studies have documented that even those who do marry have a higher probability and longer duration of single-parent status than do women who delay first birth until their twenties (Card and Wise, 1981; Moore and Burt, 1982; Gilchrist and Schinke, 1983; Hofferth, 1985). For example, according to the 1985 Current Population Survey (CPS), 90 percent of black teen mothers aged 16-19 and 30 percent of whites had never married. Of those who had become married, 12 percent were divorced or separated. As female heads of families, they face high risk of poverty, poor employment prospects, and high chances of being dependent on welfare for long periods.

In 1983, there were at least 200,000 teenaged mothers on the AFDC rolls, according to an AFDC Information Memorandum, May 1, 1986; this represents a small percentage of the welfare caseload.[1] In the late 1970s, approximately 25 percent of all 15-19 year-old teen mothers were recipients, as compared to AFDC rates of 10 percent of all mothers (all ages) and 15 percent of all teen girls (Chamie and Henshaw, 1981, p. 118). By 1984, 30 percent of teen mothers aged 16-19 were recipients, according to the 1985 Current Population Survey. Those on welfare are likely to be high school dropouts rather than graduates and to be black rather than white (Mott and Maxwell, 1981).

## FACTORS THAT INFLUENCE CHOICES AT EACH DECISION STAGE

This section assesses causal factors at each decision point, focusing in particular on the role of AFDC and the potential of other policies for reducing welfare dependency. The types of nonprogrammatic influences on decisions that are discussed are demographic, family, and social psychological characteristics. The types of programs that may promote alternative opportunities for young women include comprehensive sex education, vocational guidance and employment education and training, family planning services, adoption counseling and services, child support, and multi-faceted services for teen parents. The latter programs may involve medical care, day care, educational counseling, and job training for pregnant or parenting teens, many of whom are AFDC recipients. All of these will be considered as possibly targeted to serve young men as well as women.

## Stage 1: Sexual Activity

Demographic patterns. While the exact causal factors are unclear, early premarital sexual initiation is more likely among teen girls with the following demographic and family characteristics:

- Black
- Low income family
- Single parent family
- Parents have little education
- Less religious families
- Family and peers have more permissive sexual standards

Early sexual behavior is more likely among teen girls with the following personal characteristics, attitudes, and behavior:

- Low school grades and low educational expectations
- Early physical maturation
- Early dating patterns
- More dependent, traditional female sex role attitudes

The impact of policies and programs. No government programs or policies to date have been found to be associated with early onset of sexual activity. Welfare programs do not affect initial age of sexual intercourse or premarital sexual activity (Moore and Caldwell, 1977). Several studies find no correlation with either exposure to sex education or availability of family planning services.

Three recent studies look at national random samples of youth and find no consistent relationship between exposure to sex education and age of sexual experience. The data from the 1984 National Longitudinal Survey of Work Experience of Youth showed that prior exposure to sex education was associated with slightly increased probabilities of first

intercourse among 15 and 16 year old girls, but had no effect for older teens (Marsiglio and Mott, 1986). The analysis of teen women surveyed in the 1982 National Survey of Family Growth showed that a particular type of sex education (that covers both pregnancy and contraception information) slightly increased the odds of becoming sexually active at age 14. Sex education had no effect on age of first intercourse at other ages, and other types of sex education courses (that did not cover contraception) had no significant effect for teens of any age (Dawson, 1986). Finally in the 1981 National Survey of Children, 15 and 16 year old males and females who had been exposed to sex education classes were less likely to report being sexually active than were those who had not taken a course (Furstenberg et al., 1985). Approximately 17 percent of those who received some form of this instruction and 26 percent of those who had not were sexually experienced.

The role of access to family planning services in influencing age of onset of sexuality has been difficult to determine, primarily because very few young women avail themselves of services prior to becoming sexually active. Several studies of teens at their initial visit to family planning clinics corroborate that only about 14 percent have that first exposure to services prior to initial intercourse (Zabin and Clark, 1983; Jones et al., 1982; Zelnik et al., 1984; Herceg-Baron et al., 1986). The more typical pattern is for youth to delay that first clinic visit for a year or more after becoming sexually active. A recent study evaluated the effects of a school-based clinic program in Baltimore, one of perhaps 60 in the country that offer contraceptive services and other medical care at the public school. The schools that provided direct

access to family planning over a two-year period (1982-1984) had lower proportions of sexually active females during the period of the program, as compared to in the years prior to the program. For example, before the program began, two-thirds more of the 14 year olds had had intercourse than had done so after services had been offered (Zabin et al., 1986, p. 122). These results suggest that a postponement of premarital sexual activity occurred as a result of increased availability of sex and contraceptive education, counseling, and health care services.

Sexual activity of teenaged men. The research to date on determinants of early sexual behavior is weak in certain areas. Few of these studies address characteristics that differentiate sexually active and nonactive male youth. Premarital sexual intercourse is both more likely among young men and first occurs earlier than among young women (Zelnik and Shah, 1983). Trends over the last decades for the two groups are similar in that males also report higher rates of premarital sexual activity and earlier ages of sexual initiation over the last decades, but the determinants of these patterns may differ for males.

A recent study reports the sexual experience and attitudes of a sample of Baltimore's inner-city black males in grades 7-12 (Clark et al., 1984). Of the 660 respondents, aged 11-19, 13 percent reported that they had never had intercourse, and of the sexually active, the mean age of first experience reported was at age 12. Almost half of the boys believed that their parents would not care if they had intercourse with a girlfriend.

