PUNISHING THE PREGNANT INNOCENTS

Single Pregnancy In St. John's, Newfoundland

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by

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ABSTRACT

THESIS: PUNISHING THE PREGNANT INNOCENTS

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by LAURA HOPE TOUMISHEY, B.N.

The primary objectives of this study are to determine, from data obtained from 40 single pregnant girls in the city of St. John's,

(a) to what extent social and emotional factors are inhibitory to a healthy pregnancy outcome for all persons concerned.

(b) whether the established and generally accepted social norms for sex-related behavior are relevant to the attitudes and behaviour of young people living in St. John's today.

The primary concerns of those interviewed, were closely related to their own perceptions of anticipated responses from significant others, i.e. parents, sexual partners and social groups etc. Data analysis also served to identify significant emotional milestones along the route to, and during an illegitimate pregnancy.

A discussion of the role and responsibility of any society, mainly through use of the family, to prepare its youth for future sex relationships, motherhood and parenthood revealed that, in reality, there were serious discrepancies, irrelevancies and serious shortcomings in attitudes and programming within the existing and generally accepted socialization process.

A breakdown of this process served to better isolate and identify the level of "educational" input provided for each of three major age groups. These were pre-puberty, early adolescence and young adulthood. A fourth group, single pregnant women, was then discussed to determine if the process, so described, plus the existing programming and services currently provided in this community were sufficiently adequate to (a) ensure the conformity of today's youth to the established sex-related behavioral norms and (b) provide for the re-entry, without social and emotional jeopardy of those who inadvertently, temporarily, and sometimes deliberately, deviate from these norms.

Grounded Theory as described by Glaser and Strauss (1967)[1] was used to generate a formal theory called - Punishing the Pregnant Innocents. The extent to which specific punishments are imposed upon these "social deviants" are described in this study. The question is raised as to whether such punishments are justified or are they in response to a sense of frustration over the inability of society to prepare, control and appropriately direct the sex-related behavior of its youth.

Recommendations for changes in social attitudes and approaches to the problems associated with illegitimate pregnancies in the city of St. John's, are included. These are suggested in the hope that they may contribute in the alleviation of the physical, social and emotional traumas too often experienced by these pregnant young women and their children.

[1]Glaser, B.G., Strauss A. The Discovery of Grounded Theory: Strategies for Qualitative Research, Aldine Publishing Co., Chicago, 1967.

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DEFINITION

INNOCENT - This word is used in the context of this study to illustrate a particular dilemma faced by many single pregnant girls. Today young people are expected to conduct themselves as responsible adults in their sexual relationships, including marriage and parenthood. In preparing them for such roles, society, through its' family structure and educational system, has been shown to be frequently inadequate. In consequence, a young girl who becomes pregnant outside marriage, could be considered an "innocent".

PREFACE

> . . .we continue to neglect to utilize information from impaired, partially functioning people that inform us about the failures of the systems...all these are of an intense informational value that we need as feedback without which, indeed, the system would wither away and die. It is noted, of course, that in each of these instances the desires, needs, wishes, hopes and expectations of the smallest unit of the living system may be in strict conflict with those of the next level or the total system in and of which he is an integral part. (de Groot and Strauss 1970:13)

These statements perhaps best epitomize the purpose of this study. By examining the expressed desires, needs, wishes and expectations of single pregnant girls, and including their perceptions and use of the health care delivery system in St. John's, Newfoundland, two major objectives may be reached.

These objectives are (a) to determine those factors considered by single pregnant girls to be inhibitory in seeking health care during early pregnancy, (b) to develop from these findings, services appropriate to the meeting of their specific needs.

CHAPTER I

"The innocence that feels no risk and is taught no caution, is more vulnerable than guilt, and oftener assailed"

Nathanial Parker Willis (1806-67)
American Journalist and Poet.

INTRODUCTION

Research carried out in the City of St. John's to identify pertinent existing physiological, psychological and social problems relating to the pregnant unmarried adolescent, with a specific focus on their own explanation for their delay in entering the health care delivery system during early pregnancy, was initiated in 1974 by this researcher. This was under the supervision of Dr. Boyd Suttie, the then director of the Community Medicine Department of Memorial University of Newfoundland.

Difficulties in determining a feasible method of sampling for the collection of data for analysis, ruled out an experimental approach and directed the study towards employing the sociologically sound, grounded theory method.

Pregnant single women and, in particular, the teenager, are largely a "hidden" population in St. John's. This fact, as substantiated by the present study, is closely related to imposed and/or anticipated impositions of stigma and sanctions from significant and influential groups within the social structure of the city.

The more "visible" groups of pregnant single women from whom data could be collected include:

(a) those who remain in the formal school system for differing lenths of time after pregnancy is confirmed,

(b) those who utilize health and social service programs during pregnancy and before coming to term for delivery of their infant.

For the purpose of this study - to determine the strength of possible inhibitory factors delaying the entrance of the pregnant single woman into the formal health care system - it was felt necessary to contact the subjects as early in their pregnancies, as possible.

Service and educational agencies, while recognizing the necessity for research as a means to the development of relevant programming, to meet the needs of the population at risk with an illegitimate pregnancy, tend to support such studies in principle; but, for many reasons are very reluctant to participate significantly in these studies. The most often stated reason is the protection of the individual's right to confidentiality and privacy.

The first attempt to interview single pregant teenagers was made through the high school system in St. John's. Interviews were conducted with the respective guidance counsellors at the five major high schools. There are no special educational programs for pregnant school girls but, in general, they are encouraged to remain in school for as long as it seems feasible for all those concerned. The counsellors estimate that approximately 50% of students who become pregnant leave school under some pretext, some to return following an abortion or delivery of their infant. Many girls never return to school.

Without exception, the guidance counsellors expressed the need for special programming to which they could refer these students. Because of their accessibility and role within the school there is a greater opportunity for the development of a close rapport and close relationship between the counsellor and student. Too often, however, the counsellor is forced to assume a major responsibility for the physical, emotional and social welfare of the pregnant girl - a role for which he/she has either not been adequately prepared or has not the time to properly fulfill such responsibilities. (See Appendix A. for ratio of Guidance Counsellors to students).

As a result of genuine concern and interest in the development of a future service to which they could refer a pregnant student, the counsellors consented to act as interviewers and submit a formal interview schedule to all pregnant girls who request their help. This would be for a period of one school year.

The interview schedule was developed with the help of three of the guidance counsellors and submitted for approval to the Avalon Consolidated School Board and the Roman Catholic School Board. (See Appendix B-V). It was under consideration for a period of approximately nine months. Permission was refused on the grounds that:

(a) parents might become upset if their daughters were being questioned at this particular time,

(b) such a survey would be an "intrusion upon the privacy of the student in such a delicate situation",

(c) the guidance counsellors, while meeting as a group with the superintendent of the Avalon Consolidated School Board, had

apparently changed their minds about participating in this research,

(d) one board felt their programme was adequate to meet the needs of this population. (See Appendix B.I - IV).

Because of the lack of any programme designated to meet the special needs of single pregnant girls, the only other major agency which provides for contact with this population, in sufficient numbers, is the office of The Planned Parenthood Association (P.P.A.). By their invitation, the collection of data was conducted on their premises. The P.P.A. board and staff gave every assistance to ensure the best possible circumstances for this purpose. The change in venue did not significantly alter the purpose of this study. It did, in fact, provide for a closer analysis of those factors and variables, so important at the initial stages of pregnancy, and which play a major role in directing the single pregnant girl towards the pathway chosen for the outcome of her pregnancy.

THE SETTING

The Planned Parenthood Association, St. John's Branch, had by 1976, become sufficiently well established to encourage and welcome research into the subject of illegitimate pregnancies and their consequences for the girl, her offspring, the family and her community. A significant number of single women now request pregnancy testing from P.P.A., thus allowing for such a survey and the analysis of relating factors associated with illegitimacy.

The collection of data took place principally in the offices of the P.P.A. St. John's Branch. This service, the only one in the entire city, is offered free of charge to anyone requesting assistance, the only requirement being to complete a short admission form for statistical purposes. (Appendix C.) These forms, once the data has been recorded and tabulated, are destroyed. The population utilizing this service, represent various socioeconomic groups from the city itself and outlying areas (sometimes as far away as Labrador).

Other data were collected through formal and informal interviews with nurses, social workers, physicians, school principals, school board administrators, teenagers and others who expressed interest or knowledge on the subject of illegitimate pregnancy.

The general data were collected over a period of two years, starting in September 1974. The specific data from the study population, comprising those single women between the ages of 14 to 24 who requested a pregnancy test at the P.P.A. office, and who were found positive for pregnancy, were collected over a period of six months from February 1977 to July 1977, during which time 40 subjects were interviewed.

Acting as a participant observer this researcher, and two P.P.A. staff members, with the permission of the client, conducted interviews. It was necessary to train these staff members as interviewers to ensure that the majority of the potential subjects were reached, as the service was still under-utilized by this population during this period of time.

The interviews were open-ended employing various techniques tempered by the emotional climate of each interaction. Specific

questions were directed only when the respondent indicated an ability to verbally express her concerns, anxieties, fears and desires for her future, in the light of present circumstances.

Because of the emotional atmosphere during the interview, and the need for more than one interviewer, an informal schedule was devised, as a directive, to ensure some continuity of approach and to aid in the determination of commonalities in contributing factors, that possibly projected the subject towards pregnancy outside marriage.

Data required and not already on the admission form included:

(a) status of family relationships

(b) relationship with the putative father

(c) immediate reactions and responses to the verified state of pregnancy

(d) anticipated responses from significant others

(e) proposed immediate action

(f) preferred person for support and guidance

(g) personal level of understanding of immediate and future health needs for the pregnancy

(h) perceptions and past utilization of physician's services

(i) formal education ambitions

(j) level of understanding of the significance and probable consequences for self, her child, and significant others of immediate or later decisions made for pregnancy outcome

Where the circumstances allowed, some were asked:

(k) to evaluate present services and identify preferred options, and services to meet their preceived needs.

Data was recorded in writing immediately following the interview.

THE THEORETICAL APPROACH

Grounded theory as described by Glaser and Strauss (1967), was used to generate the formal theory called - punishing the pregnant innocents. This theory has two basic premises - (a) the social imposition of punishment for pregnancy outside marriage; and (b) stigmatization as a major inhibitory factor to the satisfactory outcome of a pregnancy outside marriage.

Formal theory is:

> ...that developed for a formal or conceptual area of sociological enquiry such as stigma, deviant behaviour, socialization, status congruency, authority and power, reward systems, or social mobility. It differs from substantive theory which is developed for a substantive, or empirical area of sociological enquiry such as patient care, race relations, professional education, delinquency or research organizations. (p. 32)

Glaser and Strauss (1971) further state that

> In social research it is not necessary to hypothesize or conceptualize relevant theory prior to the collection of data systematically obtained. Theory in sociology is a strategy for handling data in research providing modes of conceptualization for describing and explaining. Generating a theory from data most hypotheses and concepts are not only data but are systematically worked out in relation to the data during the course of the research. (p.8)

Elements of theories generated from data include (a) categories which when derived, must be readily applicable to the data and relevant to the behaviour under study; and (b) hypotheses or generalized relations among the categories and their properties. (p. 35). As categories are derived, developing in abstraction and become related, the accumulating interrelationships form a conceptual framework which Glaser and Strass describe as - the core of the emerging theory. This

provides for redirection in the research process for changes in focus or sampling without having to ignore important implications generated by the data which do not appear relevant to the testing of the hypothesis.

Christensen (1969:24) in defending grounded theory in his study, entitled "Normative theory derived from cross cultural family research", defines research theory as:

> ...composed of systems of organized generalizations - often designated as propositions or principles or laws - growing out of these investigations. Starting with some basic assumptions he moves to either adopt or develop a series of relevant concepts, sees that these concepts are organized into a conceptual framework within which he can operate, become acquainted with previously established theory covering his range of interest; and out of all this, formulates certain hypotheses concerning the relativeness of the phenomena he wishes to study.

Hammond (1964:4) in introducing the collective studies of some prominent Social researchers, discusses the weakness in believing in the dichotomy between theory and research, the argument being that:

> ...research is only the classification of facts when, in reality, as science, it is concerned with evolving conceptual schemes...research by induction is patently not what scientific discovery typically involves, but rather what has been called abduction or 'leading' away, that is theorizing, dichotomizing into theory and research diminishes the value of either activity.

Social researches[1] continually state concerns in being tied to defending a particular hypothesis. There is a danger of being forced into a narrow focus allowing for oversight or neglect in exploring inferences and other leads identified from data collected but not pertinent to the hypothesis under challenge.

The literature in essence states, that research starts and ends with theory. Every question asked leads to new questions and new directions for the exploration of every newly generated theory.

When dealing with human behavior and interrelationships this process is continuous with no possible end. Research, therefore, can be instigated at any point in the process. Such research needs to be encouraged as a way of reducing the stress and the trauma of those caught in conflict within our existing social structures and environments.

FOOTNOTE

[1]Other studies using a grounded theory approach include one by Reiss (1967) "The Social Context of Premarital Sexual Permissiveness" where she illustrates the process of theory building by testing various hypotheses, formulating propositions and integrating them into formal theory. Christensen (1969) Lindemann (1974) and Dinham (1977) all used grounded theory for their studies.

CHAPTER 2

"Better be unborn than untaught for
ignorance is the root of misfortune"
Plato (427-347 B.C.)

THE NATURE OF THE PROBLEM

The single pregnant girl, whatever her age, social status and educational level, appears to fear more than any other factor, anticipated and perceived negative social responses to her pregnancy. This is the principle reason for her delayed entry into the health stream thereby exacerbating problems rather than diminishing them.

This study attempts to substantiate or refute this statement. To what extent these fears are based on fact or supposition are explored.

The study design allows for the collection and analysis of data from a variety of sources with major imput being supplied by subjects immediately following the confirmation of pregnancy by test. How decisions are made for outcomes, and the pathways followed for different outcomes, are the two major components of the study. The identification of options for pathways and the examination of their contacts with significant others along the route should serve to isolate those factors which could lead to a potential crisis. Examination of these points leads to the theory which explores the concept of the imposition of blame and punishment upon a single pregnant girl (and her child) for her violation of the accepted social norms for sexual intercourse and pregnancy, sanctioned only within marriage.

ILLEGITIMACY

Hartley (1975:4) states that illegitimacy is broadly defined as a state of being of illegitimate birth (from the Latin-illegitimus-meaning "not in accord with the law") that is, born outside a legal marital unit. Cutright (1975:26) broadens this definition to include the incestuous or adulturous issue of a married woman. Newfoundland defines illegitimacy through The Children of Unmarried Parents Act 1964 where "mother" is defined to mean:

(a) a single woman or widow who

(i) has been delivered of an illegitimate child, or

(ii) is pregnant and likely to be delivered of an illegitimate child; or

(b) a married woman who

(i) is living apart from her husband and has been delivered of an illegitimate child, or

(ii) is pregnant and likely to be delivered of an illegitimate child and was living apart from her husband at the time of the conception of the child.

