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AN INTERDISCIPLINARY PROGRAM FOR UNWED PREGNANT ADOLESCENTS. A PROGRESS REPORT.

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DESCRIPTORS- *COMMUNITY HEALTH SERVICES, *UNWED MOTHERS, COOPERATIVE PROGRAMS, *PROGRAM EVALUATION, MEDICAL SERVICES, *PILOT PROJECTS, EDUCATIONAL COUNSELING,

BECAUSE OF THE MEDICAL, EDUCATIONAL, SOCIAL, AND PSYCHOLOGICAL PROBLEMS WHICH TEENAGE PREGNANCIES PRESENT TO THE UNWED GIRL, HER CHILD, AND THE COMMUNITY, A COMPREHENSIVE, INTERDISCIPLINARY PROGRAM WAS ESTABLISHED BY THE SYRACUSE BOARD OF EDUCATION, THE ONONDAGA COUNTY DEPARTMENT OF HEALTH, AND THE STATE UNIVERSITY OF NEW YORK, UPSTATE MEDICAL CENTER AT SYRACUSE. KNOWN AS THE Y-MED PROGRAM (YOUNG MOTHER'S EDUCATIONAL DEVELOPMENT), IT UTILIZED A STAFF OF 23, INCLUDING MEDICAL PERSONNEL, SOCIAL WORKERS, AND TEACHERS. THIS REPORT EXPLORES THE OBSTETRICAL, PEDIATRIC, EDUCATIONAL, AND SOCIAL SERVICES, AND THE PSYCHOLOGICAL ASPECTS OF THE PROGRAM. THE REPORT ALSO DEALS WITH SOME OF THE PROBLEMS FACED AT THE PROGRAMS INCEPTION AND SOME OF THE RESULTS APPARENT AFTER TWO YEARS OF FUNCTIONING. THESE SERVICES, COVERING THE PREGNANCY, THE DELIVERY, AND ONE-YEAR POSTPARTUM, WERE OFFERED UNDER ONE ROOF, BUT AVOIDED A CLINIC-TYPE ATMOSPHERE. THE RESULTS OF THE Y-MED PROGRAM INDICATE THAT IT WAS SUCCESSFUL ON MANY LEVELS. NO SERIOUS MEDICAL COMPLICATIONS DEVELOPED, INFANT DEVELOPMENT WAS GOOD, AND THE GIRLS ADJUSTED WELL TO SCHOOL. (CG)

AN INTERDISCIPLINARY PROGRAM FOR UNWED PREGNANT ADOLESCENTS

-- A PROGRESS REPORT

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In recent years, the problem of the pregnant schoolgirl has been receiving a great deal of attention. From medical, educational, social service, and psychological points of view, these girls are high-risk individuals with extremely complex and difficult problems. Obstetrically, many problems have been found to be more common, including toxemia, excessive weight gain, anemia, fetopelvic disproportion, prematurity, and even perinatal mortality.[2,3] Further, in the surviving infants, a higher incidence of neurological complications has been reported, with the suggestion being made that the teenage mother offers her infant the poorest neurological prognosis of all disadvantaged groups studied.[3,6] Educationally, pregnancy looms in some states as the number one condition resulting in teenagers leaving school prior to graduation.[8] Socially and psychologically, also, the pregnant teenager appears to be at considerable risk. In spite of many indications that such individuals have accompanying and underlying psychological problems, the bulk of pregnant teenagers receive little if any counselling. Maternity homes care for less than ten percent of out-of-wedlock pregnancies.[1] Because of the expense involved, and because maternity homes usually accept girls who are planning to place their babies for adoption, the majority of patients cared for under such conditions are from the middle class, and only twelve percent are nonwhite. This is in spite of the fact that the bulk of the pregnancies which are carried to term occur in the lower socioeconomic groups, and sixty percent are

reported to occur among nonwhite mothers. In 1963, Adams found that only one out of six out-of-wedlock mothers received any voluntary or public social service assistance; among the poor and the nonwhite, these figures would be considerably lower.

Because of the major medical, educational, social and psychological problems which teenage pregnancies present to the girl undergoing the pregnancy, to the baby which results from the pregnancy, and to the community which has to deal both with the mother and with the infant, it has seemed most appropriate and important to try to evolve a comprehensive interdisciplinary approach to the overall care of the teenage pregnant female. Such a program was set up in Syracuse and Onondaga County in the fall of 1965, and was fully functioning by May 1966.[4,5] This program, sponsored jointly by the Syracuse Board of Education, the Onondaga County Department of Health, and the State University of New York, Upstate Medical Center at Syracuse, is known as the Y-MED Program (Young Mothers' Educational Development). It has been set up as an attempt to provide obstetrical, social, psychological, and educational services for pregnant adolescents and pediatric service for their infants. The Program, as conceived and established, is extremely broadly based and attempts to meet the needs of the individuals, and to provide both the mother and the infant with maximum opportunity to lead useful, productive, and fulfilled lives within society. The Program, in many concepts is unique and differs from other programs throughout the country. In the following sections, an attempt

will be made to explore the obstetrical, pediatric, educational, social service, and psychological aspects of the Program, dealing with some of the problems which faced it at its inception, and in addition, some of the results which have become apparent during its two years of functioning.

DESCRIPTION OF THE PROGRAM

The Y-MED Program has been set up in a school building, which had previously been closed to usual school function. The school was selected for two reasons. The first was that a traditional school would have been unacceptable to the parents of nonpregnant schoolgirls; in New York State, schoolgirls are usually excluded from classes when pregnancy is apparent to the teachers or principal. The second reason for utilizing the building described was its close proximity to the Upstate Medical Center. It was felt that since the girls were pregnant, in addition to going to school, medical care must be an important part of the overall program, and laboratory and hospital facilities must be closely available at all times. Within the portion of the school devoted to the Y-MED Program, rooms have been utilized as classrooms, social service offices, a cooperative kitchen and cafeteria, a medical facility for examination and prenatal observation, and a nursery facility for the infants -- in order that mothers might continue to attend school after the delivery of their offspring. Although combining such facilities under one roof was most nontraditional, it was felt that such a

combination was absolutely necessary if a truly meaningful program was to be offered.

In the two years the Program has been functioning, the staff has grown from a group of three -- a caseworker, a former visiting teacher, and a social work consultant to a staff now numbering twenty-seven. At present there is a full-time coordinator of the Program who also functions as director of educational services. In the educational area there are five teachers, three full time who teach social studies, English, and home economics, and two part time who teach mathematics, reading, and English.

Regarding the medical staff, there exists a part-time medical director from the Ob-Gyn faculty of the Upstate Medical Center. In addition, there is a part-time obstetrician and pediatrician -- both also from the faculty of the Upstate Medical Center. The psychological staff consists of a part-time director of psychological services from the Division of Child Psychiatry at the Upstate Medical Center, a half-time clinical psychologist, and a psychiatrist on a part-time basis. In the nursing area, there are four full-time persons, one public health nurse, one registered nurse in the obstetric department, one licensed practical nurse, and one nurse's aide. In the division of social work, there is a director of social services on a part-time basis from the Onondaga County Health Department. In addition, we have a full-time social work supervisor and a social worker. There is one full-time caseworker and one

part-time caseworker. Also assigned to Y-MED from the Welfare Department's unmarried mothers unit is a full-time caseworker. Finally there is a social work student from Syracuse University at the Center on a part-time basis. Rounding out the staff is a full-time nutritionist, a part-time YWCA leisure time activity worker, and two full-time secretaries.

Within one week of entry into the Program each girl is seen by an educator, social worker, physician, and psychologist or psychiatrist. Together with the girl, assessments and plans for the future are made. During this period of time, the girls are also introduced to the Program, the teachers, and the other girls. By the end of the first week, a short-term plan is derived and at least suggestions are made for possible long-term goals. Such long-term goals would by necessity need to remain flexible. Although some compromises were necessary during the first two years, because of the physical difficulties of setting up the Program and because of the difficulties in obtaining and integrating a sensitive staff, these goals have constantly been kept in mind and have been adhered to as much as possible.

Following the initial intake week, each girl enters the total program encompassing medical care, education, social service counselling, and psychological guidance. When the Program first began, it was anticipated that comprehensive care would include the pregnancy, the period immediately after delivery, and three months postpartum. Experience, however, has

indicated that for most girls a minimum of one year postpartum within the Program is required for real benefit to be apparent. Many girls have appeared to make considerable progress during the pregnancy but then seem to demonstrate considerable anxiety shortly after delivery -- often related to the prospect of being quickly cut off from the Program. As a result, greater flexibility in regard to the time of reentering the regular school system has been incorporated within the Program, as well as the development of aftercare programs.