Summary: Stage 1. Government programs--whether welfare, sex education, or family planning--have not been shown to influence initial age of

sexual activity. Families with lower socioeconomic status (SES) and less traditional values have daughters with lower educational goals who are more likely to engage in sexual behavior at younger ages. Low SES occurs more often among single parent, less educated, and black families. As we see in the next section, this earlier onset of sexual activity is also correlated with a higher probability of experiencing adolescent pregnancy. Poverty and inequality thus contribute to restricted family role models and decrease the chances that young girls will develop the motivation to postpone sexual intercourse and/or pregnancy. As previous researchers have stated:

> Like whites, young blacks from intact, religiously oriented families with well-educated parents have a lower probability of sexual intercourse. However, since fewer blacks are reared in homes with two well-educated parents, the cultural milieu . . . is undoubtedly relevant . . . . Difficulties faced include protecting children from the urban environment, a lack of achievement-oriented role models, and the inability to provide incentives like a college education that make the postponement of sexual activity worthwhile for teens. The lack of viable alternatives like a job or a challenging school environment place poor, minority parents at a disadvantage in motivating their teenagers to delay sex. Unfortunately, to date it is not known whether participation in government job training or other special programs aimed at minority, poor, or simply jobless teenagers has an effect on the probability of initiating sex, the frequency of sex, or the motivation to avoid pregnancy (Moore and Burt, 1982, p. 44).

## Stage 2: Pregnancy

Contraceptive attitudes and behavior. The factors associated with poor contraceptive use or greater pregnancy risk are more directly related to attitudinal and behavioral characteristics of youth than to their demographic profiles. These personal traits generally reflect lack of understanding and motivation, both of which could be influenced by access to information and services. Programs that provide comprehensive

education and health have been shown to improve contraceptive knowledge and practice (Zelnik and Kim, 1982; Forrest et al., 1981; Zabin et al., 1986), and therefore reduce the rate of unintended pregnancies among youth (Forrest, 1984; Chamie and Henshaw, 1981).

Age and race of the adolescent are important predictors of pregnancy risk. The older a person at first intercourse, the more likely she or he is to have used contraception at initiation (Zelnik and Shah, 1983; Zabin et al., 1979). By 1979, half (51 percent) of all white teen women, 41 percent of black teen women, and 44 percent of all adolescent men reported having used some form of protection at first intercourse. These figures represent an improvement since 1976, when only 38 percent of teen women reported contracepting the first time (Zelnik and Kanter, 1980).

Among those women for whom the first experience occurred when they were younger than 15 years old, only 31 percent contracepted. In contrast, among those who delayed this event to age 18-19, over 62 percent used a method. These older teen women were also more likely to use a more effective method, e.g., the pill, IUD, or diaphragm (Zelnik and Kantner, 1978; Zelnik and Shah, 1983). Both black and white women who use birth control when they begin having sex are likely to continue to be regular users and to eventually switch to the more effective medical methods.

However, over the late 1970s, surveys showed an overall increase in use of contraception but a decline in use of the pill and IUD in favor of barrier methods--diaphragm and condom--and the least effective methods of withdrawal, rhythm, and douche (Zelnik and Kantner, 1980). The cause for

this change may be that more younger teens are engaging in sexual behavior and, thus, a higher proportion of the sexually active are resorting to these less reliable methods. Another phenomenon may be that teen women, like other women, are beginning to turn away from those birth control methods that pose greater health risks. Medical technology and research have not developed contraceptive methods suited to typical patterns of teen sexual relationships. Sexually active teens are most likely not to plan intercourse and to engage in sex only infrequently and erratically. When they become committed to one partner in an emotionally intimate relationship, they are more likely to use birth control in a more regular fashion.

For the majority of sexually active teens who take the risk of unprotected intercourse, the chances of experiencing a pregnancy are of course high. Fifty percent of all teen pregnancies occur to those who never use any birth control (one-quarter of the sexually active, see Figure 1). Within two years after initial intercourse, two-thirds of those who never use a method become pregnant.

The effects of family characteristics on contraceptive risk-taking are not clear. A popular belief that has been influential in policy debates is that increased communication between parents and teens on such matters would reduce unprotected intercourse. Yet two recent studies find little difference in either sexual or contraceptive behavior of teens who have mother-daughter discussions on sex and contraception and those who do not (Newcomer and Udry, 1985; Furstenberg et al., 1984).

On the other hand, a study of black female and male youth found that family socioeconomic factors do differentiate contraceptive use at

initial intercourse, but are not predictors of subsequent birth control practice (Hogan et al., 1985; Hogan and Kitagawa, 1985). Black young men were more likely to use contraception at first intercourse if they were of relatively high social class (based on parents' education, occupation, unemployment experience, income and housing) and if they had higher career aspirations (expected adult income and educational and occupational goals). For young black women, family social class, parents' marital status, and neighborhood quality (based on census tracts) had direct effects on the probability of initial risk-taking (Hogan et al., 1985).

Even among those groups with the higher percentages of users of birth control, the patterns of use are not encouraging. Surveys of youth reporting reasons for nonuse indicate a strong lack of incentives to take responsibility for avoiding pregnancy. The most common reason given for nonuse is the belief that the respondent could not get pregnant (Guttmacher Institute, 1981). Usually, the young women are mistaken about fertility probabilities during the monthly cycle. The next most common reason for nonuse is that the young women do not expect to have intercourse. Nonavailability of a method at the time was the third most frequent reason given. A fourth reason that authors interpret from teen behavior is that contraceptive nonuse results from ambivalence over their sexuality or discomfort with the "planning" that birth control methods entail. A small sample in-depth interview study of teen girls in Wisconsin (conducted in 1980) also affirmed that the younger the teen, the more likely she was to associate being on the pill with being "loose" (Danziger and Worth, 1982).

