13. Barbara Gomez-Day, "Hispanic youth and education", chap. 4 in *A profile of Hispanic youth*, Youth Knowledge Development report 10.2, Office of Youth Programs, HEW, April 1980.
14. Bureau of the Census, final report PC(1)-C1, United States Summary.
15. Department of Commerce, *Persons of Spanish origin*, table 5, p. 7.
16. Josefina Card and L. Wise, "Teenage mothers and teenage fathers: The impact of early childbearing on the parents' personal and professional lives," *Family Planning Perspectives* 10, no. 4 (July/Aug. 1978): 199–207.
17. Alan Guttmacher Institute, "Annual Report: 1976" (Washington, D.C.: Alan Guttmacher Institute, 1976), pp. 3–5.
18. Ibid.

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Bringing in the Family: Kinship Support and Contraceptive Behavior

Frank F. Furstenberg, Jr.,
Roberta Herceg-Baron,
and Jay Jemail

Though social programs are usually based on a presumption of empirical knowledge, it is no secret that research typically follows, rather than precedes efforts at social intervention. More often than not, social scientists are called in to assess the impact of an existing programmatic initiative, and are asked to render a judgment about the wisdom of a particular course of action *after the fact*. Only rarely do they take an active part in planning the experiments that they evaluate.

The case study presented in this paper represents an exception to this general rule. We shall review the development of an experimental program to involve family members in the provision of family planning services to female adolescents. The program, "Kinship Support for Adolescents Enrolled in Family Planning Programs,"[1] grew directly out of research conducted by one of the authors and reported on at the Conference on Teenage Pregnancy and Family Impact, sponsored by the Family Impact Seminar in 1978. Because it is too early to talk about results, this paper will trace the intellectual origins of the Kinship Support Program, and provide some preliminary observa-

tions on its implementation. We will relate some of the incipient and unanticipated findings about a program that:

- modifies the conventional family planning service setting to allow more opportunities for counseling and other supportive services for adolescents;
- implements a prospective evaluation design within the family planning setting; and
- enhances family planning counselors' skills to work with families and broadens their counseling roles.

The Origins of the Program

As described elsewhere in this volume, awareness of the influence of the family on adolescents' contraceptive behavior initially emerged from a longitudinal study of adolescent childbearers in Baltimore a decade ago. One of the first findings of the Baltimore study[2] was that most adolescents took great care to conceal their sexual activity from their parents. The adults, in turn, professed ignorance that their daughters might be engaging in sexual relations, even though they acknowledged that most adolescents in their neighborhood were sexually active. Thus, it seemed as though many mothers and daughters entered a mutual "agreement of nonrecognition" that was violated only when the teenager became pregnant. In accord with this pact, most teenagers regarded intercourse as spontaneous and uncontrollable ("It's something that just happens"); and parents provided little in the way of preparation for the eventuality of coitus ("Be sure not to mess around.").

When families departed from the strategy of concealment by openly acknowledging that relations were occurring, and accordingly made some effort to impart information about contraception, there was a noticeable improvement in the teenager's use of birth control measures. Adolescents were more likely to use contraceptives and had greater success in delaying conception when their mothers knew that their daughters were sexually active and talked to them about using birth control.[3] Recent research, most notably work by Greer Litton Fox (see Chapter 3), has provided evidence corroborating this finding. (See also the perceptive ethnographic study by Rains.)[4]

In 1978, at the conference sponsored by the Family Impact Seminar, papers presented by both Furstenberg and Fox noted the paradoxical effect that occurred when parents restrict communication about sex (whether due to discomfort or disapproval); there was a marked increase in the risk that their daughters would not use contraception when they engaged in sexual intercourse. Both researchers observed that sex education and family planning programs that do not allow for parental participation may be removing an important influence on the adolescent's sexual socialization. In their summary of the conference proceedings, Ooms and Maciocha conclude by advocating that public and private agencies make parents "full partners in both preventing and coping with teenage pregnancy."[5]

During the same period that the final report of the conference was being prepared, Furstenberg served as a consultant to the Family Planning Council of Southeastern Pennsylvania, a private nonprofit organization that coordinates family planning programs in the five-county Philadelphia area. Under the direction of Dorothy Mann, Executive Director of the Council, a plan was developed to improve family planning services through selective research and training projects. In the course of working out some of the details of the plan, Furstenberg participated in a series of meetings and conferences in which family planning service providers and researchers exchanged observations and ideas. The tenor of these meetings was invariably frustrating. Practitioners looked to researchers for effective ways of serving the adolescent population; researchers had little to offer in the way of practical suggestions.