OBSTETRICAL SERVICE

With the knowledge that the adolescent pregnancy is obstetrically at high risk because of multiple physiological, nutritional, social, and psychological reasons, the obstetrical program at Y-MED was set up in a somewhat unique manner. The overall concept of the Program was to provide an extremely broadly based service with a high degree of both intensity and personal attention. Girls were to be given care from the earliest possible point in pregnancy, and this care was to continue throughout the pregnancy, labor, and delivery.

From the start, the traditional "clinic" concept was abandoned. Y-MED has operated within the framework of a medical center program, but the girls have been treated completely as private patients. This has been done both in an attempt to provide more effective obstetrical care and to allow the girls

to establish meaningful relationships with physicians -- perhaps the first meaningful patient-physician relationships in their lives. The program was designed as a group private practice arrangement for Ob-Gyn chief residents under the supervision of the medical director. They met the girls at the initial visit and followed them throughout the pregnancy, labor, delivery, and postpartal period. The girls were always given appointments to see their physicians with no long waits in an impersonal room. If an emergency developed, the girls could call their physicians through a twenty-four hour answering service. When labor began, again the individual relationship prevailed. Their physician was called, he would come to the hospital and follow the girls as any other private patients.

The obstetricians, pediatrician, and nurses have conducted classes in small groups for the girls. These classes have met an average of three to four times per week. The girls have been taught basic facts about their bodies, pregnancy, delivery, and infant care.

In this manner, the obstetrical aspect of the Y-MED Program has been established. Care has been taken to appreciate the special problems of this group of high-risk pregnant adolescents, and their individuality has always been the main consideration. The obstetrical part of the Y-MED Program has been in full operation for one and one-half years. During this time, 175 girls have been fully enrolled in it. At first the numbers were

deliberately kept small to ensure adequate function of services; during recent months, however, an average of three to five new patients have been seen per week. Of the 175 girls, 100 have now delivered a total of 102 babies (two sets of twins). As we hoped for, the majority of the girls have been seen early in the course of pregnancy. Forty-seven percent have received medical care by the twentieth week of pregnancy, and only eight percent have had no care prior to the last ten weeks of pregnancy. The average number of prenatal visits has been thirteen per girl, and all but twelve percent have had at least six visits. The hoped for relationship between patient and doctor has been observed to develop. Not only has this been obvious within the Program, but within the community the effects of these relationships have been observed. For example, at the hospital where all of the girls have delivered, the labor room personnel have commented that whereas at the beginning of the Program, it was anticipated that the girls would be unruly and uncooperative, since the onset of the Program their relaxed and cooperative spirit has been apparent. The labor and delivery room nurses have felt that the Y-MED girls transferred a trusting relationship to them, and that they were unusually pleasant patients. As a matter of fact, a request has been made by the nursing service that these patients be utilized as an intensive care experience for student nurses, even though no "clinic" patients have previously served in this function.

In spite of the intensive obstetrical care, a greater number of complications have been observed than could have been expected in a routine population. Twenty-four of the girls have required antenatal hospitalization because of complications of pregnancy. Insipient or early toxemia, excessive weight gain, and anemia have been frequent problems. Prematurity has complicated eleven percent of the pregnancies and cesarean section has been necessary in six percent. Although complications have occurred somewhat more frequently than would be anticipated from a population at large, they have been considerably less common than might have been anticipated on the basis of reports concerning similar populations. One might indeed assume that many more complications would have developed had the high intensity of prenatal care been lacking. Lending support to this theory is the fact that in spite of frequent complications, only one major complication has been reported in the entire series. In addition, to the present time there has not been a single perinatal mortality. Obviously, this finding will not last forever. Within any normal population there is bound to be some mortality incidence if enough deliveries are performed. However, the absence of perinatal mortality to the present time, together with the diminution of other problems, is most exciting since obviously a higher percentage of complications could be anticipated within this population. Thus, obstetrically, it would appear that progress is being made.

The approach to contraception is the same as the approach to any other issue in the Program. We are not primarily interested in preventing the girls from having more children. We are interested in helping them exercise options based on rational considerations emerging out of meaningful relationships with various staff members. All contraceptive possibilities are described to the girls in the medical lecture series and by the individual obstetricians. This approach is supplemented by the use of printed material such as brochures and pamphlets. Out of this effort each girl ultimately makes her own decision on the issue. Some decide the best contraception is to eliminate intercourse and this decision is of course respected. Others who want to continue sexual contact but avoid pregnancy are met with individually by the obstetricians in order to determine the contraceptive approach most acceptable to the girl. All contraceptive devices relevant to the female are prescribed by our obstetrical staff.

The preceding statements outline our approach in the ideal sense. In practice, however, the ideal is not totally realized. There is not a consensus within the staff regarding "what is right" on this issue. Since the "value aspect" of this matter is so potent, the girls' decisions regarding contraception can have less to do with rational considerations and more to do with the implicit "values" held by the various staff members with whom she speaks. We cannot and should not eliminate our values

but they can become explicit. In such instances, we are in a better position to assess their relative influence on the girls and to as well examine the flaws in logic if any.

The work of Sarrel[7] concerning a similar population suggested that almost all of these girls might be anticipated to have repeated unwanted pregnancies. At the present time, only seven of our girls have become pregnant a second time. Five of these occurred during the first few months of the Program, when the girls were being referred to another agency for counselling, and when long waits and parental consent were required by that agency. Of the two remaining girls, one had married and desired a future pregnancy. The other was pregnant at the time of her six-week postpartal checkup. Thus, it would appear that the contraceptive aspect of the Program is also producing good results as far as allowing the girls to postpone further pregnancy until a more desirable time for them. These results are indeed meaningful since many have disputed the effectiveness of contraceptive advice and counselling in similar populations.

PEDIATRIC SERVICE

In view of the fact that most of the girls entering the Y-MED Program are under the age of 18 years, the pediatric interest includes the expectant mother in addition to the infant after birth. There are a number of major areas of service that are offered by the pediatric staff.

To begin with there is the taking of the history and physical evaluation of each girl entering the Program. This is conducted by the obstetrician but the pediatrician is consulted if there is a specific medical problem with the girl. However, beginning in July 1968 a combined obstetric-pediatric evaluation will be conducted since such an approach would be most helpful to the entire well being of the girl and her unborn infant.

A seminar of three to four girls with plans to keep their infants is conducted during the last trimester of pregnancy. The purpose of this seminar is to outline the course of events in infant care in the hope that this will provide information and afford an opportunity for a free interchange of views which may decrease anxiety around the care of infants.

The pediatrician is designated as the responsible attending physician for all Y-MED infants and is notified of the birth within twenty-four hours of delivery. An initial examination of each infant and review of the labor and delivery record is completed within this period. If a problem should arise during labor, the pediatrician is contacted immediately to be present at the delivery. During the hospital confinement the infant is observed and the mothers are visited briefly for questions they may have. A final visit is made at the time of discharge to go over specific instructions about infant care and to outline plans for emergency care if the need arises. No infant is discharged unless plans have been coordinated with the public

health nurse and social service staff to insure maximum care of the infant.

After discharge from the hospital, the girl and her infant remain at home for periods ranging from one week to one month. During this period, close follow up is effected through a coordinated effort of the pediatric staff and public health nurse. The latter makes at least two home visits, the first within forty-eight hours after discharge. In some cases more frequent visits are necessary. This is determined by the staff on an individual basis. Each girl is instructed to communicate directly with the pediatric staff, via the answering service for emergency or general concerns regarding the infant.

A pediatric examining area has been set up at the school and well-baby conferences are conducted by the pediatric staff. An interim history, a complete physical examination, developmental assessment, and immunization schedule are completed.

The pediatric program provides care for the infants until one year of age, but extension of this service is presently under review by our staff. For the sake of continuity of care, because of the close relationship that has developed between the girls and the pediatric staff, and because of the increase in the number of infants, the number of well-child conferences has been increased from two to three per month.

In keeping with the concept of total care for the infants, the pediatric staff manages any illness that may develop and

the examination and treatment is accomplished in the pediatrician's office at the Upstate Medical Center or at the girl's home. Should hospitalization be necessary, the infant is admitted as a private patient of the pediatrician.