Most researchers argue that the most important barrier to use is ignorance of the risk of pregnancy and facts of fertility; a second obstacle often cited is ignorance of the availability of low-cost contraceptives from public clinics. An additional and perhaps more critical factor among black poverty-level teenagers is the perceived opportunity structure. Several researchers suggest that these young women may risk nothing by becoming pregnant; many expect to have babies and become unmarried mothers at a young age. They perceive no alternative life options in terms of jobs or educational goals that they would have to disrupt, delay, or forego due to a pregnancy (Moore and Burt, 1982; Dryfoos, 1983; Hogan, 1984).

Males may also lack the incentive to worry about conception. Among the Baltimore ghetto youth, only 20 percent of the sexually active claimed they had never used a contraceptive, although 40 percent did not use a method the last time they engaged in sex (Clark et al., 1984). The method most recently relied upon was most likely to be the condom, which the boys perceived as the most effective method (even compared to the pill, IUD, and diaphragm).

On other contraceptive attitudes, roughly equal proportions of the young men reported very inconsistent beliefs: on one hand about 46 percent claimed that they would only have sex if some form of birth control was used; on the other hand, 43 percent claimed they would be "too embarrassed" to buy birth control in a store. A promising 70 percent reported that the responsibility "to see that a girl doesn't get pregnant" was both the boy's and the girl's. However, the majority in

this study incorrectly believed that a young person needs parental permission to go to a birth control clinic and to buy nonprescription contraceptives at a drugstore.

The findings on these youths' ideas about teen fatherhood also merit reporting, as they highlight the need for realistic counseling and education. About 10 percent correctly answered the time of the month of greatest pregnancy risk--about two weeks after the period begins. Even though most responded that adolescent fatherhood would bring considerable economic, educational, and employment problems, as well as problems for the girl and the baby, only one-third of the sample reported that they would be "very upset," and a full one-quarter would be not upset or would be happy if they were to get a girl pregnant in the near future. A final note on the acceptability of out-of-wedlock conception to inner-city black male teens is the discrepancy in their attitudes toward the "best" age to have a first child and to get married, both of which they ideally think should occur in a man's twenties. In their minds, the best age for fatherhood typically precedes the best age for marriage by two years, 22.5 for becoming a father and 24.5 for getting married.

The impact of policies and programs. Very little data exist on the role of AFDC in affecting contraceptive use. One study of minority adolescent patients of a health clinic in a ghetto neighborhood found no differences in contraceptive practice by welfare status of the women's families (Jones and Philiber, 1983). However, this nonrandom sample includes never-pregnant but sexually active teens who obtain health care. In contrast, a number of studies over the last decade point to the positive potential of increased access to family planning services and sex

education for reducing (but not eliminating) the number of youth who engage in pregnancy risk-taking (intercourse without effective and regular contraception).

While exposure to sex education does not increase overall sexual activity, it definitely increases contraceptive use among those who do engage in premarital sex. In the 1982 National Survey of Family Growth, sexually active young women who had taken formal courses that included pregnancy and/or contraceptive education were significantly more likely to have utilized a method of birth control. Of those who had ever used a method, those who had received more comprehensive sex education were more likely to have used a method at first intercourse. Unfortunately, in this sample most recent use of a method was not related to exposure to such instruction (Dawson, 1986, pp. 186-187).

In the National Longitudinal Survey of Work Experience of Youth, sex education instruction increased the likelihood of use of the more effective methods of contraception--pill, condom, diaphram, IUD--among women aged 17-18, in particular for whites in the sample (Marsiglio and Mott, 1986, pp. 159-160). In this study, the direct effect of sex education on the probability of experiencing a pregnancy was also measured in four logit models with the following lack of relationships: "Regardless of which model we examine, it is clear that attendance at a sex education course in no way increases a young woman's probability of becoming pregnant" (Marsiglio and Mott, 1986, p. 160).

The effects of publicly funded family planning services for reducing teen birthrates and teen pregnancies have been estimated for the late 1970s (Forrest, 1984; Forrest et al., 1981). For every 100 teenaged patients served in 1975, there were 10 less births in 1976; had these not

been averted, there would have been 21 percent more teen births, an additional 119,000 to the 559,000 that occurred among 15-19 year olds (Forrest et al., 1981, p. 115). From models that measure the effect of clinic enrollments on birthrates in counties, estimates were derived for averted pregnancies, abortions, and miscarriages. If births represented 36 percent of unintended teen pregnancies, then over 300,000 additional pregnancies would have occurred. Of these 300,000, over half would have resulted in abortions. In addition, cost-benefit ratios using these estimates of averted births and abortions were calculated for 1979 federal expenditures for family planning, AFDC, and medical care for abortion, maternal, and pediatric health services (Chamie and Henshaw, 1981). For every one dollar spent for services to teens in a family planning clinic, an estimated three dollars were saved in health and welfare costs in 1979 (Chamie and Henshaw, 1981, pp. 122-123).

Finally, the experimental school-based comprehensive health care programs are an important innovation in reducing pregnancies. Preliminary findings across a number of programs show that students in these schools have fewer pregnancies and utilize services to a greater extent than they did prior to the opening of a school clinic, when they could only obtain such care in medical settings (Kirby, 1985). However, the most effective school clinic programs are not simply contraceptive dispensaries, but rather those that provide comprehensive health care, counseling, and education for adolescents. The St. Paul, Minnesota, experience suggests that school clinics that provide only family planning are not well utilized by students, largely for fear of stigma (Edwards et al., 1980).