In the spring of 1979, Furstenberg approached the Council with the idea of designing a program to counteract the tendencies of families to isolate the sexually active teenager. With

Furstenberg's assistance and input by several staff members, Roberta Herceg-Baron, research analyst at the Council, drafted a proposal that was submitted to the Office of Family Planning at the Bureau of Community Health Services within the Department of Health, Education and Welfare. Three months later, the Kinship Support Program was funded.

Program Design and Objectives

The primary objective of the program was to build family support for contraceptive use among young adolescents, those under age eighteen, who enrolled in family planning programs. We need to clearly state at the outset that we were only interested in obtaining family support with the voluntary agreement of adolescent clients. We, as a team, do not believe that informing the adolescent's parents should be a required condition of receiving services at family planning clinics. The proposal described a two-stage process for reaching this objective.

First, experienced family planning counselors from participating agencies would be trained to work with the families of adolescents who sought family planning services. It was recognized that most counselors would probably not feel comfortable or competent to work with families (particularly parents) unless they were given a background in family counseling. Thus, the main objective of the training program was to provide skills for family planning counselors who had previously worked individually with adolescents, enabling them to reach out to family members who might provide support to the adolescent who sought contraceptive services. The basic assumption was that the adolescent's family could become a significant support system, enhancing her ability to use contraceptives successfully if they accepted her sexual behavior and reinforced her decision to use birth control. We recognized that peers, health, and other social service agencies, and other socio-cultural factors also play a significant part in the adolescent's sexual development. Even so, in the training program, we emphasized the family network

as being capable of attenuating or accentuating the impact of these other factors on the adolescent's life.

In the second stage, after counselors had completed the course of instruction, a carefully designed research program was to be implemented in each agency. The purposes of the research program were to: (1) measure the amount of support provided to the adolescent seeking contraception by various family members; (2) determine whether family support could be enhanced by having discussions first with the adolescent alone and then together with designated family members who might be able to provide assistance to her if and when she encountered difficulties using birth control; (3) ascertain whether contraceptive effectiveness was improved when barriers to sexual communication within the family were reduced; and (4) determine whether secondary effects such as improved contraceptive use and reduction of unwanted pregnancies among other members of the family might result from their participation in the program.

Details of the research design have been described elsewhere[6] and will only be summarized briefly in this paper. We planned to recruit enough staff to provide services to 300 families. After an initial session, the adolescent and at least one member of her family would meet with the trained counselor for up to six sessions to share problems relating to sex and contraception. The aims of these sessions were to deal with potential conflicts, reduce the atmosphere of secrecy, and devise strategies for rendering assistance to the adolescent in the event such aid was required. Two types of "control" services were developed to provide a baseline for measuring the independent effects of the program. A group of 150 adolescents would receive frequent telephone contacts by clinic staff for a similar period (about six weeks) to assist the adolescent in her use of birth control, but with no specific encouragement to guide communication with the family. A third group of 150 adolescents would receive no additional support services aside from those provided through the conventional services offered in family planning programs

for teenagers. Assignment to the three groups would be random, and all adolescents would receive the conventional family planning services upon first entering the clinic. Research assistants would interview each adolescent seeking birth control, and agreeing to participate during her first visit to the clinic. A series of follow-up interviews would be conducted six, twelve, and twenty-four months after enrollment. By comparing the groups of adolescents who received family support counseling to the groups who were exposed to the two "control" services, we hoped to determine the relative effectiveness of each of the three programs on the adolescent's contraceptive experiences and her ability to avoid unwanted pregnancies.

Selection of Program Sites

Using public funds from state and federal sources, the Family Planning Council of Southeastern Pennsylvania supports and coordinates comprehensive family planning services provided by twenty subcontracting family planning agencies. From this pool of agencies, six were selected for the program. The agencies included two hospital-based programs, two freestanding clinics, a community health center and a public health service. Selection of these agencies was based on the following criteria:

- *size of teenage population*. We sought to include programs that serve a large adolescent population. Adolescents under eighteen years old comprised 15–25 percent of the client load in each agency.
- *type of clinic*. We wanted to include a variety of agencies so that the results of our study could be generalized to various service settings that are supported in whole or in part by public funds.
- *characteristics of clientele*. By establishing a multi-site project base, we expected to find a good distribution of potentially relevant characteristics in the research population such as socioeconomic and racial status, variations in family structure, and pregnancy experience.

- *experienced counselors*. We required that programs selected for participation have one or two experienced family planning counselors available for the intensive twelve-week training program in intergenerational family counseling skills. Our interest was to upgrade the skills of these family planning counselors so that they could provide the service components we wished to evaluate.
- *interest in the project*. We selected programs where there was an interest in developing a family involvement program for adolescents. Many of the selected sites had experienced an increase in the number of family members accompanying adolescents to the clinic.