The Nursery Program

In the early development of the Y-MED Program the need for a nursery became apparent for three major reasons. First, to provide infant supervision so that the girls could return to school; second, to create good standards of infant medical care and to provide stimulation during the first year of life; and third, to create a setting that would allow the mothers to learn good techniques of child care.

With these thoughts in mind, a classroom at the Y-MED Center was renovated and set up with cribs and accessories for ten infants. A practical nurse was hired on a full-time basis to be responsible for infant care. Direct supervision of the nursery operation was the responsibility of the pediatricians and public health nurse.

Each girl was expected to be responsible for feeding and general care of their infant during her free time and lunch period.

This gave the staff an opportunity to observe and make suggestions about infant care on a daily basis.

The nursery program operated on this basis for the school year 1966-67. The year's experience reflected several pitfalls

in our concept of the nursery program. Some review of our thinking was necessary and from it emerged some new concepts which may encourage the broad goals and ideals of the entire Y-MED Program.

During the year, nursery attendance fluctuated from a maximum of ten to a minimum of one infant per day. The average daily census was three to four.

Based on daily attendance figures for the girls and infants it became apparent that the nursery was not being fully utilized. Many girls elected to remain at home with their infants. A random informal inquiry among the girls revealed some interesting findings. First, in the opinion of some, the nursery did not provide care of the quality that could be provided at home. Further, in our judgment the nursery did not provide enough stimulation for the infants. Most remained in their cribs throughout the day. Personality problems and conflicts with the nursing staff were other factors that kept attendance down. In addition, 21 out of the first 77 girls in the Program had an older infant at home. Many of these girls did not have babysitters and with the arrival of the second infant, their hopes for finishing school were further diminished. Finally transportation to and from school presented problems especially in bad weather.

The acquisition of sensitive nursing personnel, plus the concern of the pediatrician and others on the staff has brought

about some striking positive changes in this program. Infant stimulation increased markedly, conflict between students and nursing staff has been reduced considerably, and the daily attendance has steadily increased with an upper range of fifteen babies and average daily census of three to four times that originally observed.

Even though the major problems with the nursery were being overcome, the staff came to recognize some further areas of concern. First, girls are remaining at the Y-MED Center for periods longer than three to four months and in some cases have become pregnant while the first infant was being cared for in the nursery. Second, if there is a problem of infant care while attending classes at the Y-MED Center, the problem is likely to continue after the girl returns to regular school. Since no such facility exists in other schools, the girls will probably be forced to drop out to care for their infants at home, Third, the goal of the Y-MED Program has been stated "to enhance the educational, psychological, physical, and social well being of the girls and their infants." Further it states that the individual service units "while providing direct individual service to the girls and their infants, do not operate independently from one another, but collaboratively." If we are to fulfill this goal, with all the emphasis placed on the girls before delivery and during their transition after delivery, we felt it necessary to go beyond a three to four

month period of "babysitting service." In affect we were asking an adolescent to take full responsibility for the most crucial period of child development; the period one to five years with minimal guidance and support. If we intend to live up to our stated goals, then it seemed important to develop a more complete and comprehensive program of infant care.

Emerging out of these considerations was a proposal to provide a day care facility for infants and children of girls enrolled in the Y-MED Center and of previous students who have now returned to school. Such a center would provide daily infant care, as well as guidance and supervision for the mothers in the areas of infant and child care. In addition, it would provide an educational, social, and physically enriching experience for the older children which we thought would positively effect formative development. The Program will include infants four to sixteen weeks of age who will be cared for in a fully equipped nursery facility similar to the present one. Also included would be infants and toddlers divided into two groups -- four to eighteen months and eighteen months to three years. They would be given individual care and guided towards a healthy development in a warm, stimulating environment offering developmental challenges commensurate with age and ability. Finally children three to five years of age will be integrated into a prekindergarten program already in existence under the Syracuse Board of Education. This program has been developed

out of a consideration of the most acceptable theories and practices in the field of child development. The overall staff will consist of two nurse-teachers and six teacher aides. The mothers of the infants will be completely involved in planning and implementing all aspects of the program for an ongoing parent education program is in keeping with the overall goals of Y-MED. Medical services will be provided on a continued basis by the pediatric staff as previously outlined. This day care proposal has not yet been funded but application has been made to the Special Projects Division, City School District, to the State Education Department and it is our hope that implementation will soon be a reality.

Evaluation

The pediatric staff believes that the improvement in nutrition and close medical supervision during pregnancy has caused a lower perinatal morbidity and mortality rate despite a large number of obstetric complications during the prenatal and natal periods.

In order to systematically assess this belief, a study is being conducted in which the results of the first one hundred deliveries in the Program will be compared to two other groups of adolescents who delivered at a local hospital during the same time period. These two groups will be (1) approximately one hundred girls with private obstetricians and (2) approximately one hundred girls who had their prenatal care from an outpatient clinic, or no prenatal care.

Among the parameters to be compared will be weight gain, time of first prenatal visit, number of prenatal visits, birth weights, and perinatal morbidity and mortality.

SOCIAL SERVICE

Prior to October 1965, services and policies of agencies were geared to adolescents who concealed their pregnancy, who continued their education, and who eventually returned to "normal activities." Such girls were usually members of the middle class who were financially able to leave home, enter another environment and with some assurance, plan upon adoption for their babies. Agency services for the pregnant adolescent not concealing her pregnancy were more limited and usually consisted of financial assistance and determination of paternity.

The Commissioner of the Syracuse Health Department together with interested professionals from the Upstate Medical Center and the Syracuse School System became concerned about the infant mortality rate in Syracuse because it was not less than the national average of 25.1 deaths per 1,000 live births. The services and resources in Onondaga County were more than adequate (in fact, superior to many communities) to lower this rate of infant deaths.

The Commissioner plus this group of professionals met and formed a Maternal and Child Health Committee. A subcommittee on social services was appointed to study the needs of pregnant

adolescents and to submit a program that would: (1) assist in the effort to reduce the rate of infant deaths (2) decrease the alarming number of female dropouts from public schools (3) provide social services to the mother, her infant, and her parents (4) ascertain the needs of the adolescent males identified as fathers of the infants (5) determine the causes of the increasing number of girls in the population of pregnant adolescents (6) study the environment to determine the resources needed in the community to assist parents of adolescents prior to out-of-wedlock pregnancies (7) evaluate the problems experienced by the girls in their early school years to determine a program of prevention.

The Maternal and Child Health Committee approved a plan submitted by the subcommittee on social services. It involved offering to the girl and her infant within a school facility medical care, education and all other services necessary to provide a total program. Those girls under the age of sixteen would be required to attend under state law. Those up to the age of twenty-one could attend on a voluntary basis.

The national foundation of the March of Dimes provided "seed money" to hire medical staff, to buy essential medical equipment, and to pay the part-time salary of a social work coordinator. As the result of increasing referrals, the Syracuse Board of Education accepted a proposal to request funding for the total program from Title I Elementary Secondary Act Money.

The proposal was submitted in February 1966, the funds were granted and the prenatal clinic opened in March. Prior to the opening of the clinic in the school, the students were cared for in community clinics or by their private physicians. The Title I funds were available for the total program for six months, and after that only for the educational division. Thus, a request for monies for the medical part of the program was made to the Bureau of Maternal and Child Health of the New York State Department of Health. The funds were granted and the Y-MED Center has been jointly funded since that date.

Prior to the onset of Y-MED, no social service agency in Onondaga County accepted girls for counselling services regarding pregnancy if they planned to keep their babies or if they did not plan to conceal the pregnancies. As a result, there has been little accurate information regarding the problems and backgrounds of this population. Of some note, there has been a belief within the community at large that the population who do not conceal the pregnancy and who do keep their infants, do so because of a cultural acceptance by their family and friends. This theory is especially accepted in regard to the adolescent Negro pregnant female. The experience of Y-MED has led to some different conclusions. One of which is that the willingness of nonwhite females to keep and care for their babies is related to the unavailability of adoptive homes, and agencies to provide major counselling. Some of the pregnant girls at Y-MED

have indeed stated that one of the major reasons for their planning to keep infants is the unavailability of adoptive homes and the feeling that foster homes for nonwhite children are of inferior quality. In our judgment the decision for surrender or keeping the baby cannot be explained on the basis of unidimensional concepts but is the result of the dynamic interplay of a variety of forces in the girl's life.