Most dramatic findings on the positive effects of the school-based clinic were reported in the evaluation of the Baltimore program (Zabin et al., 1986). Attendance at the clinics went up among sexually active males and females in grades 7-12 in the experimental schools, compared to the comparison-group schools; visits to clinics were more likely to occur before or soon after (within months) the time of sexual initiation (Zabin et al., 1986, pp. 122-124). Both males and females who were sexually active were more likely to report effective contraceptive use (the type that requires preparedness at most recent time of intercourse). Finally, pregnancy rates were measured in a number of ways over the course of the 28 months of the school clinic operation; all the analyses indicate that pregnancy rates of 9th to 12th graders fell in program schools while pregnancy rates increased in the nonprogram schools (Zabin et al., 1986, pp. 123-125). Such changes are especially critical when one takes into account that at baseline, these schools had very high rates of pregnancy. Almost one in ten sexually active 7th and 8th graders, one in five of the 9th graders, and 22 percent of high school females who were sexually active reported having been pregnant (p. 120).

Stage 3: Resolution of Pregnancy

A much larger commitment of resources poured into widespread and comprehensive sex education and health care, particularly if school-based, would increase knowledge and understanding of fertility risk and reduce problems of access and availability of services; however, reductions in the unintended pregnancy rate among adolescents would still be

limited by at least three sets of factors. Problems with contraceptive technology and the nature of adolescence as a developmental life stage both preclude eliminating sexual risk-taking. Third, the independent effects of poverty and inequality for teen fertility are likely to persist if policies are developed only in the areas of sex-related education and health care directed at youth. Socioeconomic status and government programs may affect attitudes toward pregnancy resolution decisions. One way in which status differentials can be illustrated is in the choices faced by black versus white pregnant teens.

Racial differences. Table 1 summarizes black-white differentials at all of the first three stages of teen pregnancy and parenthood (see Moore et al., 1986). The top rows provide the rates per 1000 teens of the number who engage in sexual intercourse, become pregnant, obtain abortions, and give birth as single or married women. It is clear that black teens are more likely to be sexually active and become pregnant.

The bottom rows in Table 1 compare resolution choices at pregnancy. Blacks are less likely to be married when they give birth, and are also slightly less likely to have an abortion than are white teens.[2] It is clear that the abortion rate differential is small compared to the differences in the rate of premarital sex and the chances of becoming pregnant. This has led some researchers to argue that while black teens may have less access to abortion than white youth, it may be more critical to develop policies for pregnancy prevention that would be targeted especially for low income blacks, rather than policies that would seek to increase reliance on abortion among teens.

Table 1

Fertility Differentials by Race among Women, Aged 15-19

| | Whites | Blacks |
|---|---|---|
| Rates per 1000 Women | | |
| Sexually active, 1979 | 466 | 662 |
| Pregnancies, 1979 | 135 | 300 |
| Abortions, 1980[a] | 38.3 | 66.0 |
| Total live births, 1982 | 44.6 | 97.0 |
| Births to unmarried women, 1982[b] | 17.7 | 87.0 |
| Ratios | | |
| Pregnancies to sexual activity | .29 | .45 |
| Abortions to pregnancies[c] | .28 | .22 |
| Unmarried births to births[d] | .37 | .97 |

Source: Adapted from Tables 2.1, 2.3, 2.5, 2.6, 2.11, 2.15 and 2.16 in Moore et al., 1986, Chapter 2.

[a]Abortions to blacks includes all nonwhites.

[b]Per 1000 unmarried women ages 15-19.

[c]This ratio does not subtract the number of miscarriages from the number of pregnancies in the denominator. Because black women may have higher rates of miscarriage, their abortion to pregnancy ratio may not be much lower than that of whites (Nagatoshi, n.d.).

[d]Calculated from numbers of births in 1982.

The one alternative that is frequently promoted in policy circles but is currently only rarely chosen--and almost never by black youth--is formal adoption. Between the 1950s and 1970, the number of legally adopted children grew steadily, as illegitimacy and overall birthrates rose. Since 1970, the number of adoptions has fallen. A report on 20 states, for example, found a decline of 39 percent between 1970 and 1975 (Costin and Rapp, 1984). This precipitous drop in adoptions is typically attributed to more acceptance of premarital sexuality and of illegitimacy as well as to the liberalization of abortion laws.

It is important to note, however, that black families have never utilized this option to a significant degree; adoption agencies in many communities have historically had little or no demand for minority infants (Musick et al., 1984). Informal adoption into the extended family is thought to occur in many more black than white families, if only on a temporary basis while the mother is still young (Flick, 1986, p. 139). During the peak period of formal adoption--1969--28 percent of children born out of wedlock were placed for adoption; approximately 65-70 percent of white unmarried mothers who gave birth and 5-6 percent of black single mothers gave up their children for adoption (Kadushin, 1974).

Several ongoing studies compare attitudinal characteristics of young women who choose to abort, offer for adoption, or keep their infants. The decision to not become a mother--to seek abortion or adoption--seems to be associated with having plans for further education or career aspirations (Resnick et al., 1986). Such goals may help a young woman make the choice to <u>not</u> keep her baby, which is often an emotionally difficult one (Resnick et al., 1986; Musick et al., 1984; Moore and Burt,

1982). Any attempts to increase adoption for babies born to teen mothers must consider its impact for both the young women and the children.