Recruitment of Agencies

A letter describing the project and inviting participation was sent to administrators at each of the six agencies. The letter described several direct benefits of the project to the agencies:

- One or two staff members from each agency would receive training, supervision, and experience in the techniques of family counseling. Agencies could thus provide this service to adolescents even after the study was completed.
- Since the design of the study would be longitudinal, the agencies would have data on their adolescent clients over a two-year follow-up period. The data would be useful in understanding the effectiveness of a variety of support services for adolescents, as well as providing important information on what happens to adolescents during the two-year period following the first clinic visit.

The administrators all responded to the invitation with great interest; and a meeting was arranged to discuss the program.

Introducing the Program—Concerns of Clinic Administrators

The response of the administrators was encouraging but tempered with several areas of concern: (1) how to involve family members in counseling sessions with adolescents; (2) barriers to implementing the program in family planning clinics; and (3) problems associated with conducting on-site program evaluation.

Involving the Family

In listening to the perceptive observations and apprehensions of the administrators, we were compelled to recognize the delicacy and difficulty of the project we had undertaken. The following comments are typical of the concerns which the administrators brought to our attention:

- To what extent should family planning agencies get involved with a program that not only advocates the family's knowledge of the teen's visit to the clinic, but attempts to bring about parental involvement as well?
- Is it possible that teens won't come to our clinics once word is out that we're asking them to bring their mothers or aunts or grandmothers?
- Is it realistic to expect that teens will even want to bring their families to these counseling sessions? After all, six weekly counseling sessions represent a big investment of time—not just ours but theirs too.

These comments originated in part in a legitimate concern for the privacy of adolescent clients. Although minors residing in Pennsylvania can receive medical services and contraceptives from family planning programs without the consent of their parents, the issue of parental consent requirements for family planning and abortion services is being heatedly debated throughout the country today. Within this context, it is not surprising that family planning service providers would worry about preserving the adolescent's free access to contraceptive services. Historically, family planning advocates have fought difficult battles to increase general public acceptance of birth control services. From their perspective, the latest battle lines have been drawn to protect the adolescent's access to these services.

Thus, some of the clinic administrators raised the possibility that our program might not only be unpopular with adolescents, but might be perceived by adolescents as requiring parental consent to receive services. This concern led us to develop careful procedures to ensure that adolescents not feel coerced to participate in the program. Hence, the Kinship Support Program was designed to be an optional support service that the adolescent would be offered upon her initial visit to the clinic. Her participation in the program would be strictly voluntary.[7]

There were other reasons as well for reassuring that the program would not have an undesirable impact upon adolescent recruitment into the clinics. First, not all adolescents would be offered the family counseling services; rather, half would be offered one of the two "control" services, thereby limiting the total number of teens invited to participate in the family-oriented service. We would not insist that adolescents randomly assigned to receive counseling services bring a member of their household to the counseling sessions with them. If they objected to the idea of including a close family member, they could instead designate a surrogate, such as a distant relative, a friend, a neighbor, or a boyfriend, to attend the sessions with them. Thus, a family member or some other support person would become involved in the counseling only at the invitation of the adolescent. The family planning counselor would be trained to facilitate this process of recruitment by the adolescent. Should no support person attend the sessions, the coun-

selor would meet with the adolescent and counsel her individually, but with a focus on the social resources and support systems currently available to her.

In response to the administrators' questions regarding the acceptance of the family counseling program among adolescents, we could only point out that we, too, were unsure of its success. Research studies indicate that this program might be an appropriate service option for some adolescents. How many and for whom, we did not know; the program was designed to explore this question. Unless they were put to the test, we would never be able to ascertain the extent to which family support systems might be utilized to help prevent unwanted pregnancies among adolescents.

Modifying Services

Other administrators helped us to see the barriers that might mitigate against implementation of the program in their agencies:

- Sure, we want to expand our services for teens, particularly if we can offer them more counseling, but can we really fit an expanded program into the way we now give our services?
- We can't spend a lot of time counseling the teen because she has to get services not just from our counselors, but from the medical staff as well.
- There's really no time to do additional counseling during the clinic and certainly there's no space.
- This program would mean redefining the job responsibilities of our family planning counselors so they can do the more in-depth counseling required by the program. Is this type of program really feasible in our clinic settings?

Essentially, the problem they raised was one of limited resources (particularly time, space, and personnel) for modifying

family planning service delivery to include more in-depth counseling. The resistance to service expansion of the type we proposed was partly a result of the way services have traditionally been provided in family planning programs. Contraceptive services are provided in a context that is based on a medical model of service delivery. Clients are offered short-term medical services and counseling assistance with the expectation that the "treatment" (dispensing a contraceptive method) will result in long-term benefits (avoidance of an unwanted pregnancy). However, there is little flexibility in this type of medical service program for client follow-up outside of medical emergencies. The service routine typically does not provide for ongoing contacts with clients unless initiated by the client. Ordinarily, efforts are not made to maintain relations with the client once it has been ascertained that they have not encountered medical problems in using contraception.