(Gushue and Day 1973:117)

The term "illegitimate" to many, is seen as offensive and held to be grossly discriminatory against the "innocent". Attempts to eliminate it from the vocabulary however have not met with much success. How else does one describe a status formulated outside the accepted legal route? Whatever word is used, and to date there is no significant substitute, it still means the same thing - outside the law. Sklar and Berkov (1974:196) states that "the handicaps suffered

today by illegitimate children result not so much from moral opprobrium attached to the label 'illegitimate' as from the circumstances in which children are raised."

The terms "unwed mother" or "pregnancy out-of-wedlock" when used exclusively, tend to focus on the parent(s) and neglects the influence of this situation on the later life of the child.

Kingsley Davis in his testimony before the Social Welfare Board on July 1972 observed:

> ...in social science, the term (illegitimate) is used for statistical purposes to designate a social and economic fact rather than to attach an epithet to children. Neighbours may know that a child's mother was single when he was born, but whether they do or not, and the attitude they take towards it if they do, does not depend on statisticians or even on official records, but on their own observations. Behind their attitudes are certain realities that social science research is designed to measure and understand.
>
> From the standpoint of child welfare, there is no inherent, or necessary, difference between a legitimate and an illegitimate child. A child whose parents live together, take good care of him, and guide him on the road to a successful life-even though they are not legally married - is better off than one whose parents are legally married but are irresponsible and incapable of supporting him. If so, the essential problem is that of irresponsible and incompetent parenthood rather than legitimacy or illegitimacy. Legitimacy comes into the picture simply because the proportion of individuals unqualified to rear children is much higher among unmarried than among married parents. As a result, in every country the rate of stillbirths, deaths, adoption, dependency, abandonment, neglect and cruelty is much higher for illegitimate children than for legitimate ones...The average illegitimate child thus has a more tragic life than the average legitimate one-not because of his illegitimacy per se, but because of the kind of parents he had. Accordingly, an effort to lower the illegitimate birth rate is simply an intelligent effort to lower the risks to children; it is not an archaic effort to stigmatize infants.
>
> (quoted in Sklar 1974:196)

Until such time when illegitimate pregnancies and births no longer result in discrimination against those affected, it is better to state facts as they are and not as we would like them to be.

Legitimacy for sex roles and behaviour has a definite purpose. (In Chapter 5 discussion on social theory systems and structures expands upon this point). The place of the child and the socialization process it must pass through, is based upon where he/she is legitimately accepted within the general scheme of things.

Cultural values and norms over time have established rules for legitimacy such as - who may procreate, with whom, and who and how they must rear their children. These rules, besides determining the social placement of children as discussed, also determine relationships among adults. Goode (1964:20) states:

> The infant indicates an intimacy between parents and its existence makes continuing demands on the network of adults. These, in turn, make demands on one another because of the child. If the child has no acknowledged father or the "wrong" father, these obligations are ambiguous or unmet, or run counter to already established duties. The already married father of an illegitimate child cannot take care of it without failing to some extent in his obligations to his own family, even if he is wealthy. The child whose parents are not married does not belong to the father's family, and neither the father, nor the father's family needs to meet more than minimal legal obligations to the child. The child's position is ambiguous, and its socialization experience is likely to be inadequate. In short, it is the consequences for adults for the society more than for the child which the rules against illegitimacy are supposed to prevent. For these reasons illegitimacy is more of a scandal than premarital sexual intercourse even when the latter is also disapproved.[1]

The extent of any problem largely depends on the numbers of persons likely to be seriously affected as a consequence of it. Published statistical data relating to the Canadian Provinces, other than Newfoundland, are reasonably detailed and current. Other sources

for statistics are surveys and research studies including those done by O'Neil (1971), Palko (1971) and Schwenger (1974).

O'Neil (1971) notes the correlation between the rising population of younger age groups, where the highest proportion of young women is to be found, and the increasing rate of illegitimate live births in proportion to the total live birth rate over the past decade.[2] M. Palko et al (1971) indicate that more than three quarters of the total number of illegitimate births are to women between the ages of 15-24 years. O'Neil also notes, however, that when considering illegitimate birth rates per 1000 single females, the incidence of out-of-wedlock births is not as striking for younger age groups, but while the teenager rates per 1000 single women are shown to be lower than older married women, they are still the main contributor to the total number of illegitimate live births in Canada. This is, as O'Neil notes, because, as this cohort ages and moves through other age groups, even though a substantial proportion will marry, there is likely to be a larger number at risk than in previous cohorts, so the number of illegitimate births will continue to rise for some time.

Schwenger (1974) reports that in 1971 Canada had experienced a drop in the total number of illegitimate births (35,000 in 1970 to 31,000 in 1971) for the first time since 1949 and attributes this largely to the increase in legal abortions in Canada.

In Newfoundland published provincial statistical data on illegitimacy rates are available only up to 1974. These do not include age specific rates nor information that might lead to estimates concerning conception prior to marriage. The illegitimacy rate for

1974 was 116.0. Other sources for data, including hospital records and physician estimates, indicate that some areas tend to show higher rates than do others, varying from 28% to 33% of all registered births. (See Appendix E for rate of illegitimate births per 100 live births in St. Anthony 1975, as an example.)

A study of the experiences of others in social and cultural settings similar to Newfoundland, is necessary in order to determine, (a) if there are in fact, significant social problems related to illegitimate pregnancy; (b) if so, what are these problems and how are they being met; (c) are the solutions, or partial solutions, meeting with any success; and (d) what further research is required to provide for relevant solutions to these problems.

The literature, particularly in the United States, abounds with studies, commentaries and statements on the subject of pregnancy outside of marriage. These studies focus particularly on the adolescent and the young adult, including to a lesser degree, the university student.

Canadian literature (Stone & Scott 1974, Claman 1969, Guyatt 1974) reiterates much of what is said by others from similar environments and societies (Zacker 1975 (U.S.) McKinley 1970 (England), Leeton 1975 (Australia), Widholm et al 1974 (Sweden)). These and other contributors generally agree that pregnant adolescents are particularly at risk, medically and obstetrically, and share with older unmarried women, a high potential for psychological and sociological complications.

The incidence of medical and obstetrical problems are closely

associated with age and where there has been minimal or no prenatal care. Zacker[3] provides a very comprehensive listing of such problems including medical conditions, namely, venereal diseases, drug abuse, vaginal and kidney infections, non-deficiency anaemia, folate deficiency and malnutrition.

Obstetrical problems include lack of pre-natal care,[4] low birth weight, prematurity, fetal mortality, pre-eclampsia, eclampsia, cephalo-pelvic disproportion,[5] caesarian section[6] and abortion.[7]

The 1976 report of the Planned Parenthood Federation of America Inc.[8] (hereafter referred to as P.P.F 1976), documenting the findings of all the major American research reports on teenage pregnancy, compiled the following list of risk factors for both the mother and her infant in relation to biological immaturity:

(a) About 6% of first babies born to girls under 15 years of age die in their first year. A rate 2.4 times higher than that of mothers 20 years of age and over.

(b) Teenagers give birth to a higher rate of low birth weight babies. A breakdown of the potential risk for such low birth weights in relation to the age of the mother are shown in table 2:1

Table 2:1 - Potential risk for low birth weight in relation to the age of the mother

Age	Times risk
15 and under	2.2
16-17	1.5
18-19	1.3

(c) Maternal death risk is 60% higher for young teenagers aged 15 and under and 13% higher for those age 15-19. Mothers aged 15-19 are twice as likely to die from haemorrhage and miscarriage, and 1.5 times from toxaemia, while those 15 years and under are 3.5 times more likely to die from toxaemia.

(d) Adolescent mothers are 1.3 times more likely to suffer from nonfatal anaemia (11%) than those 20-24 years old.

Discussion of the psychosocial problems associated with illegitimate pregnancies first requires an examination of the existing major theories as to their possible cause. These serve best to illustrate those social and emotional factors most likely to predispose a girl towards such a pregnancy. Factors such as these are generally described in terms of family breakdown, lack of parental supervision and guidance, peer and adult attitudes and pressures and ignorance.[9]

A. PSYCHOLOGICAL THEORIES

Psychological theories focus mainly on personality problems, unsocialized personalities and unconscious but purposive behaviour. Leontine Young (1945:28) was a major proponent of the last mentioned probable cause. She proposed that "...everything points to an unconscious purposeful nature of the Act - She wants a baby and specifically, one out of wedlock - without a husband."[10]

Abernathy et al (1975) in attempting to develop an instrument for identifying high risk individuals for an unwanted pregnancy, suggests

that, without reference to sexual history, there are certain psychological and experimental characteristics within this group which may allow for the development of a significant approach to the prevention of these pregnancies. These characteristics include:

(a) family life experiences in adolescence are critical in the development of relatively stable attitudes and personality traits.

(b) parent's marriage is characterized by distance and hostility,

(c) alienation from her mother as a young teenager,

(d) an excessively intimate relationship with the father to the exclusion of the mother.

Abernathy states "in these situations there is a redefining of roles, with the daughter assuming some of the mother's functions as companion to the husband/father". (p. 1028)

The mechanisms thought to translate these experiences into risk for unwanted pregnancy centre around low self-esteem and anxiety over the incestuous overtones in the relationship with the father, often generated by the unsatisfactory relationship with the mother. A relationship, therefore, with another man reduces this anxiety and temporarily raises self-esteem.

Meyerowitz and Malev (1973) outline seven causal factors contributing to what they call "the predictive model of adolescent pregnancy". These are (a) pregnancy as a response to self-esteem (low ego strength), (b) apathy and/or depression, (c) conflict between negative sanctions or illegitimacy and the peer-tolerant subculture, (d) specific delinquencies (e.g. acting out school truancy), (e)

psychosocial developmental deviance, (f) inconsistent socialization, (g) world view (locus control).[11]

Other contributing factors (discussed by Barglow et al 1968, Gebbard 1958, Reiss 1965) include poverty, anomie, pressures of the inner city and the urbanization of racial groups.

B. SOCIAL THEORIES

The three major groupings of social theories are:

(a) Social Relativism postulated by Christensen (1960) and Roberts (1966). Their premise, according to Roberts (1966:14), is that illegitimacy like any other social phenomena is subject to the value system of the group within which it occurs. Some cultural groups may have norms opposed to illegitimacy while others may have counter-norms which sanction illegitimacy or no norms about it at all.

(b) Cultural Absolutism - Legitimacy is the absolute norm. Malinowski (1930) stated there is a principle of legitimacy which is cross-cultural. Illegitimacy is under universal and inviolate taboo in any society. Deviance from this norm is subject to punishment and sanctions.

Goode (1963) in supporting this theory states that he does not accept the existence of counternorms. He explains the variations in illegitimacy rates among various social and ethnic groups in Western society as being closely related to the state of anomie. The lack of total assimilation into the majority group culture results in a diminished access to social rewards and punishments. The result is

anomie. There is therefore no real commitment to adhere to the prevailing norms including the Principle of Legitimacy.

(c) Cultural Relationism. Vincent (quoted in Roberts 1966:17), the leading proponent of this theory, expanded upon this concept which was originally formulated by Karl Mannhein (1952:76). Mannhein states that "all the elements in a given situation have reference to one another and derive their significance from reciprocal relationship in a given frame of thought". Vincent expresses the belief that illegitimacy is related not only to the Principle of Legitimacy but to other norms as well as depending on attitudes and social policy within the larger social context. A society, while holding negative sanctions against illegitimacy may, at the same time, maintain permissive norms about related behaviour. The result is a contradiction of social goals and a confusion of attitudes and values resulting inevitable in a higher rate of illegitimacy.

Other social theorists, among them Rainwater (1966) and Rodman (1966), reject the above three theories and claim that illegitimacy is a cultural phenomenon. Certain groups within a society i.e. working class, certain peer groups etc., without abandoning the general values of the society, develop an alternative set of values. Within their own cultural framework, norms governing marriage and legitimacy are such that where a nonlegal "marriage" union or an illegitimacy occurs, the participants are accepted without negative sanctions and for certain reasons, i.e. proof of fertility etc., may be considered desirable in a marriage partner.

In 1975 Hartley introduced the concatenated theory[12] of illegitimacy. He stated that:

> Illegitimacy may be studied as a result of a process of interdependent events which may be avoided at any one of several stages. At each stage in the chain of events social factors influences the outcome. The myriad considerations involved in the production of births out of wedlock influence at least five concatenated factors in a sort of funnelling process that narrows the range of alternatives to registration of a birth as illegitimate. (p. 102)

By examining the multiplicity of factors which influence the decision making of a single pregnant girl, Hartley narrows the range of alternatives to registration of a birth as illegitimate, by focusing on five major concatenated (interrelated) factors. These are (a) proportions unmarried; (b) sexual intercourse; (c) conception; (d) marriage during pregnancy; and (e) abortion.

Within each society there are well established patterns for marriage. Unmarried females of childbearing age are technically therefore at risk for pregnancy. Whether such pregnancies occur, are terminated, or brought to term, depends upon the type of social responses (negative or positive) encountered along each stage in the chain of events leading to an illegitimate pregnancy and its outcome.

Hartley surmises that, by close examination of these factors, questions as to what appropriate measures for the reduction of illegitimate births might be successfully investigated, could well be answered.

Lindemann (1974) proposed a substantive theory of birth control behaviour. She described three stages through which unmarried women pass as a means to avoiding pregnancy - the natural stage, the peer stage and the expert stage. The natural stage is where the sexually

active young girl will do nothing about obtaining an effective birth control method. The peer prescription stage is where the young girl tries to learn how to prevent pregnancy by discussing the problem with her peers. The expert stage is where the girl is ready to disclose her sexual activity to an expert in order to obtain an effective means to avoid pregnancy. There are no rules or established norms for birth control practices and the young woman chooses her own birth control behaviour patterns. Lindermann terms this the birth control prescription process. Although birth control methods become more effective with each succeeding stage in the process, there can be failure where pregnancy occurs. Knowledge of this process, to quote Lindemann:

> ...should enhance efforts in the immediate short-range interventions as well as in the context of some future comprehensive plan. (p.113)

The value of this theory, according to Lindemann, is that is specifies the stages and conditions that are accessible to change. Like Hartley's concaternated theory, it provides for stage analyses making it possible to predict what affect various interventions might have on the behaviour of the system.

The various theories discussed so far, cover many conditions and situations which could put an unmarried female of childbearing age "at risk" for an illegitimate pregnancy. An important element, insufficiently discussed in the literature, is that of change. Circumstances and opportunities for early dating, going steady, peer group activities etc., often lead to errors in judgment or impulsiveness resulting in unprotected sexual intercourse.

Where the sex act is deliberate, pregnancy may occur as a result of lack of knowledge, miscounting, a calculated risk or oversight. Where, however, the act is unanticipated, the girl usually never considers the possibility of pregnancy and she therefore, has a lesser ability to cope with reality. She is often forced to make hasty decisions, the rationality of which she has neither the maturity nor the time to adjust to and ultimately accept.

Another question for further study should perhaps be - to what extent does the responsibility for this situation lie with the girl herself? Does she, despite of having to bear the brunt of the negative and sometimes punitive responses of others, in fact initiate the sequence of events leading to her pregnancy. Statements such as "my boy friend insisted on intercourse. If I didn't go along with him I'd have lost him" are quite commonly expressed, yet on the other hand indications are that these situations are often seen to be reversed. As one high school boy expressed it:

> "You wouldn't believe how easy it would be to go that far with some of the girls at school. They all but ask you to do it".