The impact of policies and programs. In considering the impact of AFDC on the choices of pregnant teens, we must ask whether benefits influence the degree to which teens are choosing to become mothers. Some have suggested that owing to the lack of Medicaid funding for abortion and for prenatal care and delivery in the case of a planned adoption, there may be an incentive to choose to parent in order to obtain AFDC and Medicaid. Research evidence to date does not adequately examine this question.

One study found that pregnant teens enrolled in Medicaid and AFDC were more likely to become unmarried mothers than nonrecipient pregnant teens (Leibowitz et al., 1986). However, the study did not control for when recipiency began and when pregnancy resolution decisions were made. The results could thus reflect a sample bias in that those who knew they were going to become single parents would be more likely to take advantage of available programs.

Aggregate level studies have compared AFDC benefit levels with teen birthrates and out-of-wedlock birthrates across the states and found no association. Teens are no more likely to choose the birth option in high benefit states (Ellwood and Summers, 1986; Forrest et al., 1981; Brann, 1979; Moore and Burt, 1982). It may be, however, that regulations do affect teen choices, despite the lack of finding of any consistent state-by-state variation. Moore and Burt present a hypothetical scenario in which a complex set of rules could create certain incentives.

> A state that pays AFDC recipients the full standard (the full costs of those basic living needs that the state recognizes as essential), provides AFDC coverage for an unborn child, does not cover unemployed fathers under AFDC, and does not pay for abortions, may in effect be creating incentives for out-of-wedlock childbearing. Similarly, a state that pays for abortion but does not provide AFDC coverage for prenatal care might be encouraging abortion. In addition, lack of economic assistance for adoption may undermine that option, while the simple limitation of welfare to unmarried women may undermine marriage (Moore and Burt, 1982, p. 113).

This quote highlights the likelihood that government policy may favor certain choices. How this might influence teen behavior has not been demonstrated, but perhaps greater federal uniformity in regulations and more equal emphasis on both prevention of pregnancy and on provision of services to teen mothers and their children would address this imbalance.

## Stage 4: Welfare

For teenagers who have and keep their babies, the choices relating to welfare dependency are complex. Decisions involve (a) promoting marriage so there are fewer single parents; (b) obtaining more financial support from the girl's own family and the child's father; and (c) improving the girl's own economic prospects through education and employment. These choices should have a familiar ring, because the dynamics of dependency versus self-sufficiency are no different for the very young single mother than for any woman who heads a family with minor-aged children. The difference between teenagers on welfare and older women is that it is harder for the teenagers to become independent. Research on spells of AFDC and characteristics of those who are most likely to remain dependent for long periods suggest the young, nonwhite, never-married women with young children are the least likely to leave welfare early (Ellwood, 1986). It is therefore imperative to understand who among very young mothers receive welfare, and how other options can be encouraged.

Economic status and household arrangements. Table 2 provides recent estimates of the economic prospects of these young mothers. The data, from the 1985 Current Population Survey, report the marital, educational, poverty, and welfare status of U.S. girls aged 16-19 who have at least one child and are heads or spouses of heads of families or subfamilies (i.e., including those who reside with their parents or other relatives). It is important to note that of this total sample, over half, 53 percent, live in subfamilies. Of the nonwhites, over two-thirds are black. These families represent approximately 5 percent of all mothers aged 16-55 who report receiving public assistance in the preceding year. The benefits they receive as families with dependents are primarily AFDC, but the category also includes general assistance and Supplemental Security Income (SSI).

As shown in Table 2, a higher percentage of black teen mothers and other minorities compared to whites live in households with incomes below poverty and are dependent on welfare. Those teen mothers who are married are equally poor but less likely to receive assistance, perhaps because of the lack of AFDC-U in many states. Education levels hardly vary by marital or ethnic status. Not listed in the table is the finding that public assistance varies by household type as well as by marital status, as in the following percentages.

Percentage of Teen Mothers, Aged 16-19 Who Receive Public Assistance, 1984-1985

| | Own Household | Lives with Family |
|---|---|---|
| Married | 12.3 | 7.5 |
| Never Married, Divorced, or Separated | 80.7 | 36.0 |

Source: 1985 Current Population Survey.

Table 2

Economic Prospects of Teen Mothers Aged 16-19, by Race and Marital Status, 1985

| | Percentage (%) in Each Marital Status, 1985 | Mean Years of Schooling, 1985 | Percentage (%) with Incomes at or Below Poverty, 1984 | Percentage (%) Who Receive Public Assistance 1984-1985 |
|---|---|---|---|---|
| Total - 559,926 | | 10.4 | 32.0 | 30.0 |
| Never-married | 50.0 | 10.4 | 34.6 | 44.6 |
| Married | 44.3 | 10.3 | 29.7 | 11.5 |
| Divorced/separated | 5.8 | 10.8 | 28.1 | 46.5 |
| Whites - 374,943 | | 10.4 | 26.5 | 20.7 |
| Never-married | 30.3 | 10.5 | 27.5 | 35.7 |
| Married | 62.1 | 10.3 | 26.2 | 10.6 |
| Divorced/separated | 7.7 | 10.7 | 24.7 | 43.1 |
| Nonwhites[a] - 184,983 | | 10.3 | 43.4 | 49.0 |
| Never-married | 89.7 | 10.3 | 39.4 | 50.7 |
| Married | 8.2 | 10.8 | 83.5 | 24.5 |
| Divorced/separated | 2.0 | 11.5 | 53.8 | 72.5 |

Source: 1985 Current Population Survey Extract, analysis prepared by Institute for Research on Poverty.

[a]Hispanics are included in the white and nonwhite categories. Blacks comprise 97 percent of nonwhites.