Our program was predicated on the assumption that follow-up was essential to effective service delivery. Thus, it was necessary to negotiate separately with each of the administrators how to integrate the proposed program with the medical service model at their clinic, since resources, patient flow, and clinic schedules varied among the sites, thus generating different implementation problems.

The administrators tactfully reminded us that they were under considerable pressure to meet the external demands of large patient loads, to juggle personnel to respond to staffing needs, and to attain other service priorities. Consequently, the program we designed could not make excessive demands upon staff time and clinic space.

As the process of planning for the program evolved, it became apparent that one of our tasks was to convince agencies, accustomed to the medical model of service delivery, that some reorientation was necessary and desirable. Ultimately, this redirection required that administrators weigh the trade-off between increasing the size of their client population and the efficacy of the services rendered. The case for reexamining the

medical model rests on the assumption that adolescents, particularly those in their early teens, face a number of severe obstacles in using birth control. Unless client routines are modified to take into account the problems that teenagers encounter once they are equipped with contraception, there is strong evidence that services will have a limited impact on the adolescent's contraceptive behavior.[8]

The administrators who became involved were responsive to this argument, and showed some inclination to build up the follow-up component of their program. Yet, it often proved difficult to modify established client routines even when wisdom dictated otherwise. One of the lessons we have learned, which we will refer to again in the conclusion, is that programs must be restructured to promote long-term follow-up. This requires additional resources as well as a strategic reorientation on the part of professional staff.

Evaluating the Program

Administrators also brought to our attention the inevitable disruptions a research program would pose to their clinic routine.

- Let's say we do get involved with the training program and our counselors do some in-depth counseling as described in your program, we don't know if we can see as many teens as you need for research purposes.
- As part of your research, you need to interview the teens when they come into the clinic. Won't that mean they have to spend more time waiting in the clinic than they already do?
- We don't have enough space in our clinics for our own staff; where will we put the research assistants so they can do their interviews with the teens in private?

We responded to these concerns with our assurance that we could work to make the research elements as unobtrusive as possible and that we could remain flexible with our procedures

in order to avoid bottlenecks in the clinic patient flow. We also stated our interest in fitting our interviews into existing "waiting" times that the adolescents were already experiencing in the course of their visits to the clinic, thus minimizing the possibility that adolescents participating in the program would spend more time at the clinic. We suggested that adolescents might find our interview an acceptable alternative to the time they would ordinarily spend in the waiting room. In fact, this turned out to be the case. The interviews, which last about twenty to twenty-five minutes, have been carried out with only minimal changes in clinic routines.

Regarding their participation in the program, the clinic administrators suggested that since the training program for the counselors was twelve weeks in length, plans for the implementation of the research program in each agency could develop concurrently with the training program, and during that time agencies could commit themselves to the research program or withdraw. Thus far, most agencies have shown a commitment to implementing the program by freeing up additional counseling time for their staff involved in the training program and by working within their institutional settings to find appropriate space for the counseling program and research assistants.

The Training Program—Overcoming Barriers to Family Involvement

Fourteen counselors were selected by the six clinic administrators to participate in the training program, which was conducted by Jay Jemail, Ph.D., an experienced family therapist on the staff of the Philadelphia Child Guidance Clinic. The counselors were broadly representative, in their age, experience, and educational background, of counselors employed in family planning clinics. Their ages ranged from twenty-three to forty-nine. Regarding their experience working in the clinics, the least experienced participant had been counseling in the family planning setting for one and one-half years and the most

experienced, for fourteen years. Educational degrees held by the participants ranged from high school diplomas to a master of social work degree. A few of the trainees held supervisory positions in their agencies. Most had had little or no previous exposure to, or training in, family counseling techniques.

Initially, the participants were skeptical about involving family members in their counseling of adolescents. This is understandable, given that family planning clinics are generally designed to deliver services to the individual adolescent. The adolescent is typically treated as if she were isolated from her relatives. Our training program challenged the counselors to assume a posture antithetical to that of the system they worked in. They were to intervene with adolescents in ways different from those used by co-workers in their agencies.

The counselors were asked to approach the project, at least hypothetically, with the premise that inviting a relative of the adolescent to the session was a positive step. Although there would be cases where clinical judgment justified seeing the adolescent alone, the counselors were asked to regard cases where a relative would be excluded from services as the exception rather than the rule. This, of course, was a significant departure from the approach commonly employed by family planning practitioners.