During the first year of Y-MED, most of the referrals were from schools and/or school health services. With increased understanding and knowledge of the Center by the community, the referrals became more widespread. Of 133 girls, 24% enrolled in the Center in the first trimester of pregnancy, 48% in their second trimester, 17% in their third trimester, and 9% post-partum. Eighty-one percent of that enrolled were pregnant for the first time while 19% had one or two other pregnancies prior to enrollment. Eighty-eight percent of the students were single and 11% were married. Three percent of the girls were 12 and 13 years of age, 19% were 14 and 15, 56% were 16 and 17, 20% were 18 and 19, and 2% were 20 years of age. In the early months of the Program, 90% of the girls were Negro, but as the Program gained greater community acceptance, the ratio has changed to 60% nonwhite and 40% white. As well, there has been an increase in the number of students enrolling from families with a higher income level.

There are a number of reasons for the increase in referrals noted previously. A deliberate attempt was made by the staff

to involve agencies serving the girls enrolled in the Center. To avoid fragmentation of service, a formal request was made to the Commissioner of Welfare to assign a worker from the Department of Social Services of the Children's Division to the Y-MED Center. This caseworker participated in every phase of our Program and was based in our facilities. She served her assigned students by providing direct service as well as interpreting Y-MED to the Department of Welfare.

The leisure time activity program at Y-MED is coordinated with the YWCA. The Board of Directors of the Y assigned a member of the Y-Teen Department to Y-MED and assumed responsibility for the person's salary. The facilities of the Y day camp were used one day per week during the summer and the Y is now used on one afternoon per week for various recreational and leisure time activities.

The Children's Day Care Center sponsored by Syracuse University and the Upstate Medical Center permitted us to utilize their facilities for older infants until our nursery program could be expanded.

One of the major objectives of the Y-MED Center then is to continue to incorporate services to pregnant adolescents and their infants into the programs of existing agencies in our community. We feel that adherence to this objective will eventually lead to an easier transition of a demonstration program into a community sponsored one.

Statistics gathered indicate that this objective will be less difficult to achieve than appeared at the end of the first year. Contrary to popular belief, the majority of students enrolled in the Y-MED Center were residents of the county for three or more years. Eighteen percent of the students resided in the county for three years or less, 18% four to nine years, 25% from ten to fifteen years, and 37% all of their lives. The marital status of the students' parents were as follows: Forty-one percent lived with both parents. Forty-six percent of the parents were divorced or separated and 12% were from families where both parents were deceased, widowed, or singled. More than 85% of the girls have received partial or full support from the Department of Welfare.

Of the 133 girls enrolled in the Program from October 1965 to August 1967, all resided within the city of Syracuse and Onondaga County. Of some note, each of the sixty census tracts within the city of Syracuse has had at least one girl referred to the Program. However, more than fifty percent have come from nine of the census tracts which are located in the lower socioeconomic areas. In addition, when the girls have come from other census tracts, they have generally been from the lower socioeconomic families within these areas. This, of course, would have been anticipated since the more mobile middle class girl would be more likely to conceal (or even abort) the pregnancy.

The social background of the girls requires some further comment. There have been significant factors appearing in a large number of the girls' case histories that have begun to establish patterns of problem areas. A large number of the girls referred have had an early history of repeated unexplained

absences from school. Often this history has stemmed from the age of ten or under. Many have had a truancy record and a number have already been adjudged delinquent. Somewhat in excess of fifty percent of the girls have freely discussed prior sexual experiences. Of this group, 73% have had sexual experiences for two or more years prior to pregnancy. The history of early sex experiences and lack of interest in school is significant in view of the repeated absences and later truancy. This pattern coupled with the poor housing environment, should be indicative of the need for preventive social education and leisure time activities for the preteen girl, especially in the lower socioeconomic groups.

Some of the problem areas observed by the social work staff appear to be worth sharing. Several of the girls have been of low intellectual capacity with some degree of emotional instability or mental retardation. Frequently, the girls have appeared unable or unwilling to protect themselves from the males in and around their household. When these factors have been combined with high population density in the area of residence; poor relationships with parents, particularly the mother and/or stepfather; and a continuous pattern of adolescent pregnancies by other siblings in the family; obviously the stage is set for the present pregnancy. In addition, there has frequently been an inability to participate in meaningful leisure time activity. There has been little or no knowledge of such

activities for individuals or family groups. Frequently the girls have demonstrated hostility towards one or both parents. As has already been mentioned, there has been an early disinterest in school. It appears then that there is a definite need for community resources to screen and work with adolescents and preadolescents who require early supportive care which may prevent one or more of the pregnancies experienced by such girls.

Further, in addition to the preventative measures outlined, specific needs of the girls already pregnant have emerged. For many, with a long history of educational underachievement, the role and type of education has to be redefined. As counselling has become more adequate, there has been an increase in the number of girls who have demonstrated a desire to place infants for foster or adoptive care. This has raised the issue of creating new and better resources for such facilities, especially for the nonwhite mother. Several of the girls have demonstrated an inability to fully attend school because of familial pressures to remain at home and care for young siblings. In such instances day care facilities must be available within the community to prevent such an inadequate solution. Another problem of major importance concerns the living arrangements of the girls themselves. Many can and should continue within their existing family unit. However, this solution is not appropriate for all of the girls. For some, in spite of their relative youth, an apartment with the infant would seem to be most appropriate.

For others, sheltered apartment living with or without the infant under the supervision of foster parents would be most sensible. For still others, when the family situation is extremely bad and may indeed be threatening to the girls, foster arrangement for the entire pregnancy as well as the postpartal period should be available. At the present time, few of these services are in existence. Y-MED is now attempting to deal with these issues and is hoping to effect solutions within the near future.

One other area of concern to the social service staff has been the absence of resources available to the adolescent male identified as the father of the student's infant. In determining the financial status of our students, 45% stated that the fathers accepted responsibility for planning and caring for the infant. Twenty-seven percent of the students stated that the father was unknown. Ten percent stated that there was limited acceptance of responsibility by the father and 17% said there was no acceptance at all. The number of fathers accepting responsibility is sufficiently large to indicate that there is reason for the staff to reach out and provide a service to the adolescent male. A male social worker has been assigned to this phase of the Program and is developing a plan of service to meet the needs of the young men. A number of the fathers have requested such service and are currently participating in a limited program at Y-MED.

EDUCATIONAL SERVICE

The girls who have entered the Y-MED Program have often been those with extremely complex educational difficulties. Prior IQ test results have been low in the majority of cases. Recognition has been given to the fact that many girls from low income areas may have little parental support for education and the girls themselves low educational motivation. As a result they can be expected to have low scores on IQ tests, with such scores being unrelated to true intellectual capacity. The problems of the educator are complicated by the variability within the group. Although the bulk of the girls have had low IQ testings and prior school difficulty, a significant number have been average educational achievers with desire for future education. Several programs like Y-MED already in existence have coped with these problems by either eliminating the low achiever, focusing primarily on the high achiever, or else by having an extremely limited educational facility. Within Y-MED, such approaches have been untenable. The feeling educationally has been that the girls should obtain the maximum education of which they are capable. Further, in addition to offering educational opportunities, schools do represent an avenue for transmitting society's standards to the student. Therefore, the success of an educational program must also be judged by its ability to help the girls become useful and productive citizens within the society at large.

New York State law dictates that a girl who is attending school and who is known to be pregnant may remain in school until such time as her condition becomes observable to others, or in the judgment of the school staff, is detrimental to the pupil or to the morale of other students. In either case, the decision is left to the discretion of the principal as to when exclusion from school is requested. Educationally, in spite of homebound programs, the girl who leaves school because of pregnancy usually becomes a dropout. When there is no plan for adoption of the infant, one or two years may pass before the girl can reenter school. Consequently, such girls fall far behind in school work, and since motivation has often previously been poor, a high percentage of the girls never return for further formal education. Obviously, there is a need for preventing the girl from falling behind in her class work and for giving her every opportunity to progress at the same rate as if she were not pregnant. The Y-MED educational program has been attempting to solve these problems.