The impact of policies and programs. The high proportion of welfare recipients among single mothers who live in separate households raises the issue of whether welfare benefits in any way promote different living arrangements. It is likely that many who live in subfamilies live with parents whose family incomes exceed eligibility. Teens in their own households are far more likely to have low levels of additional household income. A recent report analyzed the impact of AFDC benefit levels on the propensity of young mothers to form separate households and the consequences of different living arrangements for schooling and employment (Hutchens et al., 1986). It concluded that in many states, young women are discouraged from remaining in their families of origin by lower benefits and that those who form separate households (and get higher benefits) may be less likely to continue with their schooling (Hutchens et al., 1986, pp. 1-8). In the long run, this may increase their welfare dependency and poverty. However, simulation techniques that estimate impacts of policy changes find little change in socioeconomic prospects through programmatic reform in this area:

> We conclude that a policy which eliminates within state differences in AFDC benefits across living arrangements by raising the level of AFDC benefits paid to women in subfamilies would both increase the number of subfamilies and decrease the number of female heads. These changes would, however, be quite small. Moreover, this policy would have almost imperceptible effects on labor force participation and schooling (Hutchens et al., 1986, Chapter 1, p. 7).

The next few sections focus on possible alternatives or additions to welfare that might be available to teen mother families. They address the prospects for reducing dependency through increased child support and through comprehensive service programs for teen parents.

## POLICIES AND PROGRAMS AVAILABLE FOR TEEN PARENTS

### Child Support

Historically, any child born outside of marriage was afforded very few rights regarding the legal relationship with his/her father. Until the United States Supreme Court intervened in a series of cases in 1968, the "nonmarital" child was often denied rights of paternal support, as well as inheritance, custody, name, and claims under such programs as Worker's Compensation. In addition, prior to 1968, even if the child was awarded paternal support, some states extended these rights no further than the period of time the child was likely to be unable to support itself, or to a period not exceeding a set number of years (Krause, 1981). Although today the established principle is that the out-of-wedlock child is entitled to legal equality with the child of married parents, some states continue to place a statute of limitations on the establishment of paternity. With the passage of the 1984 federal Child Support Enforcement amendments, state paternity laws must now permit the establishment of paternity at least until a child's eighteenth birthday. However, only 23 states have statutory provisions for setting child support amounts for illegitimate children, compared to 34 states that have such statutes for divorce or separation proceedings (Melli, 1984).

When one examines the participation of teen never-married mothers in the current child support system, it is clear that the major obstacle to support occurs at the paternity adjudication stage. Until paternity is established, a father cannot be legally compelled to provide child support, yet in only a small fraction of the births to unmarried teens is

paternity typically adjudicated. From data on selected jurisdictions in the state of Wisconsin, Table 3 shows the number of cases of unmarried teen mothers over a two-year period and the extent to which fathers become legally identified in the following several years.

By 1985, 57.4 percent of the children born in 1981-82 to unwed mothers have no legal fathers (opposite of row 2, Table 3). Since 92 percent of all paternity suits in these counties occurred before the child reached age 3, very few more paternities are likely to become established among this group after 1985. Of those with fathers' names on the birth record, less than half are processed as paternity suits through the courts so that child support can be legally required. In just a few instances are the parents married after the birth of the child.

The financial arrangements of the group who have fathers' names acknowledged on the birth record are unknown. It is possible that many of these fathers either live with the child or informally provide some support to the family. If we combine those with formal legal obligations for support through marriage or through court-ordered support after adjudication, only 999 of the 5724 children born to teen single mothers, 17.5 percent, have legal rights to support. Of those, only in the case of married parents plus just over half of the adjudications, does the child receive some financial support from two parents. Even this estimate is high compared to the number who may be receiving <u>adequate</u> support (Wisconsin data indicate that paternity cases with child support orders receive 42 percent of what they are owed, on average; cases with teen mothers receive only one-third) (Danziger and Nichols-Casebolt, 1986a).

Table 3

Births to Unmarried Teens and Percentage with Paternity Actions, Sample of Selected Wisconsin Counties

| | Number | Percentage |
|---|---|---|
| Births to unmarried mothers aged 19 or younger, 1981-1982 | 5724 | |
| Those with father identified through marriage, paternity acknowledgment, or paternity court case by 1985 | 2438 | 42.6% |
| Of 2438, those legitimated by 1985 (via marriage) | 161 | 6.6 |
| Of 2438, those having paternity acknowledged by signed affadavit in birth certificate by 1985 | 1165 | 47.8 |
| Of 2438, those with paternity adjudicated through family court by 1985 | 1112 | 45.6 |
| Of these 1112 paternity cases, those with court orders for child support | 838 | 75.4 |

Source: Danziger and Nichols-Casebolt, 1986a; data from Wisconsin family court records and Wisconsin Division of Health, Section of Vital Statistics.

The chances in the short run that child support can reduce welfare dependency without substantial reform of the system are not promising. However, reforms of the child support system that would insure greater income to these families are currently being designed, implemented, and evaluated in Wisconsin (Garfinkel and Uhr, 1984; Garfinkel, 1986). These involve several improvements in the current system; first, all parents living apart from their children are obligated to share income with their children. The sharing rate is specified in the law and depends only upon the number of children owed support. The obligation is collected through payroll withholding, as social security and income taxes are. Children with a living noncustodial parent are entitled to benefits equal to either the child support paid by the noncustodial parent or a socially assured minimum benefit, whichever is higher. When the noncustodial parent can pay less than the minimum, the custodial parent is subject to a small surtax up to the amount of the subsidy. Any remaining difference would be financed out of general revenues.