This new role was obviously not an easy one. There was no reason for us to expect that families would necessarily be ready to participate in a support system for adolescents enrolled in the program. As explained earlier, parents often act as if their teenage daughters are not sexually active. Similarly, some parents prefer to be ignorant of the adolescent's contact with a family planning clinic, and other parents clearly oppose that contact. Therefore, the counselors were asked in the training to devise techniques that might eventually involve some of these parents in supporting the adolescent's decision to use contraception. The trainees first had to convince themselves that the family's support might be important and helpful, then convince the adolescent, and finally convince her family.

The exercise of devising ways to bring family members into the counseling was a significant departure from the counselors' routine. Family planning counselors had developed very sophisticated schemes to protect the adolescent's confidentiality. Unfortunately, these were, at the same time, ways to exclude the adolescent's relatives from any possible involvement in the deliberations. For example, the participants in our training program described how they called the teen's home under an assumed name or identified themselves as friends who needed homework. They carefully made their calls at times when the teen was supposedly able to speak in privacy. Needless to say, the identity of the counselor was occasionally discovered, and these efforts annoyed some of the teen's parents or other relatives. When this occurred, the result was to alienate an adolescent further from her family. Such incidents placed the agency staff in a coalition with the adolescent, and, unfortunately, in an adversary relationship with the family.

Yet, the training had to deal with the problem of confidentiality. Counselors were encouraged to explore ways to respect confidentiality, but still seek to include family members in a constructive and supportive way. For example, the counselors were encouraged to allow the adolescent to tell her mother about her contact with the clinic. In this way the adolescent was free to disclose to her mother as much or as little information about her visit to the clinic as she chose. Hopefully, the counselor would then be able to form a trusting relationship with both the mother and the daughter, and encourage more constructive sharing of information between them rather than building an alliance with one or the other.

Some of the trainees' skepticism about including the adolescent's relatives resulted from previous experience with family members. Parents who brought adolescents or sent them to family planning clinics often expected the counselor to assume a surrogate parent role. Frequently, their expectation was that the practitioner would convince the adolescent to choose an abortion, bring a pregnancy to term, or use a particular birth control

method. Counselors were asked by parents to dissuade the adolescent from becoming sexually active or even to influence the adolescent's choice of a sexual partner. In the past, these family planning counselors had dealt with domineering or intrusive parental figures by excluding them from the counseling session. Our training program attempted to show that, by excluding family members, the counselors had given up an opportunity to change the communication and transactional patterns of the adolescent and her parent. Moreover, the professional had assumed responsibilities that were more appropriately assumed by a parental figure.

Individual counseling of adolescents forced these family planning counselors to adopt a surrogate parent role. In our training, participants described how they had to call the adolescent before her clinic appointments, or provide support through a difficult decision about a pregnancy. Some teens, particularly the younger and less mature ones, looked to the professional to make choices for them (e.g., about whether or not to become sexually active or about which contraceptive method to use). The counselors worked with a handicap because they lacked information about the adolescent's resources and her social support system.

The willingness of family planning counselors to assume, if only temporarily, this surrogate parental role was not surprising; other health professionals also share in this role. Physicians, psychologists, social workers, and others working with children, the handicapped, and the elderly frequently assume that parents and other family members are incapable or unwilling to provide guidance and support when needed. These assumptions are rarely tested by the professionals. Consequently, family planning counselors pass up many opportunities to involve a sister or other relative by working exclusively with the adolescent.

There were other reasons cited by the counselors for excluding family members from counseling. The conditions in which contacts took place were usually poor. Sessions were frequently

conducted in small cubicle-like offices where two people could barely sit comfortably, let alone three or more. Their offices were sometimes not soundproof. The counselors had very limited time for their sessions, and the flexibility required by an ongoing relationship with a client was rarely available prior to this program. These family planning practitioners were expected to provide effective counseling in one fifteen-minute session. The trainees also pointed out that in order to do counseling with family members, sessions would need to be held in the evenings. But, most of their appointments were scheduled during the day. The counselors were not enthusiastic about rescheduling their working times from day to evening hours unless they were appropriately compensated for the changes in hours and additional professional responsibilities. In order to implement the program we had to negotiate more time for counseling, more private space, and compensatory time for evening hours.

Expanding the Counseling Role

Through the training, the program challenged a commonly accepted definition of the counseling role and of the kind of interventions family planning practitioners should use. Counselors have usually been told what they are not—they are not psychotherapists, nor are they educators. Their functioning in the educational role, however, has been more acceptable than their tampering with "therapy." The counselors' functions traditionally have been to provide information, guidance and support to the adolescent during her visit to the clinic. If the adolescent's needs extended beyond this brief contact, she was generally referred elsewhere in the social service system. Expanding the counselor's role, of course, was potentially threatening to others, for example, psychologists, social workers, physicians and those who engaged in "real" therapy. Unfortunately, these limitations in role definition too often served to inhibit the family planning counselor's behavior and thus limited the potential for effective intervention. Our training pro-

gram attempted to broaden the counseling role beyond its educative aspects.