Who seduced whom? And why? The answers could very well lead to the further identification and clarification of those factors precipitating men and women towards an illegitimate pregnancy.

SEX NORMS AND SOCIAL CONSEQUENCES

The one area of concern in the choice for outcome of a pregnancy outside marriage, and not sufficiently discussed in the literature, is the nature of social responses, especially in the form of stigmatization and sanctions against a single pregnant woman.

The violation of the accepted sex norms and the resulting social consequences such as sanctions from religious, peer and/or other influence groups are generally given but token mention. Bernstein (1960) as one exception, discusses the effect of social mores and the consequences of general cultural norms as a means of possible clarification and identification of what these specific sex norms really are. She recognizes that this is never easy, and that most people are very ambivalent when asked to define or describe their personal values and beliefs about single pregnancy and their own preferred or actual responses. She further discusses the problems associated with these professed codes of behaviour and their not keeping pace with changing practices. Moreover, she postulates:

> the ideal of chastity and marriage continues to be cherished along with other cultural fictions. As long as the violation of the professed value is conducted with a decent regard for secrecy or is not otherwise detected, society is content to accept the implied and overt contradictions resulting from the gap between our professional and operational codes. (p. 102)

The despair and panic responses of many single girls at the initial stages of their pregnancy, reflects, in good measure, their own perceptions of their probable social status within their communities and their future relationships with their parents and significant others.

Christensen (1966), in attempting to determine whether sex norms and their consequences can be generalized across cultures, compares Danish, midwestern American, and Mormon cultures to determine the consequences of differential levels of restrictiveness on such factors as (a) deviation from the norm (b) the consequences of norm deviation and (c) how such restrictiveness could affect patterns of

subcultural variations. Social science, however, does recognize, in general, peculiarities in different cultures and tends to adhere to a theory of cultural relativism (see Roberts 1966).

Christenson argues[13] however, that not everything is relative to cultural norms. He explains this by identifying some phenomena found in his research which could be applied to each of the cultures studies, although not always to the same extent.

1. Most sexual intimacy and reproductive pregnancy occur within the institutional bounds of marriage.

2. The modal timing of first postmarital conception is approximately one month after the wedding.

3. Patterns of sexual behaviour are strongly correlated with personal attitudes and social norms; permissive thinking tends to beget permissive behaviour and restrictive thinking, restrictive behaviour.

4. Approval of non-marital coitus, as applied to the premarital period increases with each specified advance in involvement and/or commitment between the couple, but, as applied to the postmarital period, the reverse is true.

5. Females are more conservative in sexual matterns than are males, almost without exception and regardless of the measure used or whether it measures attitudes or behaviour.

6. Females who engage in premarital coitus are more likely than males to do so because of pressure or felt obligation, and also, more than males, to have as a partner either a "steady" or a fiance(e).

7. There is a suggestion - though the testing was inconclusive - that persons who have premarital coitus are disproportionately low on satisfaction derived from their courtships.

8. Couples who marry for reason of pregnancy subsequently experience higher divorce rates than the postmaritally pregnant.

9. Of the married couples, higher divorce rates are found for the "shotgun" type, that is, those who wait for marriage until just before the child is born, than for those who marry soon after the pregnancy.

10. Of those couples who marry for reason of pregnancy, higher

divorce rates are found for the early conceivers than for those who wait a few months before starting their families.

11. Premarital pregnancy is greater among young brides and grooms in contrast to older ones, among those who have a civil wedding in contrast to a religious one, and among those in a labouring line of work in contrast to the more skilled and professional occupations.[13]

The complexities of social living are constantly being exacerbated by both unexpected events (Claman 1969), and the continual barrage of conflicting life patterns, attitudes and beliefs imposed by the sophistication of today's communication channels, in particular, the media. Furstenburg (1976:1-4) reviews the consequences of these factors on the norm compliance and disturbances of social roles for those who become pregnant outside of marriage. For instance, Moss (1964) states that "the scheduling of marriage and parenthood will depend on the type of kinship systems, on the social and economic value of children and probably on demographic constraints on population growth". (p.99)

It is, therefore, of major importance to determine what exactly does occur to those who supposedly deviate from the established norms for marriage and pregnancy. How do 'others' handle the situation? How do their responses affect the outcomes of illegitimate pregnancies?

One of the objectives of this study is to attempt to answer these questions.

The attitudes of young people towards sex are strongly dependent upon (a) the quality of their relationship with significant others, (b) their knowledge of human sexuality and the human reproductive cycle, (c) the availability and extent of expertise of resource persons for counselling and service, (d) and their own personal beliefs and adherence to the norm values and schedules subscribed to within their

social and cultural environment.

In Canada the main contributions to the literature in these areas come from major surveys conducted by Arnold (1974) in Hamilton, Ontario, Le Riche (1974) in Kingston, Ontario and Selin (no date available) in Saskatchewan.

The study by Arnold (1974) of 466 males and females showed a discrepancy between the rates of non-virgin males (63%) and non-virgin females (37%). This was particularly true for the 13-15 year old group. The 16-19 year old group indicated a suggestion that female non-virgins had a greater number of coital experiences per individual than male non-virgins. In both the female and male population, age and grade level were positively correlated with coital experience. For the males, 100% of 16-19 year olds not living at home (N=12) were non-virgin compared to 68.9% of those living at home. Males whose fathers had less than grade nine level of education had significantly greater incidence of coital experience than males whose fathers had a grade 11 education or more. 83.3% of girls whose mothers did not live at home were non-virgins compared to 34.3% of those whose mothers did live at home. For the male, however, no such correlation existed. A survey in Saskatoon of 265 teenagers, carried out by Selin (date unknown), and which focussed on the degree of their knowledge and attitude towards birth control shows that:

(a) 83.4% of the respondents indicated a greater need for birth control information with 49.4% stating that such information be made available to those from 15 years of age and up and 41.1% to 14 and under.

(b) Although 90% wanted birth control information to be made available from 14 up only 37.7% said they planned to use it in the next three years.

Reasons most commonly given for not using contraceptives were:

(a) lack of information - 26%

(b) personal moral reasons - 14.3%

(c) requires too much planning - 14.3%

(d) methods not available - 6.4%

The level of the respondent's control methods was poor:

(a) 29.9% falsely believed that feminine hygiene products could be used as contraceptives

(b) 25.7% believed that withdrawal is a reliable form of birth control

(c) 31.7% thought orgasm was necessary before conception could occur

(d) 48.4% did not know which methods would protect them from venereal disease

(e) 20% did not know when to take birth control pills.

Studies of the attitudes and utilization of family planning services by Alderdice (1972) who focussed on Newfoundland in general, and Kirby (1975) and Bruce-Lockhart (1973) in the city of St. John's serve to demonstrate, to a degree, the extent of the need for more comprehensive contraception information and ongoing counselling for Newfoundland men and women. Kirby (1975) concluded that more than 85% of the respondents stated that there was a great need for such services, particularly for the teenager. He also stated that the

finding revealed that, while physicians were the most preferred source for contraceptive information and counselling, they were more likely to be contacted by the younger, more schooled 'professional' person and not by the older blue collared and less schooled person. The latter group were also more strongly opposed to the dispensation of abortion information from any source.

Bruce-Lockhart (1973), in an earlier preliminary survey to determine the feasibility of opening a birth control clinic facility, concluded that contraception information and counselling was generally being provided "after the fact", usually while attending a pre-natal class or when she returns to the physician for her six-week postnatal examination. One conclusion from the above findings, is that the unmarried pregnant woman who rarely avails herself of the first program and, if under age, is seldom offered the second choice, remains in ignorance or must rely upon sources other than the physician for this service.

The lack of knowledge concerning basic human anatomy and physiology, human sexuality, menstruation and the reproductive cycle is of particular concern in most studies (Cutright 1971, Arnold 1974, Berg 1975, Kirby 1975 and Alderdice 1972). Malo Juvera (1970) for example, found, in her study to determine the adolescent girls' "true feelings" towards sexuality and their sexual habits, that their responses to questions concerning menstruation were very "matter of fact". They had difficulty pinpointing the dates of onset, but could identify some specific event occurring around the time of menses. Their responses did indicate a significant correlation between the age of

onset (usually around the age of twelve) and the age of coitus. A period of two years generally preceded a pregnancy, coitus usually occurring, on an average, once a week.

In another study of 421 male high school students, Finkel (1975) found that, at last intercourse, 55% of the boys used no contraceptives or relied on withdrawal, or on their partner's douching, and that half of the sexually active boys had begun sexual activity before the age of 13.[14]

While these surveys cannot in themselves, present the complete picture, they do show that access to correct knowledge, and professional counselling on human sexuality, relationships between males and females, birth control methods, and social resources are minimal, or too often incomplete or misunderstood. The family's role in the development of attitudes and practices is not necessarily positive and cannot be relied upon, as too many parents and other female members have not themselves had previous opportunities to acquire the means to a "guaranteed" healthy or successful sexual attitude or relationship with others.

DECISION MAKING FOR PREGNANCY OUTCOMES

Literature focussing on decision making for outcome in the event of prenatal conception, demonstrates the importance of taking into account the particular value systems, norms and social structures of different settings within their own environmental context before evaluating significant trends in decision making (Hartley 1974, Cutright 1973, McKilligan 1976).

Options for pregnancy outcome, whether chosen by the girl herself, or chosen by others for her, largely depend on (a) the known and/or anticipated responses of others, (b) whether alternatives and their implications for the future of all involved have been properly weighed and evaluated and (c) the extent of their knowledge and understanding of such alternatives for pregnancy outcomes.

Making decisions for pregnancy outcome, regardless of all factors, are limited to the following choices:

(a) marriage prior to giving birth.

(b) single parenthood

(c) adoption of the infant.

(d) abortion

(e) marriage to the putative father after birth of a live infant.

Each of these options as discussed in the literature will be dealt with separately.[15]

MARRIAGE

Zelnick (1974), in a survey of statistical data in 1971 from available United States sources, concluded that about 35 per cent of the women who experienced a premarital first pregnancy, married before the outcome of that pregnancy. Whites were about six times more likely to do so than blacks. There was a greater propensity of whites to marry following a premarital conception, even if the pregnancy ended before the marriage. More than one-fifth of the women who did not marry before the outcome of their first pregnancy ended it by abortion.

Women who did marry reported no abortions.

McKilligan (1973) estimated that approximately 2000 out-of-wedlock pregnancies occur in Newfoundland each year. More than half of the teenage marriages were due to pregnancy.[16,17] Traditionally in some areas of rural Newfoundland, proven fertility, through pregnancy, generally leads to marriage; but should such a marriage not occur, the illegitimacy is "tolerated" and the child integrated into the girl's family.[18,19]

Studies by Furstenburg (1974), and Sauber (1970) serve to illustrate the fragility of marriages performed for the legitimation of offspring. The literatures does not yet provide enough data on the long term effects on the couple and other family members of these precipated marriages. What is generally referred to, however, are observational statements that premarital pregnancy greatly increases the probability of marriage breakdown and its dissolution.

In the Baltimore study in 1976, Furstenburg looked at marriage patterns of adolescent mothers who were followed for a five year period, ending in 1972;- 3% had been married at the time of conception, 20% married before the first visit to a prenatal clinic, and at the end of the five year period only 36% remained single (most marriages were to the fathers of their child). Of those married, more than one third married before delivery, three-fifths within one year following delivery, and three quarters within two years after delivery. Furstenburg suggests that their findings also strongly indicated that, were it not for the births, most of these marriages would not have taken place when they did. Furstenburg also found that three out of

five premaritally pregnant mothers, aged 17 or younger, were separated or divorced within six years of marriage. One fifth of the marriages were dissolved within 12 months, two and one half times the proportion of broken marriages among class-mates who were not pregnant premaritally. Those who married the child's father prior to giving birth were more likely to stay married than those who waited until after the child's birth.[20]

The P.P.P. report of 1976 shows (a) that 10% of United States teenagers get pregnant and that 6% give birth each year, (b) one-third of teenage births are conceived prenuptially, (c) brides of 17 and younger are three times more likely, and husbands twice as likely, to separate from their spouses than those who marry in their early 20's, and (d) more than one quarter of first marriages where the bride is 14-17 ends in divorce or separation compared to 10% where the bride is 20-24.[21]

An ironic fact is that marriage for the legitimization of a child does not necessarily prevent single parenthood status for approximately 50% of those "mothers" who choose it. Emotional immaturity, frustration at the interruption in educational pathways for both mother and father, social difficulties and economic restraints, ignorance of parental responsibilities and roles, including child care, are often too overwhelming to allow for the building and maintenance of a solid relationship between the couple forced into such early marriage.

SINGLE PARENTHOOD

Studies of mothers in the United States who keep their babies; focus generally on their reasons for making this decision. Discussions centre on emotional, religious and social pressures, combined with the social and emotional adjustments of the mother and her child in a society which considers the triadic family (mother, father and child), as the acceptable norm. (Vincent 1961; Leyendecker 1961; Rainwater 1960; Furstenburg 1976; Giovanni 1970; Osofsky 1973; Corrigon 1970; Sauber 1970).

Vincent (1961), in a study of 268 mothers, found that those who kept their children were usually older, had less education, came from larger families of lower socio-economic status, broken homes, and were working mostly in unskilled occupations rather than attending school.

Grow (1960), in her review of the literature on the unwed mother who keeps her child, states that while the findings of other studies do not present such a uniform picture as that provided by Vincent, they do suggest that:

(a) White mothers who kept their babies tended to be less educated than white mothers who relinquished their children for adoption. However, both white and nonwhite mothers who kept their babies were similar in education.

(b) Mothers who kept their children were in lower-status occupations, although the job difference between these mothers and the other mothers was not so great as that found earlier by Vincent.

(c) Among the mothers who kept their babies, a larger percentage of their parents were separated or divorced, and parental incomes were lower than among the other mothers.

(d) More of the putative fathers were not legally free to marry the mothers who kept their babies.

(e) Religion, which at one time was considered a factor in the unwed mother's decision about keeping her baby, proved not to be one

in the case of these women.

(f) For the white mothers, age was not a factor. However, the medium age of the nonwhite mothers who kept their children was about a year younger than that of the other group.

The P.P.F. (1976) report gives the following findings on teenage single parents:

(a) 8 out of 10 women who first become mothers at age 17 or younger never complete high school. For those aged 18 or 19, the risk of dropping out of school before graduation is 1.4 times higher.

(b) Pregnancy is more often cited by female teenagers as the reason for dropping out of school.

(c) 91% of teenage mothers in the New York study (Presser 1973) who had babies at ages 15-17, had no full-time or part time employment - 72% of whom were on welfare.

(d) The younger the women at first birth, the poorer the family. Young families are 1.8 times more likely to be poorer than older families.

(e) Married women who begin child-bearing before they are 18 will have 1.8 times more children than those who wait until they are 20-24 years of age.