The state of Wisconsin has currently implemented only part of this overall child support assurance system. Several counties have instituted payroll withholding, and a standardized sharing rate, which many judges have been using for award guidelines, is about to become presumptive in state law.

With respect to paternity cases for women of all ages, early impact data suggest that in counties operating under the withholding rules, the average ratio of payments to orders has improved to .56 (compared to .42 in the previous period). While the number of adjudications have

increased since the reforms began, very few non-AFDC mothers file paternity cases and pursue the out-of-wedlock child's right to court-ordered child support (Danziger and Nichols-Casebolt, 1986b).

Until this income is perceived as a valid right of children and as a clearly important economic gain for these families, we are not likely to see child support reducing the impoverishment and welfare dependency of never-married mothers. However, even incremental increases in income must be viewed as terribly important. For example, there is as yet no information on the impact of the recently implemented DEFRA child support disregard of up to $50 per month. In Wisconsin, a separate check comes to the recipient with the AFDC monthly payment when a child support payment has been made by the absent father. It seems clear that increased child support will have to be combined with other measures to improve employment opportunities, education, and child care options, etc., if poverty and dependency among these single mother families is to be reduced.

## Teen Parent Programs

Since the late 1970s, over a thousand private and public programs have developed around the nation to provide a wide range of interventions for teen parents and their children. Most of these projects have been designed to be comprehensive in scope. They address the multiplicity of problems that plague these families through providing several of the following components:

--Pregnancy testing and maternity counseling;

--Family planning counseling and services;

--Primary and preventive health care;

--Nutrition counseling, education, and services;

--Venereal disease counseling, testing, and treatment;

--Pediatric care;

--Family life education, including parenting education;

--Educational and vocational counseling, referral, and services;

--Adoption counseling and referral;

--Other health care;

--Child care;

--Consumer/homemaking counseling and education;

--Counseling for male partners and extended family members;

--Transportation;

--Employment programs that provide job skills training, work experience, job search and placement (Burt et al., 1984).

A number of shortcomings, such as lack of comparability, poor design with respect to outcome measures, short-term nature of programs, etc., limit evaluation of the success of these programs to date. A particular problem has been the lack of experimental design in the program evaluations (Quint and Riccio, 1985). A current federally funded demonstration that will begin in 1987 and run for three years will utilize a random-assignment experimental-control group procedure to test the effect of a mandatory, comprehensive program in two states, expected to serve over 3500 teenaged AFDC parents (ASPE/ISP Current Policy Research Activities, October 1986). To date, these programs have been quite costly and are not widespread enough to generate a decrease in the negative consequences of teen parenthood. However, some results of the programs that have been tried are promising, as recently summarized in a National Academy of Sciences report (Hayes, forthcoming).

- Increases in prenatal care produce more healthy birth outcomes for the young mother and her baby;
- Nutrition services reduce the incidence of low birth-weight babies among teens;
- Regular preventive, pediatric care improves the health of infants and young children;
- Contraceptive services increase birth control use and continuation among adolescents;
- Income support improves the economic well-being of disadvantaged adolescent families and subfamilies;
- Child care services facilitate young mothers' return to school or entry into the job market;
- Parenting education improves teen parents' knowledge of infant and child development and child care and can prevent early developmental delays in the children of teen parents;
- Alternative school programs help pregnant and parenting teens stay in school and boost their academic achievement;
- Employment programs that teach job skills and place teens in jobs increase work-related skills and attitudes.

To what extent this plethora of interventions reduces the overall welfare dependency or poverty rates of teen mother families has not been identified. One significant positive effect of such programs was demonstrated in one group of programs, the Project Redirection demonstration, which emphasized increased employability of young mothers. Teens who were served compared to those not enrolled had achieved more work experience and had higher test scores on knowledge of the labor market and career alternatives and on motivation to work (Polit et al., 1985). One important and consistent negative finding has been that young women who participate in most of the comprehensive projects do not have lower subsequent pregnancy and fertility rates in the long run compared to the general population of teen childbearers. Because those with repeat

pregnancies are at the greatest risk of social and economic disadvantages, prevention of these pregnancies as well as of initial early teen pregnancy is an important goal for new policy development.

In addition to the above set of comprehensive programs, the 1985 Children in Poverty report to Congress suggested two other policies that increase services to teen parents (U.S. House of Representatives, 1985, pp. 354-360). The school-based programs that offer infant and child care and other support services are important for reducing drop-out rates after pregnancy. Very few such programs currently operate nationwide, but those that provide day care for children of school-aged parents at the high school report relatively high rates of graduation among teen mothers (pp. 358-359). Another policy that may be informally occurring is an expanded role of welfare offices in referring adolescents to needed resources. Here, AFDC agencies with a number of adolescent mother recipients have at least one caseworker who specializes in problems of minors--finding child care, drop-out prevention, family planning, etc. The extent to which such services are currently offered to teen recipients is unknown and their feasibility as a statutory requirement has yet to be addressed (pp. 359-360).

## POLICY RECOMMENDATIONS TO INCREASE OPTIONS

Some researchers argue that the average American adolescent is facing contradictory pressures in regard to his or her sexuality that result from broad-reaching conflicting trends (see Wagner, 1980). Compared to previous decades, physical sexual maturity is occurring at increasingly younger ages while social maturity occurs at more delayed ages for the

majority of youth. Advances in years of schooling, later average age of beginning one's occupation or career, and delayed age of marriage and first birth are evidence of later social maturity. In very few cultures, for example, is there such a long delay between becoming physically able to bear children and the social expectation of appropriate age of parenthood (Konner and Shostak, 1986).