The training attempted to expand the family planning counselor's skills to fit this new role. In general, the trainees were experienced at working with individuals or peer groups, but lacked the skills required to work in concert with the adolescent and her family. They needed to develop skills to work together with parental figures, siblings, and multiple generations. The participants in the program were clearly adept at forming therapeutic alliances with teens. However, for this program, they also needed to join with parental figures. It was important to illustrate for them how some interventions they commonly used could serve to link them with one generation, but alienate others.

For example, take the case of an adolescent who comes into a family planning clinic for the first time. Within the traditional, individualized counseling approach, the following scenario would unfold. The adolescent meets the counselor and indicates she has been forced by her mother to come to the clinic. Her mother is convinced that the teen is pregnant. The mother is described as being a very intrusive and domineering person who buys and counts the adolescent's sanitary napkins and thus monitors her daughter's menses. The adolescent is angry because she is not sexually active, yet her mother keeps sending her for pregnancy tests. The adolescent confides that the mother does not believe her. She describes her frustrated attempts to communicate with her mother and her anger because her mother treats her like her seven-year-old sister.

Using a role-playing technique, the counselor tries to prepare the adolescent to go home and deal with her mother. The practitioner assumes the mother's role, and their dialogue is as follows:

Counselor: Your mother will say, "Well, are you pregnant?"
Adolescent: Yes, she will say it just like that.

Counselor: And what will you tell her?
Adolescent: That I'm not. That they told me at the clinic I couldn't have a pregnancy test because it was too close to my period. My mother won't believe it—that I couldn't have a pregnancy test.
Counselor: [steps out of role] I keep hearing you say that the clinic wouldn't give you a pregnancy test. Maybe you could say more about that to your mother.
Adolescent: See, I told her when my last period was. She told me I was lying, and she'll say I lied to you, too.
Counselor: In that case, maybe you can tell her that the counselor at the clinic accepted everything you were saying.

The problem with this approach is that the counselor is assuming a very supportive role with the adolescent but is setting the stage to alienate the parent. Encouraging the adolescent to tell her mother that the counselor agrees with her is a mistake. The professional has involved herself in a coalition with the adolescent that she will have a hard time getting out of. Approaching this scenario from a family system perspective rather than an individual perspective, the counselor could instead suggest that the adolescent ask her mother to come to the clinic so they can all talk together about the situation.

Skills for Planning Successful Interventions

To plan successful interventions with the adolescent and build support among family members, the professional must learn to assess the strengths and weaknesses of the adolescent's family system. The counselor needs to identify what factors in the family system encourage or discourage the use of contraceptives. For example, an adolescent who is living with her mother and a pregnant teen sister is going to have a difficult time using

contraceptives effectively. This kind of information is important to consider when advising the adolescent.

The training encouraged the participants to formulate more hypotheses about how the adolescent's family functions. For example, Who assumes the parenting role? Who provides support for the adolescent? What are the rules about communication within the family?

In this way, the trainees learned to expand their assessment skills. The training focused on sharpening their ability to observe interactions among family members. Prior to this training, the counselors had been taught to be very good listeners. This new role demanded that they become competent at observing process and interaction as well. They were instructed to widen the angle of the lens through which they looked at adolescents. They had had some previous experience with assessing individuals; their new role demanded that they develop skills to assess family systems, as well.

Let us consider the following example, approaching it, again, from the traditional, individualized counseling perspective before suggesting an alternative family systems approach. A fifteen-year-old girl walks in to see the family planning counselor after a negative pregnancy test. The counselor finds she had pills but that she did not take them. In the session, the teen expresses dislike for foam and a diaphragm. The counselor clarifies myths and provides more birth control information. The teen casually mentions that her friends are getting pregnant and she would not like to get pregnant. They discuss contraceptive methods again. She resists any of the methods presented by the family planning staff. She indicates the problem is keeping them hidden from her father and mother. The professional, who is genuinely concerned about confidentiality, asks if it was a problem to write to her home. "Did your mother discover our letter reminding you of your visit?" The adolescent responded, "No, she looked at the letter and put it down in my room. I think my mother knows but is trying to ignore it." The counselor then

suggests that an intrauterine device (IUD) is the most unobtrusive method of birth control. With some hesitancy, the adolescent agrees to return to have an IUD inserted. Assuming the reason she is taking the risk of becoming pregnant is because she lacked an unobtrusive method of birth control, this adolescent will probably return for the IUD. However, many adolescents go through similar steps and still become pregnant.