ADOPTION

There is less discussion in the literature on the subject of adoption as a preferred option for the resolution of an illegitimate pregnancy. The greater accessibility of abortion services reduces the need to face, what is greatly feared by single pregnant girls, namely, labour and delivery, and anticipated social sanctions and stigmatization. A third, and probably the most influential factor, in terms of changing attitudes amongst professional health and social workers, as well as the young mothers, is the growing awareness of, what is commonly referred to in the literature as, the mother-infant bonding phenomen.

22

Klause (1976) and his colleagues have helped to provide basic insights into the process of the developing relationship between the mother and her child. The too often insensitive manner in which a young mother, while desperately trying to cope with a major social and emotional crisis situation, is "forced" to relinquish her child, results frequently in regrets, guilt and emotional ambivalence thereby seriously inhibiting her readjustment into her social milieu.

Commenting on the long standing practice and approaches to adoption in the past, and its long term effects upon the mother, Bernstein (1971) points out the necessity of helping a young mother to emerge from her pregnancy with as positive an image of herself as her personality and circumstances will permit. The danger of forcing her to block out large areas of affect by an immediate separation (following delivery) between her and her child, when an adoption is planned, can cause irreparable harm to her future ability to function as a mother.

Vincent (1969) in a study focussing on some of the characteristics of mothers who do, however, relinquish their children, as well as other contributing factors, found that of the 71 mothers in the study group, nine, who were products of unhappy homes, had dominating and/or rejecting mothers, and felt within themselves that they had little chance for a successful marriage. Approximately 42 of the subjects were strongly influenced in their decision by their strong identification with adults, peers and social groups who communicated and maintained a meaningful awareness of the stigma attached to illegitimacy.[23]

Organizations, agencies and individuals who oppose abortion for non-therapeutic reasons, are trying to reverse this trend and offer extensive and comprehensive services to unwed mothers in order to encourage them to revaluate their options in favour of adoption for their babies, rather than abortion. (Kelly 1975; Gentles 1974; Petrov 1971)

ABORTION

Legalized abortion, through the enactment of liberalized Abortion Laws, commencing in 1967 in the United States, and in Canada, with the enactment of Section 251 of the Criminal Code, Revised Statutes of Canada 1970, Chapter C-34, commonly referred to as the Abortion Law, has had a profound and dramatic effect on the illegitimacy rate in these two countries.[24]

THE UNITED STATES

Sklar and Berkov (1974: 913-924) in an overview of abortion, illegitimacy and the American birth rate conclude that, in sum, it appears that legal abortion depressed overall fertility by providing the opportunity to terminate an unwanted pregnancy when other means of birth control failed. These prevented births represented almost 10% of all out of wedlock children born in 1971. This measure reduced the incidence of marriages for reason of pregnancy and thereby helped to limit subsequent marital disruption. It also prevented large number of illegal abortions, estimated at more than a half of the legal abortions performed, that might have occurred illegally if the legal services had not been provided.

CANADA

Planned Parenthood Federation of Canada, in 1974, recorded that there were 38,626 births to young women 12 to 19 years of age and that 5,504 of these were to girls 12-16. There were also 48,136 abortions performed in Canada. Thirty-one per cent of 41,227 cases analysed were teenagers. (Of note is the fact that more than half of the 47,680 cases of gonorrhea recorded in 1974 were in the age group 15-25.)[25]

Badgely (1977:46-47) states that the increase in the number of reported abortions since 1970 may have influenced the course of illegitimate live births. The increasing trend in the number of illegitimate live births and the illegitimacy rate, clearly visible from 1966 to 1970, subsequently dropped. For British Columbia, Ontario and Alberta, which had reported induced abortion rates consistently higher than the overall rate for the country, the reduction in illegitimacy rates after 1970 was clearly visible. Newfoundland, Prince Edward Island, Nova Scotia and New Brunswick reported induced abortion rates lower than the national average, while the illegitimacy rates have increased from 89.5 per 1000 live births in 1970 to 116.0 in 1974.

When estimates of ratios of abortion per 100 live births in 1974 are recalculated to include the number of Canadian women who obtained abortions in the United States in 1975, Badgely's findings, shown in Table 2:1, are:

Table 2:1 Estimations of ratios of abortions per 100 live births of women seeking abortions in the United States in 1975	
Newfoundland	22.2
Prince Edward Island	19.2
Nova Scotia	22.0
New Brunswick	47.9
Quebec	73.1
Ontario	7.0
Manitoba	23.2
Saskatchewan	12.8
Alberta	12.9
British Columbia	3.5
CANADA	14.4

Badgely also reports that in 1974 - 10 out of every 1000 women between the ages of 15-44 had a reported induced abortion in a Canadian hospital. For every 100 live births there were 139 induced abortions. Other calculations from the national survey data survey data shows the following numbers of Canadian women who procured an abortion either by self inducement or illegal means. (Table 2:2)

Table 2:2 Canadian women who procured an abortion by self-induction or illegal means (rates per 1000 women) in 1975		
Age	Self-induction	Illegal abortion
15 - 17	-	-
18 - 23	6.8	3.4
24 - 29	15.8	6.2
30 - 49	5	12.6
50 -	15.5	2.2
	42.1	24.4

Estimates are that 46,096 women between the ages of 15-49 had an illegal abortion, and 55,061 had tried, or had one by self induction. Excluded from these calculations were women who left the country for the purpose of a self-induced or illegal abortion. (p.71)

When combining the numbers of Newfoundland women who had induced abortions both in Canada and the United States in 1974, Badgeley estimates the ratio per 100 live births to be 22.2, slightly more than 1 for every 5 live births.

Services to pregnant unmarried adolescent and others are as varied and complex as attitudes, values, times and resources will allow. Most studies incorporated suggestions and recommendations for approaches to services, techniques, organisations and qualifications of staff, best suited to meet the multiplicity of needs expressed and identified by the pregnant girl and her significant others, plus the health and social professionals who intervene on her behalf.[26] Many of these services are planned to meet needs common to all facing illegitimate pregnancy, yet specific problems are demographic in nature, and some services must, therefore, be made more suitable to the ethnographic variables found in their own environment and social milieux.[27]

Baizerman et al (1974) in their critique of literature concerning pregnant adolescents (1960-1970) made suggestions that would contribute to a stronger empirical base for future assumptions (of difference of homogeneity and special need) regarding pregnant adolescents. This critique, while it does give recognition to the research on personality, mental states, and pregnancy behaviour, plus analysing risk concepts presented by the adolescent, recognizes that such study is both

quantitatively and qualitatively limited.

There has been some work on the development of attitudes and values, and the growth of understanding and the ability of youth to cope with ever changing physical, emotional and socio-sexual selves. Theorists such as Piaget and Erikson, amongst others, contributed much to the understanding of the sexual development of youth. There has also been too little done, however, to assist society in its adjustment to the ever-changing attitudes and behaviour of their youth. Guidelines for changing sex related directives to the young without violating the very values upon which the society was built, are needed. What usually occurs is, as noted by Bernstein (1960:102)

> ...most adults sooner or later arrive at some sort of equilibrium in the cultural tight rope walking act within which their satisfactions and their consciences manage a remarkable peaceful existance.

This balance usually comes too late to be of much help to the young person faced with a confusion of contradictions with respect to acceptable sex norms and behaviour.

In the following chapter the findings from this study are discussed as a means towards reducing this dilemma where the sex-related behaviour of some lead to problems for which others including the helping professions, do not have the answers.

FOOTNOTES

[1]For more on the subject of legitimacy and illegitimacy including social rules and norms governing the social status and placement of children born outside of marriage, see Goode (1964), Chapter 3. The key role of socialization, legitimacy and role obligations and norms defining legitimization and the control of illegitimacy are discussed providing some insight into the reasons for the development of these norms for the maintenance of basic social structures, and in particular, the family.

[2]See Dwyer 1973, Duenhoelter et al 1974, Sorrel et al 1969, Utian 1967.

[3]Zackler 1975 (pp. 86-87) elatorates on the literature contributions explaining the trend where the average age of maturation in teenagers in the U.S. is dropping. This is corroborated by studies from Norway, Germany, Finland, Sweden, Denmark and Great-Britain. Tanner (1960) explains that adolescent mothers are, however, at greater risk if pregnancy occurs before the association of linear growth which is generally estimated by about seventeen years of age.

[4]See also McGarrity et al 1971, Marrinoff 1972.

[5]For further discussion on these conditions see Aznar & Bennett 1961, Furstenberg 1976, Guyatt 1972, Klava 1973, La Barre 1969, Marrinoff 1972, Osofsky 1968, Smith 1971, Sorrell & Klerman 1969.

[6]Zackler 1975 (p. 128) comparing the findings of studies by Aznar 1961, Coates 1970, Jovanic 1972, Jorgenson 1972, and Lewis 1967 found that, except for Aznar, Caesarian section rates among teenagers were lower than the general population. Significant longterm studies on the future reproductive performances of those having Caesarian sections before reaching the end of linear growth, are not yet available.

[7]For further discussion on this issue see Chapter 3 of this study.

[8]This report is entitled "11 million teenagers. What can be done about the Epidemic of Adolescent Pregnancies in the United States". A publication of the Alan Cuttmacher Institute. The Research and Development Division of Planned Parenthood Federation of America, 515 Madison Avenue, New York, N.Y. 10022, 1976.

[9]See LaBarre 1969, Linndermann 1974, Zuckerman 1969, Vincent 1961, Furstenburg 1976, Roberts 1966, Price 1954, Cutright 1971, Christenson 1969, Paul et al 1974, Kantner 1973, Pipel 1956, Middleton 1974, Gushue 1974.

[10] See also Stone 1974, Davis 1971, Klavs 1973, Wallace 1973, Berg 1975, Guyatt 1964, Le Riche 1974, Selin (date unknown), Lewis et al 1973.

[11] Supported in measure by Barglow et al 1976, Kemp 1975, Klentzos et al 1965, Miller 1974, Zackler 1975.

[12] Hartley pp. 102-118 - Webster's New World Dictionary 1972, defines concatenate as "to link together or join as in a chain." Hartley also provides an extensive overview of previous theories pp. 65-101.

[13] The references cited by Christensen are to be found in his research report "Normative Theory Deprived from Cross-cultural Family Research". Journal of Marriage and the Family. May 1969 pp. 209-222.

[14] For further discussions on the sexual behaviour of adolescents see also Osofsky 1971 and Merero.

[15] For general discussion on these choices in various settings see Hartley 1975, Macintyre 1977. The Allan Guttmacher Institute publication 1977 "11 Million Teenagers", McKinley 1970, Giovanni 1970, Roberts 1966, Vincent 1964.

[16] Cutright 1973 discusses legitimization of births conceived out of wedlock with comparisons between the United States and other countries p. 34.

[17] According to Vital Statistics Canada the population of women aged 15-44 in Newfoundland in 1973 was 103,900. The marriage rate was 9.3% (4th highest in Canada) and the median age of brides 20.7 years, lower than the national average of 21.4. There were 11,906 registered live births of which 1,345 were illegitimate. The discrepancies in these numbers with McKilligan's estimates can be attributed to the unknown numbers who abort secretly or marry for legitimization of their infants' legal status. More current statistical information is documented in Chapter 3 of this study.

[18] This was corroborated by comments from subjects as to the attitudes of the people in their own communities.

[19] Faris (1972) describes one outport community family pattern structure which includes the category known as 'fork kin'. This provides a link to those with whom one has a tie of some sort which is unnatural, extraordinary, or in some way apart from the normal kinship links established in the usual course of events. Included in these relationships are illegitimacies.

[20] See also Cutright (1971), Christenson (1960)

[21] Furtenburg (1974 pp. 61-77) provides what is probably one of the most definitive overview and literature review on the subject of marriage as a chosen option to legitimize pregnancy.

[22]Klaus explores the historical development of studies on mother-infant bonding, the impetus being the return to hospitals of babies nutured through prematurity within hospital environments, yet battered and almost destroyed by parents (p.2). Studies on the impact of early separation and loss on family development have made significant changes in attitudes of professional, health and social workers towards counselling for adoption and young mothers for decision making for adoption of their infants.

[23]Grow reports in some detail the findings of the National Data Collection Project granted by the U.S. Children's Bureau. 21,000 reporting forms were submitted by 122 voluntary agencies. Questions were based according to the mother's decision to keep or surrender her child.

[24]It should be noted, however, that while these laws now make it possible to obtain a legal abortion for therapeutic reasons (physical, emotional and social cause) there are many women who do not have ready access to available services. The reasons for this include geographical, economic, social and religious factors. This is particularly true for Newfoundland women as St. John's General Hospital is the only agency in the entire Province which performs therapeutic abortions for those referred by physicians to their abortion committee.

[25]See Planned Parenthood Federation of Canada information pamphlet, "Parenthood is as old as life." Planning for it is not".

[26]See Badgeley (1977), Chinlund (1970, Danforth (1971), Davis (1971), Dawdy (1969), Dickens (1973), Duncan (1977), Howard (1971), Johnson (1969), Khlentos (1965), Klerman (1973), Nadelson (1974), Neville-Smith (1971) Nfld), Osofsky (1973), Packer (1976), Ravenholt (1974), Roulet (1969), Schlesinger (1973), Smith (1971), Wallace (1973), Watts (1971), Webb (1971).

[27]The relevancy of existing specialized services for pregnant unmarried women in areas other than St. John's, can only be speculated upon in that, to date, options for outcome of such pregnancies must be made within the existing formal health and social services programs shared by pregnant women, both married and unmarried. This is discussed in greater depth in Chapter 5 of this study.

CHAPTER 3

"You can bear anything if it wasn't your fault".

Katherine Fullerton Gerould
(1978-1944)

THE PROBLEM

SOME PREGNANCY CAREERS

The first part of this chapter gives a brief description of some of the situations and circumstances surrounding a single pregnant woman in this community.*

Joan, a Catholic, newly graduated from Grade 11, stated she had been raped by her boyfriend's brother while working on a summer job in Halifax. "It happened one evening when he took me from a party". She flew home a few days after the event and told her mother who immediately took her to a doctor. When asked why she didn't report the incident, or at least seek medical care, she stated, "I was so tired I slept for 18 hours and I didn't know I should get help right away". She evaded any questions about the rape stating only that "I have to take 'the pill' for medical reasons and forgot my prescription at home. My mother sent it to me but I didn't get it in time."

A friend of Joan's clarified the situation later stating that Joan had in fact broken up with her boyfriend and was not raped. She invented the story as she felt that her mother would cope with the situation better if she thought her daughter was raped.

*Fictitious names have been used throughout the study.

Anne, 17 years old (Catholic). She plans to carry her pregnancy to term as her parents would never consent to abortion. She hopes to conceal it for as long as possible before telling her parents, to give her partner and herself - "time to work things out. - My father will be mad for a couple of months and then he'll forget it. Mom will be O.K." Two older sisters were married because they were pregnant. Anne's partner is 22 years old and is an unemployed carpet layer. "I know he'll be pleased as he wants me to have his baby. Oh well! We planned to get married next year anyway. He quit work because he had some money in the bank and wanted to have a holiday. I have $1,200 given me by the Court for a whiplash I got in a car accident. This is a lot of money to get married and have a baby on! I would never consider giving up my baby for adoption."