The program has been set up to provide instruction for the girls in several areas. Continuous instruction in academic areas is offered for those operating on a grade level. Basic education is presented for those functioning below their grade level. Office and business instruction in nonacademic areas are presented as option for all, and are encouraged especially for those who do not desire a traditional academic

program. An attempt is made to develop salable skills for the nonreturners by providing information and basic skills for the world of work. A program is now being set up for those girls who have difficulty functioning within any school system. Practical courses and intensive counselling are being utilized in an attempt to reorient such girls to the process of education. For those girls returning to the school system, efforts are made to provide preparation for reentry by giving intensive guidance while they are in the program and also by encouraging them to later return for individual sessions with the staff and for group sessions with other girls facing the same problems.

At the present time the majority of the girls have been operating below grade level with three percent entering from institutions for the mentally retarded. Over fifty percent have had attendance problems prior to entering school, and approximately twenty percent have had difficulties with school authorities. The school backgrounds of the girls have ranged from seventh to twelfth grade. However, most have been deficient in basic skills and have been considerably behind in their actual achievement level. Many of the girls, in spite of having passed nine to ten grades within the school system, have been barely able to read. Obviously, by necessity, classes have been broken down into what would constitute a tutorial type of teaching. Girls have been taught in small units and often individual instruction has been given. While some girls have

been preparing for regents examinations, others have been learning the alphabet and the most fundamental skills.

Every effort is made to encourage the girls to become active participants in program development. One of the best vehicles in this regard is the school magazine, published monthly under the editorship of one of the students. It contains praise, criticism, and general commentary in the Program and life in both prose and poem form -- all written by the girls. In fact it has become so potent a vehicle, that staff members when mentioned feel they have really arrived. The name of the publication was suggested by one of the students -- The Pickle Press. The speculative possibilities regarding the conscious and unconscious determinants for such a title remain almost infinite.

In addition to the regular academic program, a summer program was conducted for the first time in 1967. There were three major features to this program. The first was a YWCA summer camp program sponsored jointly by Y-MED and the YWCA. Secondly, an arrangement was made with the local poverty agency to provide summer jobs through the neighborhood youth corps program. Lastly, the school schedule was arranged so girls would only attend during the morning and receive instruction in reading and mathematics.

The Summer Camp Program

Prior to school ending in June 1967 meetings with the staff members from the YWCA and Y-MED produced an agreement where a series of six consecutive Fridays would be given to the Y-MED staff and students at Camp Avalon in Tully, New York with a representative of the YWCA being present at all times.

The first day of camp saw only nine girls, one baby, and twelve staff members attend. Although some interaction occurred between staff and students, many of the girls did not participate in the group activities. Perhaps this was due to the fact that for most of the girls it was their first time at a camp. Another observation was the positive impression the staff made with the girls by being part of them. Several staff members participated in activities not as the usual authorities with well-defined role prescriptions, but as persons who could have fun when the situation warranted it. Perhaps the most significant observation was that although the camp day was somewhat organized it was not organized to a point that it became stifling to either the staff or students. Everyone was able to enjoy themselves as they saw fit without any fixed schedule of activities or events.

Of interest to us the first day was the fact that the only Negro who went swimming was one of the teachers. Our speculations regarding the reasons for this event ranged from the girls' health concern to their concern for safety. The explanation that did not occur to us but that was pointed out by one of our

Negro staff, was that the girls were self-conscious about their hair. Many of them use a silicone preparation to keep it straight and swimming tends to remove it. We provided both the necessary preparations and a hair dryer. Once they were used by the Negro staff, the girls followed suit and the problem appeared solved. The event highlighted for us the importance of "being with it" and also how easy and dangerous it is to explain the behavior of members of one subculture with concepts applicable to another.

The following week saw a marked increase in the number of students attending. By the fifth week 25 girls and 9 staff members were participating in camp. Each week different staff members or members of the girls' family came. The impressive fact during these days was the development of "group spirit." The informality of the setting allowed staff and students to interrelate and feel that the camp was for their enjoyment. Each week more girls became an integral part of the activities. They did not have to be led into doing things as was the case in the first week or two. The bus trips going and returning were filled with singing and laughter. Nearly all of the girls ventured into the water and they joined in the games. One girl became noted for her ability to stand on her head in the water while in her ninth month of pregnancy. On rainy days, the students and staff were just as active in the recreation building as they were outdoors. Cook-ins, movies, arts and crafts, cards, etc. made up a full day.

The summer camp program then seemed to fulfill the goal of broadening the basis for two-way identification between Y-MED staff and girls. Our concern with the Program was not to teach swimming, or nature study, or arts and crafts, but to use these media as devices for the development of personal revelations regarding both staff and girls. We feel a meaningful start in this direction was achieved and our effort to perpetuate it is being operationalized in the form of a YWCA program on Friday afternoons which began on January 19, 1968. The activities involved are swimming, clay modeling, yoga, gym, and other possibilities as they develop.

Summer Job Program

Since most of the girls were interested in summer employment, a contact with the director of the neighborhood youth corps was made in order to establish a coordinated program between Y-MED and the corps. A plan was worked out whereby girls would work at the Y-MED for $1.50 an hour under the supervision of the staff at Y-MED. Necessary forms and criteria were organized and girls began to perform on designated jobs within the school. These jobs were under the supervision of two teachers, two nurses, and a coordinator. Girls performed such duties as secretarial, nursery aides, clinic aides, teacher assistants, and a team of girls reviewed and completed a list of paperback

books for a school reading center. The girls learned a great deal from this experience: deciphering and completing work applications and income tax forms, and securing social security numbers were new experiences for most of them. They recorded their own hours and made out most of the payroll forms.

From the foregoing, it must be obvious that the educational goals of Y-MED are based on the premise that learning is ultimately personal and individualized. Utilizing this approach, it can be stated that individualization through curriculum planning leads to determination of the skills and knowledge each girl possesses and guarantees that each one starts in her appropriate learning sequence. It also offers to each girl the opportunity to progress through the learning process at a rate determined by the girl herself, and by her ability to master the instructional material presented.

At the present time, the educational results appear to be most encouraging. Many of the underachievers have responded with gains of two to three years of skill with one year of instruction. Of the girls who reentered the high school program following delivery several months ago, 90% are still attending school. Nine additional girls completed requirements for their high school diplomas while attending Y-MED in June 1967, and a graduation was held at their request at the Y-MED Center. (It is estimated that no more than one or two of these girls could have graduated without the Program.) One anecdotal story

concerns a student who requested natural childbirth in order that she might take her final examinations at the hospital three hours following delivery.

Obviously, there have been some less encouraging results. A number of the girls have been so far behind in schooling and have educationally had such poor patterns of prior adjustment that a totally different approach to teaching has been found to be necessary. As a result, as has been mentioned, non-traditional programs have been, and are being, set up incorporating practical work, counselling and education to the degree which seems feasible and desirable for each of these girls.

PSYCHOLOGICAL SERVICE

The psychological problems which are encountered in attempting to adequately care for these girls are considerable. One, is dealing with the problem of a group of girls who have been exposed to deprivation in some or all areas of development -- deprivation, at least, from middle class standards. The girls have been underachievers educationally, truants, and often delinquents from society's point of view. Parents, where existent, have provided weak and confused standards. Often the structure of the family has been shaky, and the girls have been subjected to conditions of overcrowding and social interaction of a far different variety than that known to middle

class peers. Motivations, expectations, and aspirations are indeed very different. Ability to relate to possibly helpful authority figures is complicated by mistrust and by previous experiences which have revealed authority figures as not always being desirable of confidence. In addition, within the group, individual girls can be expected to have varying problems, often of major significance. The role of the psychological services, from the point of view of the girls, therefore, must be extensive and innovative.

In addition to the psychological services for an obviously high-risk class of girls, there is another area raised -- that of the complexity of evolving a program that can effectively meet the ideals and goals already mentioned. The possibilities of such effective results rest in the hands of the staff. Although the people administering and serving in a program may be dedicated to the enhancement of the social, emotional, educational, and physical development of the girls, their abilities to communicate and relate effectively are crucial for the success or failure of the program. It, therefore, seems appropriate to briefly report on some of the staff considerations encountered in the growth of the Program towards maturity.

It has been the hope that though a respectful orientation to the girls (namely, acceptance of them and their values at any point in time, and exposure to alternatives as well) that the possibility for identification with new models is enhanced

with resulting attitudinal and behavioral changes in all areas of development. The key phrase in the preceding statement is "a respectful orientation to the girls." This is difficult to achieve for it means that all members of the staff have to have insight, not only into the behavior of the girls, but into their own behavior as well. Unless this is done, none of the members of the staff can really give to the girls, but instead will use them to enhance their own status and position, or put more generally, to satisfy their own needs.