Add to this disjuncture the message conveyed by the increased explicit promotion of sexual promiscuity in youth-oriented popular culture and media, and it becomes miraculous that more teens do not become pregnant. This view implies that interventions to aid psychosocial development may be needed for the majority of our youth, rather than just for those who become teen parents (Fisher, 1982). Researchers who see such problems as generic to adolescence also point to the failure of families across all income strata to provide the necessary resources to help our youth. Because of the psychological pressures to become autonomous rather than dependent on one's parents as one inches toward political and legal emancipation, young persons pay little heed to parental authority. Instead they seek solutions on their own. Developmental psychologists therefore focus on teaching more rational thinking to young adolescents and teaching them how to apply this ability to their sexual decision-making, sexual behavior, and intimate interpersonal relationships (Rogel et al., 1980; Kisker, 1985; Zabin et al., 1984). For example:

> Adolescent development does not afford most youths with cognitive and behavioral skills to convert knowledge and intentions into action. Preventive intervention must therefore be directed toward all youth. Such intervention would then help adolescents acquire cognitive and behavioral skills before the dating and sexual experimentation years. Within the context of intimate and contraceptive situations, youths must be able to process sexual information and apply it to themselves. They also must have the skills to fully anticipate and prepare for sexual encounters and to problem solve around obstacles in such preparation.

> Adolescents also need behavioral communication skills to request information, to refuse unwanted demands, to request desired changes, to disclose feelings and preferences, to give and receive feedback, to negotiate, and to compromise. Finally, behavioral stress reduction skills may be necessary for youths to deal adaptively with sexual and interpersonal intimacy (Gilchrist and Schinke, forthcoming).

## Recommendations at Each Stage

The following list of programmatic policy reforms are geared to the prevention of teen pregnancy and breaking its connection with welfare dependency. The causes of teen welfare dependency are linked to broad societal problems such as persistent poverty, sex and racial inequalities, and unemployment. However, at each stage in the route from sexual activity to single parenthood, specific policies could be promoted to redirect more of our young people, particularly those whose families have the least economic and social resources, to make choices that result in opting against becoming dependent on welfare.

Stage 1. Policies to postpone premarital sexual activity

- Better educational and employment opportunities for youth.
- Inequality reductions in general for families with children.
- Vocational education to increase aspirations of youth and encourage the desire to postpone parenthood and provide realistic information about jobs, work probabilities for men and women, limits of welfare as source of support, costs of children, etc.

Stage 2. Policies to reduce pregnancy

- Sex education that includes:
  comprehensive information on pregnancy risk and contraception, education on parenting and family life (promoting two-parent families), knowledge of laws on child support and father responsibility, information on intimacy and relationships.

- Health care services to improve access to and availability of family planning for contraceptive services and pregnancy testing and counseling; school-based clinic programs; increased funding of public family planning; increased utilization of private and public adolescent health care services through Medicaid and health insurance coverage.

- Vocational education to increase aspirations--see 1 above.

Stage 3. Policies to reduce single parenthood

- Encourage adoption options among other alternatives in counseling and health care services, provide all types of referrals, teach all options in sex education.

- Provide information on the father's legal and financial responsibilities and obligations regardless of marital status; advocate for the child's right to father involvement.

- Current public assistance actually supports single parenthood more than its alternatives. We ought to recognize this imbalance and fund more programs that provide preventive comprehensive sex education and contraceptive services. Policy steps that would correct the imbalance in pregnancy resolution choices include among others making AFDC-U available in all states for young parents, and providing counseling to young women or couples who place children for adoption.

Stage 4. Policies to reduce long-term welfare dependency

- Experiment with and evaluate workfare-type services <u>early</u> in reciepiency while children are young.

- Promote education and training of teen mothers

    - Increase the educational status of young mothers by reducing drop-out rates (providing support to continue schooling after high school).

    - Promote use of child care to facilitate staying in school.

    - Extend remedial education and job training to fathers who live with or provide support to children of teen mothers.

    - Encourage girls to remain living with their families of origin.

    - Provide parenting/family life education to promote the welfare of the infants born to teens.

    - Encourage family planning continuance to reduce subsequent fertility.

- Reinstate social services as mandatory for teen mother AFDC recipients. They need to be linked with a variety of counseling and special services to make sure the teen mothers are getting WIC program help, other health care services, referral for counseling and any mental health, family planning, etc., housing and energy assistance, infant health screening and care, child care placements and allowances, etc.

- Promote father involvement

  - Increase the provision of AFDC-U to families in which the father lives with the family.

  - Reduce court orders for child support temporarily while the absent father is enrolled in job training or educational pursuits.

  - Increase paternity adjudication or legal acknowledgment of fatherhood early in the child's life.

  - Increase the long-term monitoring and tracking of child support cases so that when the absent father does become able to pay, the court acts quickly to get an order processed and payments started.

## Notes

[1]Although the proportion of teenaged women on the AFDC rolls is small at any one point, their long-term recipiency status has been of concern. The most frequently cited evidence of this is Kristin Moore's finding that approximately 70 percent of the total number of AFDC recipients under age 30 in 1975 began motherhood as teens (Moore and Burt, 1982, pp. 108-109).

[2]There is also wide discrepancy across national surveys on the abortion rates for black teens. Center for Disease Control figures are much higher than self-report estimates from the National Survey of Fertility Growth (NSFG), for example (Nagatoshi, n.d., Henshaw et al., 1985; Mosena and Astone, 1986).

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