Sue, 18 years old. A high school graduate, Protestant and classified legally as an emancipated teenager (able to support herself). She returned home temporarily but quickly moved out again to preserve her legal status: "When I realized the legal results of moving back home, especially now as I'm going to have an abortion, I left again. My father would blow his mind if he ever found out about my pregnancy. He would never consent to the abortion". She was afraid that she might be "too far along" for the termination and declared that "if the doctor won't get it done I'll do myself in! I had V.D. and gave it to my boyfriend. That was bad enough. I will find someone in New Brunswick to do it if necessary". Sue was not planning to tell her partner: "He's a suspected 'narc' and would probably be unrealistic and say 'keep it'. He has no money and is no good."

Betty, 22 years old. Salvation Army affiliation. She was very anxious, agitated and crying throughout most of the visit. She had been taking oral contraceptives until she broke off with her boyfriend. On the rebound she had intercourse with a fellow she met at a party and became pregnant. She continually expressed great anxiety about possible responses from her family, peers and associates. She insisted on abortion as her only recourse stating "I won't tell my parents as this would hurt them too much". A friend brought her to the P.P.A. as it was the only place she felt would assure her of confidentiality and she wouldn't be at risk of disclosure to others who might talk about her situation.

Lilly, 22 years old. University student. Her partner left school after grade 7 and is at present unemployed with very little prospects of any work in the near future. They do intend to marry later but plan to seek an abortion. They are both Catholic and as Lilly said: "We won't tell my parents as this would really hurt them. I would like to tell my sister but she might try to persuade me not to have this abortion". Lilly was very anxious about her pregnancy becoming public knowledge. "I may be able to cope with a baby but I worry about what people will think and say. I will graduate soon and I have a job to go to, but this pregnancy is really too soon to cope with."

Sally, 18 years old. 4th year university student. Her partner is Bob, aged 22, also a university student. Bob was very supportive and concerned for the wellbeing of Sally and their child. Both took time to seriously consider all the available alternative options, even to the

point of naming their prospective child.

The final decision was to seek an abortion outside the Province "for everyone's sake", although Sally said, "my mother is a very devout Catholic and would never forgive me if she ever found out. She made me sign an anti-abortion petition in Church the other day and all the while I was contemplating an abortion for myself. Mother constantly talks about moral fibre in families. There should be no sex before marriage. Father isn't so rigid, he would try to understand my position. I have always been very close to my mother and talk freely to her about everything, but this would be too upsetting for her".

Cathy, aged 18, a university student and from a Catholic family. She plans to conceal her pregnancy until she and her partner worked out a solution to their problems. "I'll probably get married. My boyfriend and I have a good relationship and I know he'll support me." Her parents are divorced and her father is an alcoholic and non-supportive financially. She sees her father about once a month and states, "he'll go crazy when he finds out but I don't care what he thinks. My mother will be hurt but she'll understand as she knows I'm human. She'll worry about what people will say - so do I. I'm known as a good girl and I did well in school. They'll say, 'see what happened to her!' I had a friend in school last year who got pregnant and she went through hell. The teachers did what they could but all the girls looked at her. I would never have an abortion. I'm Catholic and that's murder. Anyway, I want the baby as I'm baby mad. It never occurred to me to use the university health centre. I didn't know there was a doctor there".

These pregnancy careers provide some significant insights into the patterns of responses to a pregnancy outside marriage of both the girl herself and others. The following material attempts to identify more specifically those factors, as determined by the data collected, which influence the girl towards her volitional or forced entry into a pathway to pregnancy outcome.

SOME STATISTICAL DATA AND ANALYSIS

In this study 40 unmarried women were interviewed on a random basis immediately after the pregnancy test was found to be positive. By chance, 21 subjects were between the ages of 14 - 18, and 19 subjects between 19 - 24 years of age. (see Figure 3:1).

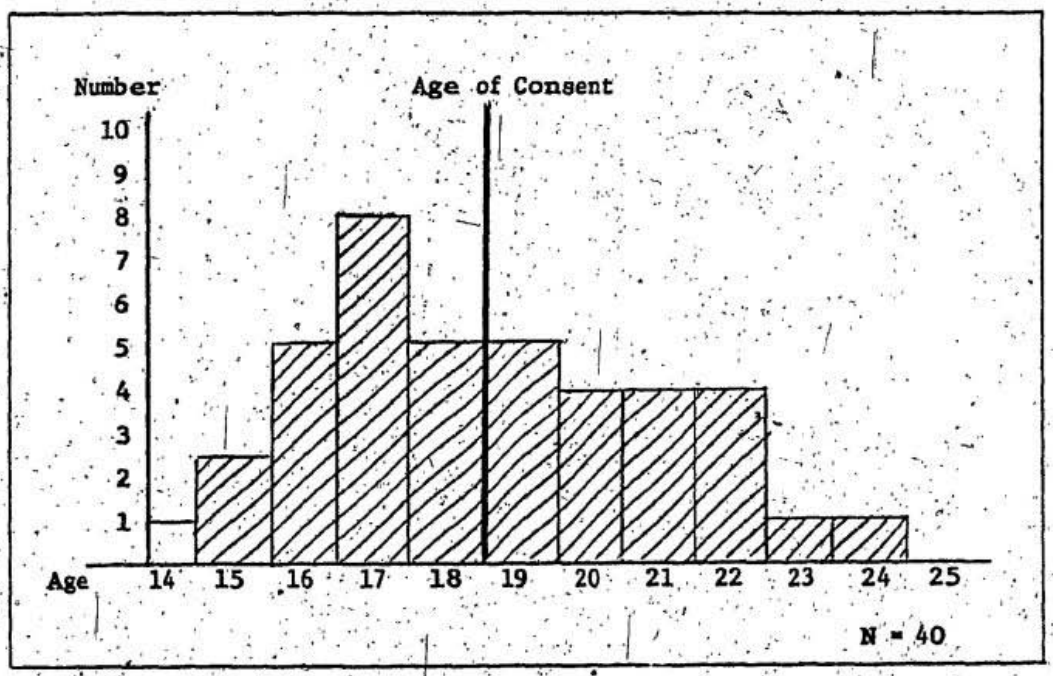

FIGURE 3:1 - Number of Subjects Interviewed - by age

In Newfoundland the legal age of consent for marriage and medical treatment is 19 years (except for treatment of venereal diseases). The legal status of a pregnant minor is therefore a factor of considerable importance in relation to decisions for outcome for such a pregnancy, both for herself and her child.

Pilpel (1976)[1] expresses the view that, while it is preferable for minors to discuss their health and sex related needs with their parents, when they cannot, or will not, such necessary services should be made available to them for alternative sources. This opinion is shared by many consumer groups and health care organizations.

In the United States and Canada there has been a significant increase of awareness and consensus of opinion (as evidenced by increasing legislation), that minors do have a constitutional right to receive sex-related health services without the consent of their parents.

These events are a direct result of major concerns for the well being of all those directly and indirectly involved or affected by these pregnancies. Delay in seeking appropriate care has resulted too often in physical and psychological complications that today are preventable, or, at least, controlled under constant monitoring by those best prepared for this task.[2]

According to Pilpel, and as far as can be determined in Newfoundland, there has been no reported case when a physician has been convicted or held civilly liable for damage for providing medical services to a minor without parental consent. This does not, however, reduce the possibility of a threatened suit for physicians who are

requested to provide service to a minor who does not wish parental involvement. As one physician explained:

> "This sixteen year old asked me to prescribe oral contraception for her. I refused and three months later she returned, pregnant and in great trouble. In future I will not be quite so rigid in my response to these requests."

Subjects over the age of 19 years interviewed in this study, demonstrated a very poor understanding of their legal constitutional rights in this province. Some who indicated sufficient knowledge in that they, having reached the age of consent, could give consent for treatment, expressed a grave doubt that their right to confidentiality would be respected by physicians and others, and that they would have no real recourse should this right be violated. Their major concern seemed to stem from the belief that, should their pregnancy become publically known, the whole situation would only become exacerbated by any action they might take against such informers.

INITIAL RESPONSES TO PREGNANCY

The state of shock, generated by the positive pregnancy test, resulted in, for all subjects, an immediate high anxiety state over the immediate future; first, with respect to the possible responses of significant others; and second, their inescapable entrance into the pregnancy cycle and possible motherhood. (see Table 3:2) Probable stigmatization and social sanctions, closely associated with parental responses and their social anxieties, precipated these girls to frantically seek the "quickest way out of the dilemma", searching for

answers from others rather than have to make decisions for situations for which they were not prepared.

TABLE 3:1 - Anticipated Negative Responses from Others to State of Pregnancy.

Responses from	Number of respondents
Social rejection	29
Hurting parents	15
Parental anger or rejection	
Mothers	4
Fathers	9
Church sanctions	2
Physical harm	2

There was a clear indication that generally anticipated responses from their fathers created a greater anxiety than did those from their mothers:

"My father would 'flip his lid' if he ever found out. He'd cause such a fuss and only make the whole thing worse. He would force me to marry because of what other people would say."

"He'd kill me. My two other sisters got pregnant. One got married but he and mum are taking care of the other child now. He couldn't cope with another one".

This fear of the father's responses was also demonstrated by some of the mothers of these girls. Four mothers who accompanied their daughters (all legal minors), and two, previously informed of the suspicion of pregnancy, advocated and sought information concerning abortion for their daughters to be performed without the father's consent.

Of particular significance is the fact that effective contraception was not used by any of the subjects in this study (Table 3:2).

TABLE 3:2 - Contraceptive use prior to pregnancy

Method used or not used	Number of subjects
Withdrawal (failure)	2
No method	38
	N = 40

21 of these 40 subjects are affiliated with the Roman Catholic Church (see Table 3:3).

TABLE 3:3 - Religious affiliations of subjects			
	Roman Catholic	Protestant	Total
Minors	15	6	21
Majors	8	11	19
	21	19	N = 40

A reflection of their attitude and practice in the use of contraception, in relation to the Church's stand on this subject, is of some significance (Table 3:4).

TABLE 3:4 Use and non-use of contraception by affiliated of Roman Catholicism	
Methods used or not used.	Number of subjects
Withdrawal and failed	2
Oral contraceptives in the past	2
Had prescription for oral contraceptives but became pregnant prior to taking them	2
No method considered	15
	N = 21

Only 4 subjects stated that they would comply with the Church's stand on contraception. Others expressed ambivalent views. These

responses seriously influenced their present situation. This was indicated by the fact that 14 girls requested information and referral to physician for an abortion.[3]

The most common reason, expressed or implied by subjects in this study for their non-use of contraception, was that the possibility of pregnancy was never a conscious consideration.

"I've always been so lucky. I just never thought I'd get pregnant. Anyway, he didn't go in very far."

"I'll go home and have a good cry. I guess I'm like all the others. I really didn't think I'd get pregnant."

Concern about the possible side effects of oral contraception had been a detterent to some of the subjects, while others expressed their hesitancy in discussing the subject with their partners assuming that they would take "care of it".

"I asked my boyfriend if I should take 'the pill'. He said he'd be careful. Hell! What can we do?"

Other reasons cited for the non-use of contraceptives were:[4]

(a) inaccessibility of contraceptive information and methods. While the majority had some knowledge of oral contraception, many were inhibited by having to request a prescription from a physician with fears that parents would find out, or in the case of legal minors (under 19 years of age), the need for parental consent for this service.

"I won't go to my doctor. He knows my parents and they would find out about it. I don't know any other doctor to go to."

The only official sources of contraceptive information in Newfoundland are physicians, nurses, and the Planned Parenthood Association of Newfoundland and Labrador. Schools are not permitted to offer any information on birth control methods.[5] Kirby (1975) reporting on findings from a survey on the utilization of Family Planning Services, recorded that the more schooling a respondent had the more likely she was to give private physicians as the source of help; the less schooling she had the more likely she was not to know where to get help.

(b) the belief that they would be labelled as promiscuous or as a 'bad girl' should it become known they were using contraceptives.

"I was on the pill but stopped as I didn't feel right about taking them."

"My mother wanted me to go on the pill but my father refused to give consent as he said that will make me a 'bad girl'". Now I'm pregnant and I don't know what he is going to do."

(c) ignorance of the process of conception and its control.

The implementation of sex education programs in the schools in Newfoundland has been sporadic and episodic depending largely on

the motivation and preparation of individual teachers. Without exception all of the 40 girls interviewed stated that they had had little or no organized teaching on sex related matters. Exploration as to the status of sex education supported by the School Boards, indicates that a concerted effort is being made to improve the quality of family life education commencing at the primary and elementary levels; but that at the senior level there is as yet only minimal programming, other than the content of biology classes which focus on the reproductive system.

"What a laugh! Our biology teacher is an older man and every time he brings up the subject he sputters and blushes and we just laugh at him".

"We had no sex education in school. I wish we had. Maybe, they could have a 'Blitz Week" where all sex matters can be discussed at all levels as well as given at other times".

Guidance counsellors are a primary referral source for those students who have access to such a person (see Appendix A). They supply appropriate information and counselling when approached. However, they usually are confronted by a girl already pregnant. The developing relationship between the counsellor and the students often becomes very positive and supportive, but is limited by the demands of others on their time. They do nevertheless, become quite involved in their efforts to direct the girl to her parents or other source of help, such as the physician etc. This situation

will likely continue until such time as sources for this kind of help become more readily available and are trusted by young students.

Indications as to the consequences of ignorance are illustrated by the following comments:

(18 years old) "She was a virgin so I was very careful not to penetrate. Now I don't know. I sure was surprised to find out she was pregnant".

(19 years old) "After my last abortion the doctor told me I couldn't get pregnant until I had had a period. I had a prescription for pills".

(18 years old) "I told my boyfriend after my last abortion that I wouldn't need birth control until after my six week's checkup".

(23 years old) "I had the pills in my purse, but was waiting for a period so I could start them at the right time".

(e) Emotional factors associated with the developing relationship between the partners.

This is usually a tenuous situation where anxiety over the strength of the relationship, the uncertainty level of commitment of one to the other, often leads to situations for which there has been no significant pre-thought.

"You know about these things, but everything happens so fast and you don't get around to it soon enough".

"We had no intention of having intercourse but it just happened".

The above findings compare with studies conducted in the United States and elsewhere in Canada. In a nationwide survey Shah (1971) reports that 79% of the respondents had either used contraceptives or only used them sometimes when having intercourse. Only 19% said they always used contraception (20% did not respond.)[6]

In Canada, Le Riche (1974) in Kingston, and Kemp (1976) in Winnipeg, report similar findings. Kemp reports 70% of all ages as having intercourse without using contraceptive methods.[7]

Lack of knowledge in relation to existing sources for sex related health services and the fear of public exposure prompts many single pregnant girls to confer with her closest friend, rather than seek professional help. The P.P.A. in St. John's has only recently become a primary centre for pregnancy testing and counselling, having over the past five years struggled to build public support and understanding for its major objectives. While many physicians collaborate with the P.P.A., and provide services in the new Birth Control Clinic (started in 1976), the major source for referral to this service still remains with those consumers who have in the past requested and received this care.

The majority of referrals to the P.P.A. (see Table 3:5) came from friends and relatives. This helps to demonstrate the fact that health professionals are rarely the first point of contact for the girl who is sexually active and may, or does, become unwittingly pregnant.