The psychological program at the Y-MED Center, therefore, exists to escalate the communication possibilities between the staff and the girls. This can be done in part by providing a variety of services such as consultations on "problem girls", psychological testing when necessary, direct psychotherapeutic intervention, or the development of referral machinery for such possibilities. All this helps the staff understand the girls, but this is not enough. The staff has to understand itself -- each person has to be self-conscious, each has to always ask "what do I want and why do I want it?" Unless each staff person can be sensitive to himself, the possibility of being sensitive to the girls' needs is seriously limited. To meet these needs an attempt is made to create a climate for frequent, open and nondefensive communication. Each staff member is responsible to every other. No one is or should be outside the realm of praise for a task well done, on the one hand, or

of a critical orientation to an incident of insensitivity on the other. Some of the insights regarding staff interactions come out of the staff meetings that are held at the Y-MED Center weekly. But some of the most significant information has been gathered by paying special attention to what might be called the "grapevine" -- passing comments at lunch, in the halls, discussions after hours, and the like. This is to be expected since there are always some discrepancies between the appearance (the rather formal situations in conferences) and the reality (the wider matrix of ongoing events and experiences) which often go unmarked in the press of time and immediate crises.

In the Y-MED Center when fruitful relationships between authority figures and adolescents have broken down, the needs of the adolescent often become secondary. In the process the relationship needed by the girls may be lost. The girls may be thrust back into a familiar pattern. Their family lives have been marked by a lack of clear and meaningful communication with their parents, and their substitute for that has been a distinct subsystem among siblings. If the staff member has to retreat from a warm and effective relationship with the girls, the girls draw back to the more familiar system which has operated in their lives to the present time. The authority figures are usually unaware that their ineffectiveness is directly proportional to the difficulties they are experiencing. In the staff meetings, issues such as these are repeatedly

brought up. Difficulties in communication between one professional member and another are probed. Attempts are made to explore conflicts between staff members, to iron out interpretations of individuals' roles and to share knowledge about observed aspects of the girls' behavior with one another. Consultants are encouraged to work more closely with the girls. Roles are often redefined. Although on a day-to-day basis feelings of discouragement may occur, there has been a gradual picture of a sensitive and dedicated staff ironing out their own problems and slowly taking the steps which make them more effective as administrators, teachers, social workers, and clinicians. Thus, what may in actuality be described as staff group therapy, appears to have positive bonus allowing more effective overall care for the individual girls.

Our effort then in the Program has been to weld together persons from a variety of disciplines who are capable of working together as a team. At the beginning of the Program, there were just a few of us and we were able to work out differences with one another quite readily in group meetings. We all felt intimacy and common purpose at that time. In fact, you could say that the staff was organized to some degree like a family. There were definitely figures who by their leadership role were the grandparents of the girls. These people are primarily the authors of this paper. The staff members seemed to be the offspring of the leaders and the parents of

the girls. The girls themselves were the children of the staff. Initially, these family perceptions seemed both structurally and functionally valid, both from our point of view and the point of view of the girls. But as we went along, as the Program gained momentum and more people became part of it, the family concept was more difficult to maintain in its original form. With growth comes, out of necessity, detachment. Small groups within the large group with a common purpose begin to band together. This is not necessarily bad but only represents testimony to the realities that come with expansion. Further, we see a staff who by their very insistence on their own grouping reveal the fruits of the efforts of the leadership. There has developed a real desire in this group to break away from a dependent status and take responsibility for policy development and program planning on their own. The interactions with the leadership is similar in some ways to a rebellious adolescent in his effort to bridge the gap between childhood and adulthood. The danger we see for the leadership is the tendency toward prohibition of this kind of expression on the staff's part. It is one thing to have worked out a set of rules that have been effective and by which all the family abides. But it is quite another thing to perpetuate these rules in the face of change. What was right a year ago may not be right now. We have to always be alert to the possibility of the leadership stifling creativity, new ideas, and criticisms, for the sake

of maintaining the status quo or comfort level. If this is overlooked, the family will slowly extinguish itself by its own inbreeding. It is the leadership who has this responsibility and it is the leadership who has to always be concerned regarding the motivations leading to its decisions concerning staff. As much as the girls desire and deserve a respectful orientation mentioned earlier, so does the staff. Their characters, personalities, defenses, ego developments, may not be the same as the leadership's but what may be the same is their common purpose -- their sincere desire to be in the Program and to be part of the decision making process. It is vital that the leadership keep communication channels open. Even with expansion and resulting detachment, it is possible for a level of intimacy to be maintained. Groups can share with other groups as individuals can share with individuals. It is the conviction of the authors that while we have had our morale problems as have all other programs, that we see these problems in a dynamic context. They are symptoms of conflict and frustration and we always ask the question from whence come such behavior? Once we have focused in on it we try to share it with one another with the hope that through open communication will come resolution. In general, this has worked for us so far. But there have been instances where staff members could not comprehend our Program and could not function as an integrated team member. Confusion and hostility developed and in such

instances separation of these members from the Program was inevitable and came to pass.

Since communication channels between staff members seemed to be relatively more open, it became appropriate to consider the development of direct service programs for the girls. In our staff meetings it was common to hear that a number of issues were discussed informally by the girls of great import to them. These were such things as parental attitudes towards pregnancy, foster home care for the baby, the legal or ethical responsibilities of the father, etc. Since the girls were discussing these issues among themselves, their concern was rather clear. It was felt that a formal forum for such discussions might help them more effectively clarify their position on these matters, as well as open up the possibility of consideration of other issues regarding themselves and their relationships to others. It was further felt that we in many instances, because of our own need to succeed, assume that the girls perceive the Program the same way we do. It seems reasonable then to meet with the girls, not only to help them better understand themselves, but as well, to permit all of us in the Program to get a clearer view of their perceptions so that service could be geared more effectively in terms of their stated needs. With these two goals in mind then -- self-examination and program development -- a group therapy program was begun in March 1967. There were four group leaders -- the director of psychological

services, a psychiatrist, an intern who was spending six months on psychiatry, and a social worker. The groups met on a once-a-week basis within the Y-MED building, and each had a total enrollment of eight girls. The project generated many problems that we had not anticipated -- problems of attendance, problems associated with grouping girls at various stages of pregnancy, problems of working with an open group, problems of having some girls assigned to group therapy and some not, problems of motivation regarding both girls and group leaders, problems of confidentiality, problems of staff attitudes towards the Program, and problems of termination by group leaders.

There is reason to question the wisdom of such a program. It must be remembered that the girls did not directly ask for it. It was created for them out of what we felt was our sensitivity to their need. This is quite different from traditional group therapy, where the participants are there because they want to be. On the more positive side, however, all of the group leaders found a nuclear group within the group. These were the regulars and they seemed to feel that there was profit for them in the meetings.

It can be said in general, however, that we reached very few of the girls through our initial effort. The reason for this was our own inflexibility, or insistence on the traditional therapeutic model, and the demand that the girls meet our needs. In other words, the program we developed for them was designed

basically for us. We were only visible during the allotted fifty minutes; the therapists dutifully asked -- "What shall we talk about today?" -- and at appropriate moments made efforts to reflect, clarify, and/or interpret. It went over like a lead balloon for most.

What we soon came to recognize was the difficulty we were having in perceiving these girls as anything but mature women and expecting responses from them related to such perception. It was very difficult to think of a girl as chronologically, emotionally, and intellectually fourteen, when her big belly hit us in the seat of our respectability and caused us to transform this child into a white, middle-class woman, chronologically, emotionally, and intellectually much older who had made a mistake but through the benign offerings of psychotherapy would be saved. If the girls needed anything, they needed structure and direction and within such a framework would most likely be capable of some self-examination. We provided none of this in our initial attempts.

Another insight that came to us, but one that should have been more obvious, was that the girls did not know us and therefore did not trust us. We plunked ourselves in their midst and asked them for their confidence. Remember they did not solicit our help, we imposed it on them. In some of the early sessions with girls they wanted to know many personal things about us, about family, about work, about attitudes concerning

race relations, about the Y-MED Program, etc., the inside stuff. In other words, they were saying "reveal yourselves." We made the effort but it was insufficient. Several of us on the staff really came across when we went to the summer camp. We sang on the bus, played a good game of pick up sticks, the senior author went in swimming smoking a cigar and was told off by the water front counselor for littering. There is no doubt that trust does not come by fiat.