Approaching the same encounter from a family systems point of view, a pregnancy could mean many things to this teen and to her family. Exploring this with the adolescent could help identify her ambivalence about contraceptives and the attractive features or substantial burdens of a pregnancy for her and her family. With this information, the counselor could plan interventions to encourage the use of contraceptives and help the adolescent introduce the subject of sexuality to her parents. The parents or another support person could be invited to discuss their response to the adolescent's initiatives for preventing a pregnancy. Thus, the choice of an unobtrusive birth control method might become less relevant. Widening the angle of assessment could allow a broader range of interventions by family planning counselors working with adolescents. With this wider perspective, practitioners could identify and mobilize the resources in the natural support system of the teens that would encourage their responsible use of contraceptives.

Accepting Challenges

The program made obvious demands upon the agencies and family planning counselors, particularly those that participated directly in training programs, demands which forced them, and us, as well, to look at how services are being provided. Out of six agencies selected as program sites, four agencies are now offering the counseling services described here. Midway through the training program, two agencies withdrew because they felt that the demands of the counseling program were too much for

their institution to undertake at this time. We are currently training counselors from two other agencies so that we will be able to offer the program in a total of six agencies, as originally planned.

Conclusion

At this stage in the study, it is too early to foretell the outcome of the Kinship Support Program. We cannot predict whether teenagers and their families will accept the services we are offering them, or whether these services will have a noticeable impact in promoting contraceptive use among sexually active teenagers. Indeed, it will be several years before a firm judgment about the efficacy of the program can be made.

This preliminary report assesses the process of implementing what we knew from the start to be a controversial and complicated undertaking: building social support within the family for contraceptive use among sexually active adolescents. Both the ideology and social organization of family planning services provide formidable barriers to involving the family.[9] For years the family planning movement has had to contend with adult opposition to programs for teenagers who are, or are about to become, sexually active. Parental consent requirements and parental notification have become the banner of resistance to liberal policies for extending services to teenagers at the risk of having unwanted pregnancies. Consequently, family planners cast a jaundiced eye on efforts to involve the teenager's family members, fearing that such a practice will discourage teenagers from seeking contraceptive services.

We sympathize with this sentiment and share the view that mandatory family involvement would do more harm than good by frightening adolescents away from clinics. However, preliminary data from our study indicate that a majority of the adolescents report that family members (usually parents as well as siblings) know of their visits to the family planning clinic; and

others indicate that they plan to communicate this information to additional family members after their initial visit; and still others report that, even though they have not transmitted the information directly, they suspect that parents and/or siblings know that they are sexually active. In short, only a minority of the first hundred or so adolescents we have interviewed report that their sexual activity is completely clandestine. Consequently, the potential for involving family members without violating the teenager's privacy is great. Most teenagers we have interviewed consent to the idea of participating in counseling sessions with one or more family members, although it remains to be seen if we will actually be able to implement the service. It is important, of course, to recognize that the Kinship Support Program is located in the Philadelphia area; other regions of the country may be more or less receptive to the idea of promoting family participation.

Regardless of whether or not family members actually are included in services, it seems clear to us that there is a need to reorient the individualized approach of family planning programs. To most service providers, it seems so obvious and logical that adolescents who want to prevent pregnancies should use birth control that they hardly stop to consider the many obstacles that teenagers face in using contraception successfully. Apart from the very real problems inherent in the various methods available, teenagers often face a climate of ambivalence, if not outright opposition, to having sex from their families. So long as contraception is required to be a clandestine activity, teenagers are likely to find it extremely difficult to use birth control regularly, especially if they elect to use a method that may be discovered by family members. It requires considerable energy to guard the secret, adding to the existing complications of maintaining a steady supply of contraceptives or managing adverse side effects.

We do not believe that all families can become agents of support for teenagers who begin to use contraception. However, at

present, the family is virtually an untapped resource. We do not underestimate the difficulty of involving family members, many of whom prefer "not to know." Even if family planning counselors are not able to reach the family directly, we think that they should be able to help prepare the teenager to accept that what she is doing may be regarded as a subversive activity in the home. We do believe that the family's position is often unresolved. Several of the adolescents in our study remarked that their parents wouldn't be happy knowing they were sexually active, but would approve of their using birth control. Parents, as well as teenagers, may welcome the opportunity to discuss their feelings about sexuality, sometimes as a precondition for coming to terms with the sexual behavior of their adolescent.

Sex educators, family planners, and health professionals have been remarkably unsympathetic to the plight of parents caught in the vortex of rapid cultural change. Practitioners have shied away from working directly with parents for fear of getting caught in the crossfire of generational differences over sexual behavior. Yet, by dodging the issue, the providers of family planning services may undermine the effectiveness of the very services they offer.