TABLE 3:5 – By whom referred to P.P.A. (St. John's Branch)	
Referred by	Number of subjects
Friends	25
Doctors	2
Sisters	6
Mothers	3
Education programs	1
Others	6
	N = 40

The genuine fear of disclosure of their pregnancy to the public inhibited many girls from approaching their physician for help. This anxiety was expressed even by those who had reached a legal majority and did not trust that their legal right to confidentiality would be upheld. That a physician would deliberately inform others was not the issue, but where he has treated other members of the family, the fear is more that he might inadvertantly rather than deliberately disclose the pregnancy. Another concern was that for many, a female physician was preferred, and referral to one was requested.

Complaints were also expressed concerning the quality of service from some physicians.

"He would not discuss abortion with me. He just sent me to the hospital for more tests. There was so much hassle there I just left".

This fear of public disclosure, as a major inhibiting factor in seeking professional care, is one important reason (as discussed previously) for the subject's reliance on P.P.A, for aid and referral to physicians other than their own family doctor (see Table 3:6). Another major concern, expressed or implied, is closely correlated to attitudes and quality of some physician services experienced, either by the girl herself or her friends in similar situations.

"I went to my doctor but he made me feel so bad that I wouldn't go back to him, so I came here. Can you give me the name of another doctor?"

TABLE 3:6 - Choice of physician while pregnant.

Legal age	Own physician	P.P.A. referral	Total
Minors	6	15	21
Majors	9	10	19
	15	25	N = 40

The educational status of the subjects (see Table 3:7) reveals that there was little difference between the levels of education and the predisposition of the girls to an unexpected pregnancy. The university and other post-high school students had, in general, as poor an

understanding of human sexual relationships and the reproduction process as did many of the younger girls. It was those in the younger group who failed in the use of withdrawal as a contraceptive method (2) and were incorrect in their use of oral contraceptives (see Table 3:2 and 3:4).

TABLE 3:7 - Educational and Occupational Status of subjects under study.

	GRADES										
AGE	7	8	9	10	11	University	In Study	Employed	Unemployed	Other	Total
14		1									1
15	1		1								2
16			1	2	2						5
17			2	1	5						8
18						1		1		3	5
19						2	1		2		5
20						1	1	2			4
21						4					4
22						2		1	1		4
23								1			1
24								1			1
	1	1	4	3	7	10	2	6	3	3	N = 40

For these subjects, age factor, family and partner relationships, social pressures and lack of sex-related knowledge appears to have greater significance in placing them "at risk" for pregnancy then does

their educational status.

Employment status was more significant in relation to the putative father than for the girl and is discussed further on in the chapter.

THE PUTATIVE FATHER

Relationships between partners of a pregnancy outside marriage depend largely upon factors such as:

(a) educational levels

(b) employment status

(c) age discrepancies

(d) family relationships

(e) attitudes towards motherhood and fatherhood.

The educational and employment status of the putative fathers, (see Table 3:8) while further study is needed to determine its significance in relation to the pregnancy of their partners, does present some suggestions for such study.

The education level of these fathers did not always correlate with that of their partners. Of the 12 males who had university students as partners, 2 had completed grade 11, 10 had left school after reaching grade 10 and 2 "dropped out" after Grade 9. Of the 21 males whose partners were under legal age (two males were known to be drug addicts), 1 was a university student, six were employed and 5 unemployed. The status of 9 was unknown. (Under the emotional conditions of the interview some subjects were reluctant to discuss their partners and the data concerning them is therefore incomplete).

TABLE 3:8 – Educational and Employment Level of Putative Fathers (None of whom attending school).

Grade level reached	Partners of Minors	Partners of Majors	Total
8	1		1
9	4	1	5
10	2 (both drug addicted)	1	3
11	2	1 (alcoholic)	3
			N = 12
University Student	1	7	8
University Graduate		2	2
Employed	6	5	11
Unemployed	5	2	7
Unknown	12		12
	24	16	N = 40

In seeking the active support of their partners during pregnancy (see Table 3:9), 20 subjects stated that they had already informed their male partners, 5 of whom refused to acknowledge their responsibility or offer any help. Included among these 5 men is the one best described by the girl herself.

"He has a drinking problem. Anyway he left town for Toronto as soon as I told him. I'll kill him if I lay eyes on him again".

TABLE 3:9 - Extent of Involvement of Putative Fathers in the Pregnancy Resolution.

Informed or not informed	of legal minors	or legal majors	total
Will not be informed	12	6	18
Informed and sought for help	8	7	15
Informed but refused help		5	5
Uncertain about informing	1	1	2
	21	19	N = 40

Eighteen girls categorically refused to inform their partners of their pregnancy.

"He's on drugs and 'tought'. I don't ever plan to see him again".

"He wouldn't want to get married and help raise a child. I met him in a club. He was just using me",

"I broke off with him three months ago. We went steady for six years. I'll just die, just die. What am I going to do? I have to get my education. How will I tell G....? I'm just not going

to tell him".

"There's no way I'm going to force him. He doesn't want to get married".

"He's a suspected 'narc'. If I told him he would probably be unrealistic and say 'keep it'".

"He will want to get married but I'm beginning to hate him. I'm still seeing him but he has no idea what is wrong. I don't plan to tell him anything".

Other potential supporters (see Table 3:10) included a significant reliance by the girl upon the mother. (There were 15 in number including 6 who were of legal age). Sisters play a significant role, while friends, although only 3 were listed as major supporters, were in fact, present as "backup" support for the majority of the subjects.

TABLE 3:10 - Individual considered to offer major support during pregnancy.

Supporters	of legal minors	of legal majors	total
Mother	9	6	15
Putative father	5	10	15
Sister	6		6
Friend	2	1	3
Brother of Putative Father	1		1
	23	17	N = 40

Decisions for outcome of pregnancy (Table 3:11) show that 76% of the study population, equally divided between minors and majors, chose abortion to relieve their crisis situation.

TABLE 3:11 - Decisions preferred for outcome of pregnancy.

Legal age	Marriage	Adoption	Single Parent	Abortion	Uncertain	
Minors	1	1	0	15	4	21
Majors	2	0	1	16	0	19
	3	1	1	31	5	N = 40

The remainder of the decisions made for pregnancy outcome do not directly correlate with the findings of other sources for this information. Social workers, nurses, doctors, etc. estimate from personal experience, that many single pregnant girls are choosing to become single parents, or get married, or to a lesser degree, release their babies for adoption. (See discussion on these options later in this chapter).

One explanation of the findings for options chosen in this study is that P.P.A. is the only agency that offers pregnancy testing and information about available abortion services, without prior referral from a physician or parental consent. It therefore "attracts" those who are either reluctant or refuse to involve physicians (especially family doctors) or their parents at this phase in their pregnancy.

Of those who stated that they would be seeking an abortion in Newfoundland, (see Table 3:12), 7 subjects (6 under legal age) were

affiliated with the Roman Catholic Church. 11 subjects (4 legal minors) had Protestant affiliations.

TABLE 3:12 - Religious affiliations of subjects who made decisions for an abortion in Newfoundland

	Roman Catholic	Protestant	Total
Minors	6	4	10
Majors	1	7	8
	7	11	N = 18

Those under legal age, who had no financial and/or parental support for an abortion had little choice but to make application for one to the special abortion committee at the St. John's General Hospital - the only centre in Newfoundland where abortions are performed as stipulated by the Abortion Act of 1974. Five under the legal age made plans, with the assistance of friends or relatives, other than parents, to seek abortions outside the province to avoid the need for parental consent for an abortion (see Table 3:13).

TABLE 3:13 - Religious affiliations of subjects who made decision for an abortion outside Newfoundland.

	Roman Catholic	Protestant	Total
Minors	3	2	5
Majors	4	4	8
	7	6	N = 13

The decision to seek an abortion outside the province was made by the majority of the subjects (13) - in response to the anticipated negative reactions of their parents, particularly those with strong religious affiliations. The majority were members of the Roman Catholic Church, but 2 sets of parents were affiliated with the Salvation Army). To a lesser degree, there was some anxiety expressed concerning possible repercussions from church-related agencies with respect to present or future employment (school boards) and student status in the two diploma nursing schools (St. Clare's Mercy Hospital and the Grace General Hospital). Reactions from family priests and other relatives were also partially influential in the option for outcome chosen by the pregnant girl.

The determination to proceed with an abortion is best documented by the comments of the girls themselves.

"I'll go to New York if I can't have an abortion here. I haven't any money but I'll find a way to get it".

"I'm mentally exhausted thinking about being pregnant. I have to have an abortion. I don't want to get married as it would probably end up with a divorce and I'm not ready for that yet".

"I don't want the School Board (R.C.) to find out I'm pregnant or that I'm going to have an abortion because then I won't get a teaching job".

While the Protestant churches do not necessarily sanction abortion, the Roman Catholic Church is actively opposing it. Circumstances, strains and tensions, and a less than favourable potential for the social and personal well being of both herself and her child, tend to take priority in the minds of these girls, despite, as expressed in conversation, strong parental opposition to abortion which is firmly based on their support of the church's stand.

"Abortion is against my parent's principles. I'm leaving the province so they'll never find out."

"Mother would never forgive me. She made me sign the anti-abortion petition in Church and I did it while I was contemplating having one. Mother constantly talks about moral fibre in the family. No sex before marriage and no abortions."

"My parents asked the priest about abortion. Even though I'm supposed to have one because of my health, he doesn't want my father to give permission. It's not Father ____ who has to raise the child and receive all the stares of the people anyway."

"My parents would force me to keep the baby. I must leave the province to have an abortion."

The laws and practices in Canada with respect to human life, portrays an ambiguity on the moral issue of preventing birth (Pelrine 1971). Most arguments against abortion and birth control are based on defending the sanctity of human life. The basic question is, however: When does life begin? Until the edict promulgated by Pope Pius IX in 1869, Catholic doctrine taught that the soul enters the embryo about forty days after conception for the male, and eighty days after conception for the female. Since 1869 the Church has decreed that the soul enters the fetus at the moment of conception. Many Catholics today want Abortion Law reform or repeal, and others advocate making abortion a matter for individual conscience. While adherents to the Salvation Army, Pentecostal, Anglican and United Churches in Canada are divided in their opinions of this matter, most other religious groups do not share the Catholic view. To quote Dr. Robert McLure, United Church Moderator in 1971, "...I conclude that the greatest sin to face in this matter is to bring into the world an unwanted child." (quoted in Pelrine 1971:47).

THE OPTION OF MARRIAGE

Marriage to legitimate the pregnancy was discussed by the majority of the women. Two would marry but, while a few expressed some uncertainty about accepting this option, the majority rejected it mainly because of the instability of the relationship between them and their partners.

Single parenthood, although the choice of only one girl, it remains an important factor in Newfoundland. An indication of this is the numbers seeking social assistance as unwed mothers (see Appendix F).

Adoption was generally rejected on the basis that some were not prepared to (a) carry the pregnancy to term and/or (b) release their child to others having no further responsibility for his/her future well being:

> "I couldn't live knowing my child was alive and living with someone else. How could I be sure he was being well cared for and happy?"

Health and social workers tend to view options for the outcome of these pregnancies, in the light of the long-term effects of each route, both on the individual and on society itself. There are those among the lay and professional groups who, for religious reasons, specifically advocate adoption as the only choice for unwed mothers who do not wish to keep their babies. Others, who do not share this view to the same extent, do generally view adoption and abortion as functional alternatives.

The women in the study indicate a very different perspective on the subject of adoption vs. abortion. Existing organizations and law groups, i.e. the Pro-Life Group, Family Life Bureau, actively promote adoption with the promise of full support but have not succeeded in reassuring those women that such a choice would protect them from social stigmatization and negative sanctions, such as discrimination against

them in employment or as students.

Another factor is that the majority of the study group at the time of interview, did not conceptualize the baby as a human being per se. The pregnancy was viewed as an unwanted 'appendage' fraught with potential problems and needed to be 'got rid of' as quickly as possible. They felt that they could not cope with the sustained tensions associated with carrying such a pregnancy to term; especially when, in a relatively short period of time, an alternative promising relief from these stresses was available to them. The need to return to 'normal' and to maintain their social status and position without prejudice was of major importance.

While this was not the sole reason for seeking an abortion, it is an important factor in demonstrating the extent to which (a) social pressure is applied for the maintenance of the family structure initiated through marriage, thus presenting an element of acceptance of the 'single' pregnancy, and (b) misinformation and ignorance of others concerning the needs of youth for better understanding and assistance during their early sexual developmental stages; and, especially, when a pregnancy occurs outside marriage.

FOOTNOTES

[1] For further clarification of the legal status of minors in the United States including categories, such as the legal definition of an emancipated minor, see Hofman and Pilpel (1973). For Newfoundland see Gushue and Day (1974).

[2] Duenholter (1974) discusses the greater potential the very young have for a recurring pregnancy within a short time span after the initial pregnancy. Hardin (1971), Beck (1971), Reiterman (1971), Forssum (1974), all discuss the major problems for the mother's youth and her emotional responses to an unwanted pregnancy.

[3] Potvin et al (1968) reported that in a survey of 56,000 United States wives (since 1955), the proportion of wives using contraceptive methods, other than rhythm, became a majority by 1965. This type of non-conforming related strongly and inversely to such measures as religiousness, as frequency of receiving communion, and less directly, to measures of socio-economic status and ethnic background. There is a systematic reduction at progressively earlier ages, in the proportion of Catholic women conforming to their Church Magisterium's position on birth control. The trend prevails for all socio-economic subdivisions and degrees of religiousness. Potvin concludes that this reversal may be associated with the advent of oral conception and the publicity about theological debates within the Catholic Church. Westhoff (1973) estimates 60% of Catholic women deviate from the church's official teaching on birth control. The most spectacular increase being among the youngest age groups. From 30% in 1955 to 78% in 1970 for women aged 20-24.

[4] See Sandberg (1975) for a more detailed outline of the psychology behind the misuse of rejection of contraception.

[5] Louisianna is now (1977) the only State in the United States that has not enacted legislation allowing schools to give birth control information.

[6] Shah also provides an analysis of relationship between motivation, educational levels and aspirations and the marriage plans and the use of contraception.

[7] See Kemp (1976) for an overview of studies from the United States on contraception knowledge and use.

CHAPTER 4

"A panic is the stampede of one's self-possession"
Antoine Pivarol (1754-1801)

THE PATHWAY TO CRISIS

The short and long term social and emotional status of a single girl depends on the time, place, accessibility of appropriate resource persons (including families) and services, when and where needed. Her pathway through her future life span is inevitably rerouted in that there is no going back. Her emotional and social behaviours will alter, affecting future relationships with others and can seriously affect the well being of her offspring. Decisions as to whether to abort, go to term, release the child for adoption, or raise him/her herself, has to inevitably be made in a climate of crisis. Decisions for an abortion, for instance, are often made almost impulsively without much forethought, in a moment of emotional crisis, where the major fear is public disclosure. Conceptualization of the consequences of momentous decisions takes more time than these girls have. The lack of adequate longterm services for pre and post abortion, including psychiatric counselling, have, according to many involved in social and educational services, exacerbated many problems considered generally to be preventable.[1]

Abortion, as the majority choice for pregnancy outcome by the study population, is closely related to fears of anticipated social stigmatization and sanctions.