This year we tried to profit from our mistakes. We decided we would conduct a psychology lecture series to be held every Wednesday afternoon. This series would be a class and the leader would be responsible for the presentation of a topic of interest to the girls. The leaders would be the psychological staff and we would rotate our participation. The topics to be discussed would emerge out of the sessions. So far they have been devoted to the effects of heredity, the reasons for intercourse, the reasons for pregnancy, the reasons for marriage, and future presentations will concern themselves with issues such as surrender, adoption, abortion, rape, infant development, divorce, mothering, etc. In each of these meetings, the leader makes a fifteen minute presentation and the discussion usually follows. All the girls are required to attend; it is part of the educational program and it is within the school day. We feel this approach has considerable merit. It is a structured activity that the girls seem to need. As they get to know us the need

for structure lessens and more interaction emerges. The girls are getting to know the psychology staff through the lectures and some are now beginning to look for individualized help from the leaders. The areas discussed come from the girls, thus interest in the topics is quite high.

Another area of direct service in which the psychological staff participates is the intake process. The effort is to utilize both interviews and testing procedures to determine intellectual and personality assets and liabilities. The testing devices include both psychometric and projective techniques. The findings of such an evaluation are transmitted in a regularly held case conference and such findings are amalgamated together with those of other members of the intake team representing the disciplines of obstetrics, pediatrics, social service, and education.

Psychological consultation is offered on a regularly scheduled basis to any of the Y-MED staff members about any girl that is presenting problems of sufficient intensity to motivate a staff member to solicit the consultation. Also curbstone consultations are more the rule than the exception.

Regarding treatment, the psychological staff meets with the girls on an individual basis for counselling as the girls demonstrate some need for it and willingness to accept it. The staff is available on this basis for girls in the Program and for those who have returned to school but still desire a

therapeutic contact. Further, the psychological staff functions as leaders in group therapy for those girls who desire such a contact. This possibility is available for the girls enrolled in the Program and for those who have left Y-MED but need and want to continue group contact. The fourth area of activity for the psychological staff is research. The staff is encouraged to develop projects on their own as well as to participate in ongoing projects where particular talents would be relevant.

There is little question that the psychology program specifically and the whole Y-MED Program in general has to be appraised by some objective methodology in order to determine whether the stated goals are being achieved. So far our approach at Y-MED has been largely on humanistic grounds. We felt a need existed and we tried to fill it. How successful we have been and are in doing it is another question and raises some basic issues.

We are all aware that within the last six or seven years there has been a tremendous proliferation of new action programs in our society, financed mainly through governmental agencies at the federal, state, and local levels. Many of these programs have been termed demonstration programs -- they demonstrate that a problem exists, can be tackled and licked, and then try to show the way. But, none of these programs can exist by themselves or stated another way they cannot operate within a community vacuum and those that do generally fade away. At

Y-MED we are very definitely reinforcing certain kinds of behavior in the girls and many are responding positively, most likely out of their identification with us. Assuming that this happens to all of the girls and there is as a result behavioral change, the question can be raised -- Will such a change persist if these behaviors are no longer reinforced? This lack of reinforcement may be exactly what will happen when the girls leave the Program and possibly accounts, at least in part, for our observation that they become depressed or begin to act out after having delivered the baby. Our job at Y-MED then is not to be content with what is going on within our walls, but to try to promote the same attitudes towards the girls within the community that exist within us. This calls for education programs for educators, for parents, and for the girls as well. In other words, Y-MED must represent the base for the development of attitude change for not only the girls but the community too.

It did not take us long then to realize that we had to devote as much effort to an aftercare program as to a direct program for the girls while they were pregnant. Working with this group of girls brought to the fore dramatically the inequities of the society -- the channels for mobility into the middle class were choked off for most. In all areas of life -- education, employment, medical care, the right to legal counsel, etc. a "second class" concept was very apparent. We

felt our rehabilitation concept had to be more total than just providing needed services during the pregnancy and that we had a responsibility to try to jar open the closed channels. The whole posture of Y-MED is that of a day care treatment center for troubled adolescents. It so happens that we are presently dealing with one symptom of trouble -- pregnancy. It is our hope that in the future and we are already developing plans for it, service to the nonpregnant adolescent will become available.

Our efforts so far have made available to the girls, full tuition scholarships for those eligible to both Syracuse University and Onondaga Community College. Negotiations are underway for scholarships at the business schools in the area as well. Those girls with available skills are being assisted in finding jobs through the Manpower Development Training Act and the State Employment Service. Legal counsel is available to represent and advise the girls in areas where discriminatory practices are discovered such as in housing, welfare eligibility, and even in the sphere of school exclusion. The whole question of the violation of civil liberties and civil rights is inherent in the exclusion of a girl from public school because of pregnancy, and in the providing of separate but equal facilities. Some of our staff have become concerned regarding this situation and these people, on an individual basis are attempting to determine the relevant courses of action to pursue regarding this matter.

Many of the girls when they are ready to leave the Program decide, in many instances through their relationship with various staff members, that supervised apartment living would be in their better psychological interest than return to their former environments. Efforts are underway to secure a building for such purposes through the Syracuse Housing Authority and once obtained, we plan to hire neighborhood couples and train them as house parents for these apartment units. These parents will be salaried and be part of the Y-MED staff. At the present time a girl who does not want to go back home, can only be placed in a foster home or in unsupervised housing.

POLICIES

Research

There was no formal research program during our first two years of operation. Only recently have inter- and intradisciplinary projects been started but no systematic approach to program evaluation has been undertaken. The reason for this was simple. The first years were years of survival. The crucial question was "Could the Program exist?" I think it is fair to say that the odds were against us. While there was some, there was no great support for a program of this nature from either the professional or lay community. We as staff were basically ignorant of medical, social, educational, and psychological problems that we would encounter with the girls and had to learn on the job. We as staff had to determine for ourselves

where we stood on a variety of issues, such as racial prejudice, class prejudice, birth control, premarital sex relations, and placing children for adoption. Differences between staff members on these issues definitely emerged and had to be dealt with. From day to day new program needs became readily identifiable -- we needed a program for the fathers, a program for the parents, an aftercare program for the girls and their babies. The need for more professional personnel became apparent as well as counselling services for the girls both personal and vocational, and also extended pediatric care. The legal rights of the girls had to be explored and constant open communications with parent agencies such as the Board of Education, the Department of Health, and the Upstate Medical Center had to be maintained. All this meant survival and it is to these issues that all our energies were devoted. We can now say that the Program has survived. It is now important to ask--"Is it effective?" It is to this end that much of our energy will be devoted in the coming year in the form of a systematic assessment of our Program as a whole.

While we feel that such assessment is mandatory, we at the same time feel that research in the Y-MED Program is an activity that has to be considered as thoughtfully as any other aspect of the Program. We have thought long and hard over this issue mainly because we have been relatively bombarded by researchers from outside the Program who have interest in gathering data on the particular population we house.

After much deliberation, our formulated policy simply stated is that we would consider research proposals that could be meaningfully integrated into the overall service aspects of the Program. We feel that the task of trying to develop a program for a group of unwed pregnant adolescents from low income families many of whom are Negro is a touchy one. The going has been tough for us and we feel we are justifiably protective of the Program as it has developed to this point. Our effort is to try to demonstrate to a community that even though a girl becomes pregnant out of wedlock, she remains capable of making a meaningful contribution to society. We feel that this goal is best achieved by trying to communicate to the girls our interest in them by providing them with the services they need such as education, obstetrical care, social service, pediatric service, psychological services, nutritional advice, etc. We feel that these services are now being dispensed by a group of sensitive professional people welded together by a common purpose. The girls and their babies, therefore, at least in our eyes, do not represent sources of data. The girls are sensitive to this issue, mainly because they have been "herded" most of their lives.

We hope that these remarks will not be misinterpreted as a wholesale dismissal of the experimental method or of an inability on our part to tolerate evaluation from an outside source. We believe that the scientific approach has limitations of

scope but we also believe that the methods of self-understanding and empathic observation and participation are inadequate when not used in conjunction with controlled investigation and replicable means of validation.

It seems to us the researcher is doomed if he expects to shed light on the intricacies of human behavior by dipping into "subject pools" rather than creating the conditions for cooperation. The best conditions in any particular instance will inevitably depend on the sensitivities of both the researcher and clinician working collaboratively for new knowledge and effective rehabilitation.