In trying to reverse this trend, we have noted a number of obstacles that lie in the path of organizational change. Family planning counselors see themselves as purveyors of information to individuals, not as persons capable of bringing about change in the community. This restricted mandate minimizes the potential for conflict in their role but also limits their effectiveness as educators of their limited clientele, let alone the wider community. The Kinship Support Program has raised the question of what the scope of the counselor's role should be. If this role were to be extended beyond its present boundaries, what kinds of training and preparation should be offered to individuals who become family planning counselors?

In initiating this project, we have also been reminded of the unrealistic nature of the medical model on which most services

are predicated. Some years ago, in discussing the approach of most family planning programs, Furstenberg[10] noted that there is among health professionals an "ideology of inoculation." Almost magically, service providers believe that short-term assistance will have long-term effects. However, there is overwhelming evidence that family planning programs that provide little in the way of follow-up have limited effectiveness in preventing unwanted conceptions.

Of course, there are obvious and compelling reasons for the lack of follow-up. First, far more credit is given for intake figures than for continuation rates. New clients demonstrate the vitality of programs. Second, considerable time and energy are required to follow up clients, especially teenagers who are extremely mobile and often elusive. Finally, programs may be uncertain how to perform effective follow-up. Like parents, some professionals may prefer "not to know" that their efforts at prevention are ineffective.

While by no means the only stratagem available, bringing in the family offers some conspicuous advantages to programs interested in strengthening follow-up services. Because the family is involved in the first place, it becomes far easier to recontact the adolescent over time. More important, the family becomes part of the follow-up procedure, reenforcing the teenager's resolve to use contraception and helping to bring problems in contraceptive use to the attention of program personnel, if and when such problems occur.

As pointed out repeatedly throughout this paper, we do not discount the problems of involving the family nor do we believe that this approach will always, or perhaps even usually, be practicable. Yet, if we have overstated our case for bringing the family in, we have done so knowingly, for we believe that there is great value to be gained in redirecting the attention of professionals toward viewing sexual behavior and its consequences not merely in the context of individuals but also in the context of family systems.

NOTES

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2. Frank F. Furstenberg et al., "Birth control knowledge and attitudes among unmarried pregnant adolescents," *Journal of Marriage and the Family* 30, no. 1 (1969): 34–42; and Frank F. Furstenberg, "Birth control experiences among pregnant adolescents: The process of planned parenthood," *Social Problems* 19, no. 2 (1971): 192–203.

3. Ibid.

4. Prudence Rains, *Becoming an unwed mother* (Chicago: Aldine-Atherton, 1971).

5. Theodora Ooms and Teresa Maciocha, *Teenage pregnancy and family impact: New perspectives on policy*, preliminary report (Washington, D.C.: Family Impact Seminar, June 1979), p. 43.

6. Roberta Herceg-Baron and Frank F. Furstenberg, "Kinship support for adolescents in family planning programs," proposal submitted to the Bureau of Community Health Services, Rockville, Md., July 1979.

7. Our consent procedures call for the adolescent to be informed by the research assistant at the time of the initial contact that: her participation in this experimental program is voluntary, and has no influence on the regular clinic services she will receive regardless of her decision to take part in the study. Consent forms are written in language comprehensible to adolescents, informing them of the purpose of the project and the extent of involvement expected of them. Each adolescent is given a copy of the form after the research assistant reviews its contents with her. The adolescent is also told that she has the right to withdraw at any time without jeopardizing her access to clinic services in the future. In fact, early experience with the consent procedures indicates that all but a very few adolescents have elected to participate in the study, although a good number may not actually avail themselves of the family counseling service.

8. Frank F. Furstenberg, *Unplanned parenthood: The social consequences of teenage childbearing* (New York: Free Press, 1976).

9. Frank F. Furstenberg, et al., eds., *Teenage sexuality, pregnancy, and childbearing* (Philadelphia: University of Pennsylvania, 1981).

10. Frank F. Furstenberg, *Unplanned parenthood*.

12

Family Involvement, Notification, and Responsibility: A Personal Essay

Theodora Ooms

Both families and government have a responsibility to address the range of problems associated with teenage pregnancy. Both have been much readier to assist after the fact—once the teenage girl is pregnant—than to help her and her partner avoid pregnancy in the first place.

The federal government's major investment has been in the teenage mother and baby, with the provision of financial aid and medical care. In terms of prevention, federal funds for family planning services have been substantial; yet support of sex education activities for the majority of teenagers who are not (yet) pregnant has been minimal. Furthermore, the government has demonstrated little recognition of the broader social factors contributing to adolescent fertility. The new federal grants program targeted on teenage pregnancy is an important but largely symbolic gesture of federal concern. State governments have, with few exceptions, given even less attention to this issue. Two

Note: This chapter presents a personal summary of the policy implications of a family impact perspective on teenage pregnancy. Although I have been greatly influenced by the ideas in the previous chapters, the particular themes I select for discussion, my conclusions, and the recommendations themselves are my responsibility alone.