The population of Newfoundland, and particularly St. John's, is predominently Roman Catholic and of Irish ethnic origin. The prevailing

ethic, subscribed to by those so affiliated, is for sexual restraint, including abstinence of sexual intercourse before marriage. This, together with social pressures from alternate sources to conform to norms antithetical of those of their peers (as discussed above) results in confusion and ambiguity in the minds of today's youth.

From the onset of this study, beginning with the early exploratory phase when formal and informal interviews and conversations were conducted, there emerged a confused picture in the minds of both professional persons in health, education, religion and social work, and among non-professionals, as to what the established and acceptable norms for sex-related behaviour, and their strengths in the minds of people, really are. Attempts to identify discrepancies of outlook, viewpoints, knowledge and understanding, as a means towards defining attitudes and approaches to responsible intervention to meet the needs of single pregnant girls and their families, were greatly hampered by the diversity of opinions and subjectivity of these respondents.

A consequence of this confusion in the minds of community elders and leaders, emerges in an ambivalence of thought and action by the young. The publically stated rationale for conforming to sex-related norms often appears illogical, and to some, hypocritical given the behaviour of many role-models including those illustrated by the media. Adults, sooner or later, establish some-sort of equilibrium within this "cultural tight-rope walking act". Their satisfactions and consciences arrive at a reasonable peaceful state of coexistance. The young person, being directed through the socialization process by these "guardians" of the norms, many of whom operate on more than one set of values, has not the time or ability to maintain a continuous

satisfactory social equilibrium with their mentors. Under this pressure, the response is often a rejection of the established code for sex behaviour.

A consequence of this dilemma, where non-adherence to the accepted norms may result in pregnancy outside marriage, forces the girl into a second dilemma. She must now seek help from the very people whom she fears do not "approve" of her new status but who are the major providers, professional and non-professional, of the services she now needs.

Dependent on the extent of her reluctance in seeking appropriate care, so is the single pregnant girl directed towards the outcome of her pregnancy. (see Figure 4:1). Whether or not she faces few or many small or large crises along these pathways, is largely dependent on the interventions of those with whom she makes contact along the way. The quality of these interventions is therefore of profound importance in determining the intensity of such crisis situations which must inevitably be faced by girls with an illegitimate pregnancy.

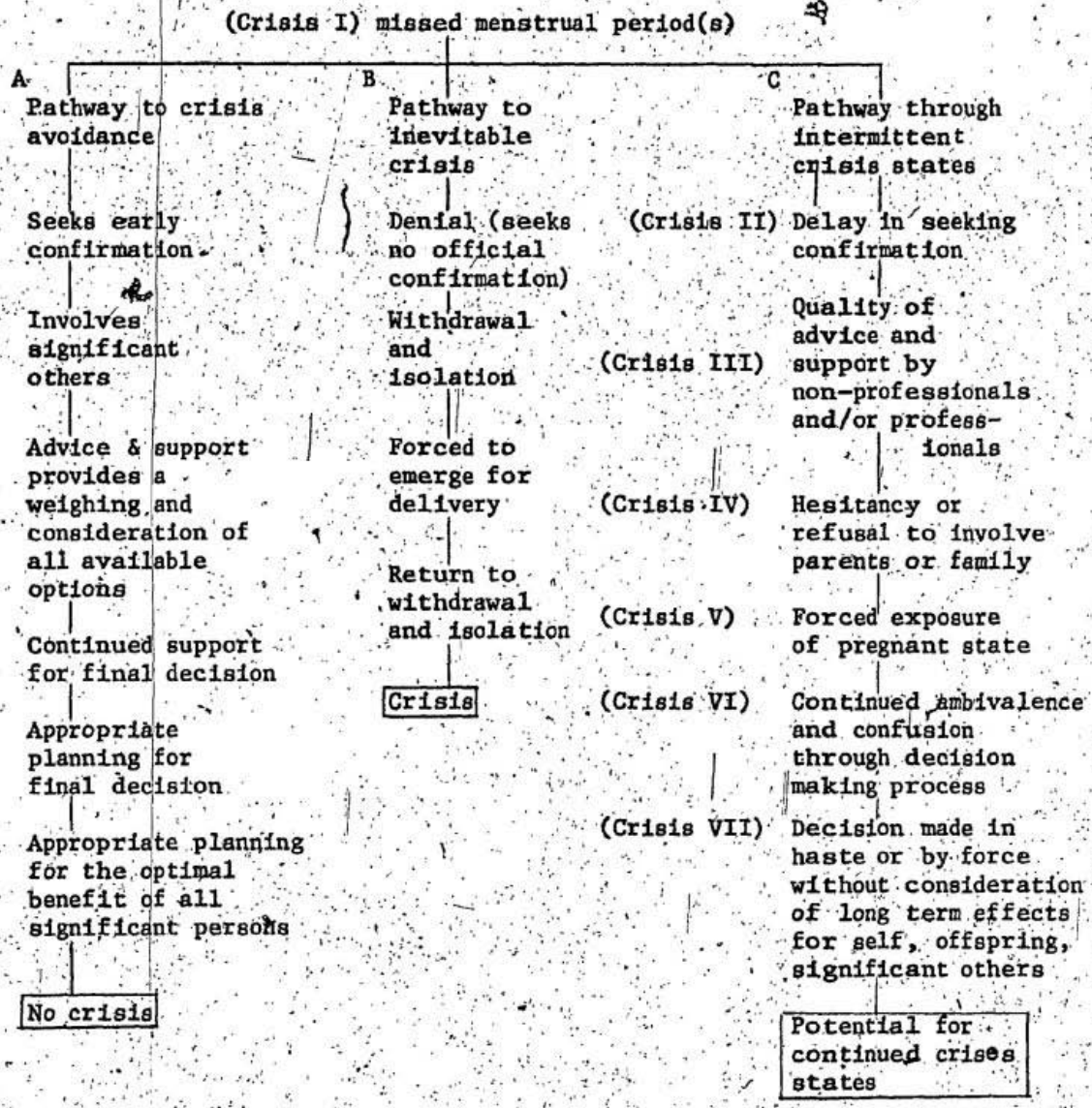

FIGURE 4:1 - Pathways to Crisis

PATHWAY A - NO CRISIS

Perhaps this is the ideal option, but in reality this route is never smooth and straightforward. The reasons for this include:

(a) emotional responses from significant others are subjective and often irrational,

(b) communities rarely, if ever, provide easy accessibility to appropriate resource persons and services prepared and directed toward meeting the special needs of this population.

Due to lack of information, misinformation and personal attitudes, pregnant couples, parents, community workers and leaders inevitably set up barriers inhibiting the girl and her infant from achieving a positive, acceptable and anxiety free resolution of her pregnancy.

PATHWAY B - INEVITABLE EXTREME CRISIS

Examination of this pathway was not possible, as study subjects, by seeking assistance from the Planned Parenthood Association pregnancy testing service, obviously did not enter this route. Evidence from past personal experiences and those of involved others, however, points to a significant number of single pregnant girls who do consciously or unconsciously, deny their pregnancies. They make every effort, very often succeeding, to hide the fact until labour starts. Claims of abdominal pain, dysememorrhea and other physical complaints are not uncommon upon admission to the hospital. Examples of this include - one girl, while in hospital, denied her infant after birth and never accepted her status as a mother. Another girl, in the first stage of

labour, passing her mother in the kitchen, used her brother's bicyle to cycle 12 miles to the city, stopping at a shopping centre to phone her partner for further assistance. Her baby was born 20 minutes after he, using his mother's car, drove her to the hospital.[2]

The major factor associated with this pathway is that the single pregnant girl is at very high risk for physical and social complications both for herself and her offspring. Preventable situations become serious disorders. Her withdrawal from the mainstream of life, results in isolation at a time when communication with others, professionals, parents and friends, is of utmost importance. Sudden contact with others, usually strangers, forced by the onset of labour, tends to impede her physical progress and emotional and social readjustments as she can no longer hide from the truth. The shock of these events propels her into a serious state of crisis, inhibiting her from making rational evaluations of her situation and decisions for both her future and that of her infant.

PATHWAY C - INTERMITTENT CRISIS STATES

This was the only route followed by all 40 subjects in this study. Identification and discussion of these crisis points through which each girl usually passes, may serve to isolate specific interventions most suited to the needs of all concerned and involved persons.

A major factor, regardless of the problems, is the quality of the interpersonal relationship between the helper and the one to be helped. Secondary to this is the level of knowledge, expertise and commitment of the helper to the service to others. With these two qualities in

mind if falls upon the community to ensure easier access to such resource persons in a setting which is conducive to the development of a working relationship for giving appropriate care.

A study of the seven crisis points in this pathway serves to demonstrate that what is most needed at each level is understanding, empathy and intelligent counselling. It is here, when tensions are at their highest, that hasty, inappropriate and irrevocable decisions are often made. Regrets are long lasting and debilitating and reduces the potential for a satisfactory outcome of these pregnancies.

If mechanisms towares proper services are made available at Crisis I, the chances of reducing the effects of Crisis II - VIII are promising and for some may even be avoided. The girl who passes through all these crisis points without help, will inevitably face many more such events in the future. As postulated by Caplan (1960) the following patterns of responses for an individual or family are considered necessary for a healthy crisis resolution:

(a) correct cognitive perception of the situation which is furthered by seeking new knowledge and by keeping the problem in consciousness

(b) management of affect through awareness of feeling and appropriate verbalization leading towards tension discharge and mastery

(c) development of patterns for seeking and using help, by using interpersonal and institutional resources.[3]

FOOTNOTES

[1]Guidance counsellors, in the city of St. John's have often had the experience of having to refer students for psychiatric help, after an abortion. Many problems arise when girls are 'forced' by their parents to have an abortion, without any consideration for their personal opinions, feelings or wishes on the matter. The need for psychiatric services for those who have abortions is well documented in the literature. See Evans (1976), Hausknecht (1972), Friedman (1974), Barglow (1976), Harrison (1969), Gabrielson (1971), Payne (1976), Kane (1973), Hatcher (1973), Walter (1970), Addelson (1973), Nadelson (1974), Conovan (1975).

[2]These events were recorded during clinical practice by this researcher.

[3]See Davis (1963 18:44) for his discussion on stage analysis of crisis situations, which can be applied to crisis responses in illegitimate pregnancy situations. For other discussions also see Lindermann (1944), Rapaport (1962), Hill (1958), Parad and Caplan (1960).

CHAPTER 5

"Oftimes have I heard you speak of one who commits a wrong as though he were not one of you but a stranger unto you and an intruder upon your world."
Kahlil Gibran

PLATFORM FOR A THEORY

This chapter provides the platform upon which the theory, generated by the data collected for this study, is built. Included are the generally accepted norms for sex related behaviour and the effects, such as feelings of guilt and shame, and punitive responses to those who deviate from those norms by becoming pregnant outside of marriage.

Social theories, including those dealing specifically with the development of social structures do, in essence, seek to demonstrate how a society, if it is to preserve the integrity of its organization, must provide rules for acceptable behaviour from its members and demand their compliance with these rules. Reward for the compliant is social security, whereas sanctions are imposed on those who threaten the social system. (Merton 1949, Monane 1962, Lofland 1971, Lemert 1972).

The stabilization and retention of social norms and guidelines depends largely upon the extent of the consensual agreement among those who live by them. The larger the rate of acceptance and conformity, the easier is the enforcement of these rules. Whereas slight deviations are sometimes tolerated, generally any action which puts stress and strain on social structures and resources generates punitive reaction and social stigmatization of the deviant.

A society has a responsibility to provide for its members reasonable access to relevant and appropriate services and resources to meet their physical and psychosocial needs. Priorities need to be defined for the greatest return on investment and economy. To ensure a measure of equanimity for all therefore, requires a high percentage of conformity from individuals and groups expecting to benefit most from the system. When these priorities become shifted through the 'delinquency' of a few, tensions increase. Massie's (1964:27) observation is apposite here:

> ...The interplay, interdependence and overlap often cause conflictual dilemmas when need and stress overstretch the resources diverted to provide the subgroup which does not comply with the accepted norms.

The social system functions within the borders of restraint imposed by the limits of its resources. Controls are imposed to keep demands within reasonable limits reducing the possibility of unnecessary 'damage' or strain to its structures through the direction of resources to repair work rather than the prevention of problems and the maintenance of a healthy physical, social and emotional environment.

The relaxation of many sexual taboos and the steady growth of permissiveness, self expression, sexual adjustment and freedom from stereotypical sex-roles and inhibitions over the past decade, have 'eroded' the parameters within which societies in the past, kept a fairly rigid control over the sex-related behaviour of its members, especially the young. Communication between differing age levels has suffered in the interim. To fill this gap the young have turned inwards towards themselves, as well as to their peers. This peer group has responded in part by formulating separate codes for sex related

behaviour and relationships often in conflict with the established sex norms of their elders. These elders, in return, have not moved quickly enough to either incorporate or modify these codes appropriately into the general system.

Young people cannot accept more than one set of values upon which to operate. Their criteria for value validity today strongly depends on two major factors as described by Blaine (1966):

(a) their demand for logical explanations and rationale for ethical standards;

(b) the inbalance between the professed code of acceptable sex-related behaviour and the changing practices of youth.

Blaine elaborates:

> It does not suffice to speak to them in terms of some kind of natural moral law or a feeling of what is right and wrong. They need also to know that consequences of their behaviour are going to be harmful or disadvantageous to their success or happiness, to be willing to restrain themselves and to exert self control. Feelings of guilt or fear of eternal damnation simply do not have the inhibiting and restricting effect on adolescents which they did a generation ago. (p.47)

There is less tolerance or understanding by youth of what to them appears to be the almost inhuman quality of some of established norms and structures which do not allow for failure or hesitancy, and demonstrate under certain circumstances an inflexibility towards issues of human concern. The credibility of these rules is under question. What was relevant in the past is not necessarily relevant today.

DEVIANCE FROM THE SEX NORMS

Change is inevitable and while there may be some resistance to it from those who find comfort and security in the status quo, time does allow for some readjustment. Deliberate or even inadvertent deviations from the norm, however, particularly if they persist and continue to grow in number, generally result in confusion and upheaval within the social system. Its inability to cope, adjust and control such unacceptable behaviour can cause related social values to become "watered down" or even lost. One major consequence of this phenomenon is the more overt double standard of sex related behaviour demonstrated by those people usually designated as role-models for the young, i.e. parents, teachers, church leaders etc. The norms become ambiguous and can no longer be clearly defined. Moreover, the development of a young person's own core of values and beliefs can be seriously hampered when adult examples are found wanting.

This disturbing climate often results in conflict between thought and action. The search for relief from stress imposed by a pregnancy outside marriage can lead to action without much forethought or concern for its consequences. The problems become exacerbated rather than alleviated. The young person, when in crisis, developes multiple identities, as a defence against the responses of others and added stresses. She is thereby inhibited from formulating a solid base upon which to make appropriate decisions for the outcome of her pregnancy and to build a solid future for herself and her baby, despite the social consequence of her illegitimate pregnancy.