Publicity

Another area that causes us much concern is publicity and we have had to develop policy on this matter as well. Our Program has become inordinately attractive to the news media, and we have had requests for releases from both the local press and national news wires. Local T.V. has expressed great interest as well as national magazines. We have been criticized in some quarters for our "no publicity" position. This is not our position. We feel that there is every relevance in communicating to both our own community and the nation our philosophies and methods regarding these girls. It is through such effort that the possibility of attitude change or reeducation may evolve. But for us the key word in publicity is "control." We want control. We have been burnt too often too badly by

press releases that totally distort the objectives of the Program. One of our nation's most respected and influential newspapers had as their lead over a Y-MED story -- "Group Gives Birth Curb Data to Schoolgirls" and the story was devoted mainly to the point that our girls do not become pregnant again after they enter the Program. First of all, this is not true and second of all, insistence on effective contraception is not a basic objective of our Program. There are other examples but we see no need to press the point. We are opposed to exploitation. We feel that our best publicity is through two devices and each permits us to retain control regarding what we say or write. The first would be to consider T.V. and/or radio presentations about the Y-MED Program but only those where the staff itself could represent the Program. The second would be the presentation of our data to scientific audiences through journal form or in scientific meetings. Our first article was published in the New York State Journal of Medicine and we have had over two hundred reprint requests from throughout the country -- many indicating their desire to develop programs such as ours in their own communities. To assist in the development of other programs throughout the nation is one of our stated goals, and we feel that the policy we have taken regarding publicity is leading us towards it.

Abortion

Our policy on abortion is in the process of being formulated. Thus the following statements do not necessarily express the sentiments of all of the staff regarding this matter. Further, the statements to follow are ones of intent rather than existing procedure.

Our position at Y-MED is, as has been previously stated, girl oriented. We feel a responsibility to present the facts about abortion and to assist the girls in integrating these facts through the counselling process. We try to refrain from insisting that their decision be consonant with our own beliefs, but this is easier said than done because many of us are emotionalized on this issue. Consensus is hard to come by but we hope that through our staff group process outlined earlier, that a meeting of the minds will come to pass.

As of this writing, our tentative plan is to present to the girls in both group and individual meetings the law regarding abortion in New York State, the penalties for violations, the medical procedures involved, and the medical risks that exist. In addition, the moral, ethical, religious, and economic factors will be considered with them. All this will be designed to help the girls exercise options emerging out of practical and rational considerations.

Our approach then is toward the individual and the decision regarding abortion, or for that matter contraception, surrender,

adoption, or what have you, is basically the girls to make with the help of a staff member who has some grasp of the biological, psychological, and cultural interplay in each instance. In other words, for us it is not a matter of should she or shouldn't she have an abortion. It is a matter of helping the girl become aware of her needs and the barriers that exist, that interfere with their satisfaction. It is our belief that through this process the girl is better able to realistically perceive herself within an existing social context and make her decisions on the basis of these perceptions.

We are opposed then to policies that rule out the exercise of individual options based on rational considerations. For example, we have heard the argument that the solution to the girls' pregnancy is more relevantly economic than it is psychological. Put more concretely, if each girl was given the sum of money it takes to finance her through Y-MED she could obtain an illegal abortion by competent personnel. Such a procedure would eliminate her school dismissal and would also relieve her of social ostracism and ridicule. We at Y-MED do not support this solution. First, it violates the law and we are committed to the value that a major method for the preservation of the society is through due process. We are unhappy with the existing abortion laws but encouraged by the fact that major revisions are being considered in the present session of the legislature

and are prepared to contribute to these deliberations. Second, the solution is rejected because of its unilateral nature. It is a solution for all the girls who become pregnant. Choice is eliminated. The exercise of option is the value to be preserved. If the girl wants to discuss abortion, she would be advised regarding the issues involved but the decision is hers to make along with the financial responsibility.

We feel that abortion is a fact of life and as such should be out of the shadows and dealt with honestly and explicitly -- with staff as well as the girls.

SUMMARY

The preceding sections of the paper have attempted to describe the operation, goals, and beginning achievements of a program designed to assist pregnant adolescents and their infants, especially those from low socioeconomic areas. The Y-MED Program, sponsored by Syracuse and Onondaga County appears to be unique in several aspects. In operation for two years, it has attempted on an integrated basis to meet the medical, social, educational, and psychological problems of teenage pregnant females in a comprehensive manner. The Program has attempted to offer all of its services comprehensively under one roof. No girl has been turned away, regardless of the complexity of her educational, intellectual, social, and psychological needs.

Each part of the Program has innovated experimental approaches to patient service and has stressed the individual needs and desires of the girls. The medical aspects of the Program have encouraged individual doctor-patient relationships, with the patient knowing her doctor throughout the pregnancy and realizing that he will be present at the time of delivery. Appointments have been encouraged. A clinic-type atmosphere has been eliminated. Socially, an attempt has been made to deal with almost overwhelming problems. New and different solutions for preexisting problems have been presented to the community. Attempts are being made to create avenues for adoption and foster home placement for a group previously denied such benefits. Techniques of child-rearing have been stressed. Educationally, a great deal of flexibility has been encouraged. Education has been promoted within a system most closely resembling individual tutoring. Whatever the background and present capacity for function, each girl has been encouraged to achieve to the maximum of her ability. Goals ranging from salable skills to college education have been fostered for girls within the Program. Psychologically, a major attempt has been made to encourage staff maturation and security, as well as services for the girls within the Program. An attempt has been made to interpret feelings and philosophy which would adversely influence the Program and impede the progress of the girls.

At the present time, the results of the Y-MED Program appear most exciting. On all levels, progress seems to be apparent. More intensive medical care has been achieved both for mothers and for infants. In spite of frequent medical complications of a somewhat minor nature, serious problems have been averted, and there has not been a single perinatal mortality. Infant development to the present time appears to be proceeding without the anticipated problems which the literature has suggested. Girls seem to be adjusting to school. The overwhelming majority appears to desire further education, and a significant number have completed high school even though they probably would not have experienced such success without the present program. Some of the girls within the Program are even indicating aspirations for higher education.

For many of the girls on a combined basis, opportunities have been made available which previously did not exist. Adoption and foster home placement have been made more accessible to nonwhite mothers. Social and psychological counselling have assisted individuals in their progress toward autonomy and maturity. As progress has been made, however, multiple problems for future growth have become apparent. Still further approaches to education have begun. Attempts at starting a program for nonpregnant adolescents are underway. Possibilities for sheltered living arrangements for mothers and/or infants will be solved in the not too distant future. A fathers' program

has begun and a nursery for the infants up to the age of three is at the funding stage. Policy statements on such matters as research, publicity, and abortion have had to be thoughtfully developed and has taken genuine team work. The going is at times rough. At the present time, however, at least it can be stated that a major positive step has been taken with extremely exciting early results.

REFERENCES

1. Adams, H.M. and Gallagher, V.M. Some facts and observations about illegitimacy. Children, 10:43, 1963.

2. Battaglia, F.C., Frazier, T.M., and Hellegers, A.E. Obstetric and pediatric complications of juvenile pregnancy. Pediatrics, 32:902, 1963.

3. Drillien, C.M. The growth and development of the prematurely born infant. Baltimore, The Williams and Wilkins Co., 1964.

4. Osofsky, H.J., Hagen, J.H., Braen, B.B., Wood, P., DiFlorio, R. Problems of the pregnant schoolgirl -- an attempted solution. N.Y.S. J. of Med., 67:2332, 1967.

5. Osofsky, H.J., Braen, B.B., Florio, R., Hagen, J.H., Wood, P. A program for pregnant school girls -- a progress report. Adolescence, in press.

6. Pasamanick, B. and Knobloch, N. Retrospective studies on the epidemiology of reproductive casualty: old and new. Merrill-Palmer Quarterly of Behavior and Development. 27:7, 1966.

7. Sarrel, P.M. and Davis, C.D. The young unwed primipara. Am. J. Obst. and Gynec. 95:722, 1966.

8. Stine, O.C., Rider, R.V., and Sweeney, E. School leaving due to pregnnacy in an urban adolescent population. Am. J. Public Health, 54:1, 1964.

9. Vincent, C. Unmarried mothers. New York, Free Press of Glencoe, 1961, p. 308.