Part of the problem may be attributed to the pluralistic character of today's communities. There is no longer any significant ultimate social authority such as that found in monolithic groups. A city's multiple identity, for instance, is characterized by its having many subsystems. The complexities of such differing structures, each of which have their own established mores and norms, serve only to complicate matters when events in one group makes demands upon another. The reestablishment of an equilibrium in their interrelationships is often slow, cumbersome and anxiety producing. (Monane 1976).

Regardless of these facts, the ultimate responsibility for child rearing and the socializing of the young remains with the adult groups. They alone have the authority and the responsibility for the preservation of the system. Too often their own failure to recognize the significance of changing trends and to make social adjustments, either by integrating new ideas into the system, or by using a logical and rational basis for their rejection, jeopardizes the stability of the system to a greater degree than does the sex behaviour of its youth.

THE FAMILY

The major communications network within society is based on a structure made up of families. The family acts as the mediator linking the individual to the larger social structure. Goode (1964:2) notes that:

> A society will not survive unless its many needs are met such as production and distribution of food, protection of the young and old, the sick and the pregnant, conformity to the law, the socialization of the young and so on. Only if individuals are

> motivated to serve the needs of the society will it be able to survive. The formal agencies of social control are not enough to do more than force the extreme deviant to conform. Socialization makes most of us wish to conform but throughout each day we are often tempted to deviate. What is needed is a set of social forces that respond to the individual wherever he does well or poorly, supporting his internal controls as well as the controls of the formal agencies. The family, by surrounding the individual through much of his social life, can furnish that set of forces.

Cousins (1950:405) expands upon this statement:

> From the time of the child's birth a subtle but unremitting process is set into motion, its result being an inculcation of attitudes and the evocation of certain potentialities at the expense of others, which thus establish positive motives to conformity with generalized patterns of action.

Parents have power of constraint or the exercising of sanctions as a means for directing their children along the accepted social pathways, thereby discouraging any tendencies towards deviance. Likewise, society acts, particularly through its legal system, when it becomes threatened by deviance.

The nuclear family is under great strain today. In fulfilling its obligations to transmit its social and cultural heritage to the young, it has to compete with many other systems for the loyalty of its members who are continually being exposed to ideologies and values not compatible with those of their families.

Adolescent problems, Ackerman asserts (1970:81) are a symptom of family disorder. He states:

> The agitation of the adolescent surely does not exist in isolation. It is matched and paralleled by the emotional insecurity of his parents, the imbalance of the relations between them and the instability of family life as a whole.

Such a sweeping generalization, while open to argument does serve to illustrate the effects of fast moving cultural changes on today's families. The family is unsure of its role and position and what it stands for; its resources for solving problems and conflicts are deficient. Leadership is wanting, and while there is often much outcry and talk about deviant behaviour, particularly if there is violence associated with it, there is very little concrete effort to correct the situation.

This does not mean that efforts are not made to alleviate these situations, (for example; pregnancy outside marriage). Programs are devised often in response to loud calls for action, but the enormity of the problem, and its potential drain upon limited resources generates a sense of helplessness and a feeling of sheer impotence to do very much to contain it.

Newfoundland society is rooted in the family. These families are formulated through marriage within the confines of the Church and governed in general by Christian dogma in the development of social mores and norms.

Like any society, Newfoundland has a strong traditional, cultural and social framework built and cemented over time by it's environment, geographical location, and ethnic origins of its people and their religious affiliations and occupations. Federation with Canada in 1949 opened the "cultural borders" of this island. The major impact and changes on a traditional way of life were mainly through an immense infusion of social influences foreign to this land, aided by advanced communication technology and improved transportation systems.

Leadership and guidance previously given almost exclusively by church and local community leaders no longer suffice, especially in the cities. The young, seeking to establish an equilibrium with this new environment, tend either to look to themselves for answers, or to turn to their peers for solution to their problems.

Premarital sexual intercourse, resulting in pregnancy, is not a generally accepted norm in St. John's and not condoned by those who must intervene on behalf of the single pregnant girl.

Community resources organized to support the human right to dignity, respect, care and support in the time of need, must in principle, be diverted to serve this population. The high cost of this action, particularly as the social and economic risks to mother and child are greatly increased, (see Chapter II), produces a 'ripple effect' upon the entire community, in that resources used to reduce such risks mean less elsewhere. Resentment and frustration by others at the loss of what is their due through their compliance with the norms, is inevitable and results in a variety of imposed sanctions by them upon the deviants.

STIGMATIZATION

People born with a physical or mental handicap do have a greater opportunity and the time to develop coping mechanisms with which to counteract their reduced social status. Those, however, who "by accident" become physically handicapped or who commit criminal acts, face instant stigmatization on which there has been no time for preparation. Similarly, a single pregnant girl faces such "instant"

stigmatization. She becomes, in a sense, a discredited person who is not given any time to absorb the responses of others and rally her own resources to counteract them. She, and her unborn child, face a lifetime of sensitivity to the opinions of others, even when their social functioning appears healthy and optimal to their limits. Using Goffman's (1963) analysis:

> [She] becomes a 'stranger'..[She] has acquired an attribute which makes [her] different from others in the category of persons available for [her] to be...[She] is reduced, in the minds of others, from a 'whole' and 'usual' person to a 'tainted discounted' one. Such an attribute is stigma, especially when its discrediting effect is very extensive. It constitutes a special discrepancy between virtual and actual social identity. (pp. 2 - 3)

Goffman also asserts that:

> an attribute that stigmatizes one type of person can form the usualness of another and therefore is neither creditable for discreditable as a thing in itself. (p. 3)

It can be concluded, if accepting this premise, that the ever increasing rate of illegitimate pregnancies here and elsewhere, can lead to where single pregnant girls, with or without their partners, are well on the way to becoming an important subgroup within our society. And, as such, may well formulate significant mores and norms of their own, thus providing shelter from being forced to cope with stigmatization.

The State, which does not generally see its role as the benefactor of those who deviate from the acceptable norms, must now, for humanitarian reasons, act as the declared protector of the human and civil rights of all who come under its jurisdiction. It therefore, finds itself in a compromising situation. It must stretch its resources to meet the physical and social needs of the culprit yet not offend the sensibilities and values of the dominant group.

*Gender changed from original quote.

The most influential group in the setting of standards for care and service, and those in economic control, is the middle class. Health services in Newfoundland generally compare favourably with those of the mainland Canada, and elsewhere, providing settings and interventions most conducive to middle class values and norms. This system provides, however, the only stream to professional health care. The single pregnant girl recognizing, that by entering the stream she will inevitably cross paths with those who have entered the child bearing cycle by more conventional means through marriage, hesitates and delays her entry into the health care system in order to reduce the length of time in which she will feel alien, shamed and guilty.

SHAME AND GUILT

The secrecy surrounding human sexuality sets the stage for guilt and anxiety (Skolnick 1973). It also tends to draw special attention to that which is cloaked in much secrecy. It creates an atmosphere of tension. Warning against doing something often generates a compulsion to do it. Once pregnancy occurs however and because of an "illegal act", another dimension is added - a sense of shame. This is magnified by the knowledge that no one will really accept the situation as a normal event. Shame is a consequence of having deliberately even inadvertently set oneself apart from family, peers, neighbours and others; or of having failed to live up to self-expectation and the expectation of others.

Lynd (1966) in attempting to separate guilt and shame as two descriptive terms rather than one, refers to both Freud and Benedict:

> Guilt, or self-reproach, is based on internalization of values, notably parental values-in contrast to shame which is based upon disapproval coming from outside, from other persons. Ruth Benedict makes a similar distinction. She contrasts guilt, a failure to live up to one's own picture of oneself (based on parental values), with shame, a reaction to criticism by other people (p.21)

Lynd further states that:

> Experience of shame appear to embody the root meaning of the word-to uncover, expose, to wound. They are experiences of exposure, of peculiarly sensitive, intimate, vulnerable aspects of self...exposure to one's own eyes. (p.21)

The pregnant girl, very young and unsure of herself, cannot articulate specifically what she really feels when she states she is ashamed and guilty, except perhaps through expressions of concern for her parents:

> "I could never tell my parents. They have never thought of me as that type of girl. This would shame them terribly."

> "My parents don't expect this of me. My mother would really worry about what the neighbours would say".

PUNISHMENT

Feeling guilty or ashamed of one's behaviour is synonymous, in a way, with the expectation of punishment for behaviour which generated these feelings. Punishment is a means of alleviating stress. When terminated, the debt is paid. Punishment is therefore not only expected following deviance, but also, in a sense, demanded.

Honderich (1969) in an overview of the theory of punishment, suggests that serious consideration be given to the view that one takes an important step on the way to becoming "a man" by being impressed by the condemnation of others. It is not that one is impressed by their reasons or arguments, but rather by the declarations in which they issue. These are punishments. He himself argues however, that one is most admirable as a moral agent if one obeys the law out of a sympathetic and important awareness of the effects on others, if it is broken.

This dichotomy of ideas, with respect to moral behaviour being based on the desire to spare the feelings of others as opposed to being "programmed" in effect through punishment for misdemeanours, depends largely upon those who play the role of "teacher" to the young. A commitment to others based on an emotional bond must result in a different approach to punishment than does the latter premise. There is sufficient evidence pointing to the fact that punitive actions taken against single pregnant girls and their offspring, are largely in response to their threat to the established patterns for family formation. This approach excludes in essence, commitment of a society to provide for the optional health and welfare of all its members regardless of an individual's inability, temporarily, to conform to the norms.

This attitude tends to precipitate into unwanted marriages and parenthood, those who break the social rule for marriage and childbearing by having illegitimate pregnancies. Such events unfortunately also impose severe economic pressures and constraints upon individuals, groups, and society alike. These factors, in themselves constitute punishment,

not only for the deviant, but for all concerned others.

One question remains - does society in fact, deliberately punish these deviants? or - do the deviants merely perceive societal responses as punishments? The identification of specific punishments, as perceived by the single pregnant girl when at the onset of her pregnancy, generally meet with heresay reports from others who have faced similar situations rather than personal experience. Major fears expressed were (a) insulting verbal comments from peers (especially boys) and neighbours, (b) verbal condemnation by parents and/or priests, (c) loss of employment, (One subject feared she would lose her teaching position), (d) loss of student status (three diploma nursing students stated they would not be permitted to continue in the program should their pregnancy become known).

It therefore follows that, if society does indeed mete out punishment to those who commit the offence of becoming pregnant outside marriage, it is necessary to identify those sanctions and how they are enforced.

The answer to these questions may well be illustrated by examination of the following statements. Society punishes by:

(a) consistently delaying, or by refusing to make provision for the establishment of appropriate and readily accessible prepared resource persons, plus services designed to meet the very special and unique problems associated with this ever increasing problem.

(b) forcing the single pregnant girl to enter the professional health care delivery system through a stream designed to better serve the more conforming members of society.

(c) providing social welfare assistance without job retraining or other educational programs and, day care facilities to facilitate a return to self support and self respect.

(d) forcing ill-prepared and often incompatible couples to marry, interrupting educational ambitions and pathways, and forcing individuals into a less than optimal status, often bordering on the poverty line.

(e) either denying the individual the right to choose the option for abortion, or on the other hand, forcing an abortion upon an unwilling girl (by parents or through fear of disclosure to parents.)

(f) denying youth their right to information and special educational programming to better prepare them for sex related relationships and behaviour including conception, contraception, motherhood and parenthood.

(g) denying illegitimate children paternal inheritance rights.

(h) forcing vulnerable young people, precipitated prematurely into adulthood, to assume responsibilities for children they have not had time to accept or prepare for, without access to suitable resource persons and services to aid them in childbearing.

(i) continuing to legally label the child of a single pregnant woman as illegitimate (there is a concerted move in the rest of Canada to remedy this but as yet there are no indications that the Newfoundland Government will change the law governing the labelling of these children in the near future.)

This discussion of (a) the social role and responsibility of adults for the maintenance of the accepted mores and norms of their social group; and (b) their more common responses to those girls who deviate from them by becoming pregnant outside marriage, now requires an answer to the question - who, in fact, must share the major portion of "blame" for providing those circumstances and situations which place so many single girls at high risk for the unexpected or unwanted pregnancy? The next chapter is an attempt to find, at least, part of the answer to this question.

CHAPTER 6

A THEORY - PUNISHING THE PREGNANT INNOCENTS

"Yea, the guilty is oftimes the victim of the injured.

And still more often the condemned is the burden bearer for the guiltless and the unblamed.

You cannot separate the just from the unjust and the good from the wicked; for they stand together before the face of the sun ever as a black thread and the white women together.

And when the black thread breaks, the weaver shall look into the whole cloth, and he shall examine the loom also."

Kahlil Gibran

The main focus of this chapter is to discuss the thoughts and rationale behind the development of the theory - punishing the pregnant innocents.

Society has failed to provide a sufficiently logical rationale, or clear guidelines for its youth, compatible with its professed beliefs and norms for sex-related behaviour. That society does not seriously recognize these shortcomings, is exemplified by the fact that the girl who becomes pregnant outside marriage, often as a result of confusion, ignorance and pressure from others, is punished by the very people who have failed to adequately prepare her for sex-relationships, motherhood and parenthood. To discuss this "failure" requires an examination of the socialization process, particularly in relation to sex-related matters.

Passage through the various developing phases towards adulthood requires contact with a number of "teachers" and counsellors, each with differing expertise in some major area of knowledge and experience. The success of this process depends immeasureably on the quality of the "lessons" learnt and the commitment of those who give them.

For examination purposes the socialization process is divided into four major phases. Each one marks particular milestones in the growth and development of a child's understanding of sex-related matters as he or she moves towards adulthood. These phases are:

I. The extension of innocence - pre-puberty

II. The twilight zone - adolescence

III. The double bind - early adulthood

IV. The downward spiral - unwanted pregnancy or motherhood

PHASE I - THE EXTENSION OF INNOCENCE

The family is the primary resource for the patterning of youth towards acceptable social behaviour. Its chief responsibility in this matter is to ensure, through this process, that the young will preserve the integrity of the system and the structure necessary for the maintenance of the society as a whole.

In performing their duties, family members, and, in particular, parents, use as a baseline what they know or consider to be morally right, or, at least, what is customary and expected. This process commences prior to the birth of the child. Preparations and responses conform to 'usual' practices shared by contemporaries and others living within the same environmental milieux.

Throughout the pre-puberty stage, sex-related matters are often cloaked in secrecy, mystery and folklore. Attempts to desexualize childhood to protect them from "exposure" to sexual matters, either through conversation, or the media, has resulted in the building up of taboos which serve mainly to keep the child out of touch with sexual reality. While for some reasons this may be commendable, it has resulted in sex education in the schools continuing to be extremely controversial, and for parents to find it very difficult to discuss sexual matters with their children.

To fill the gap children create their own cultural traditions of sex lore and misinformation. Examples of "subversive" anti-adult culture passed on through generations of children are found in their games and language notably documented in works such as Opies' Love and Language of Schoolchildren (1959).

Sex attitudes and feelings developed in this period have a tendency to persist regardless of whether people profess to codes and lifestyles alternate to those of their parents. These attitudes may be obscured but often surface again when their own daughters are concerned.

Skolnick (1973:184) equates some of the communication problems associated with negative sex learning with the lack of vocabulary for matter-of-fact discussions on sexuality. She states:

> "The four letter words have been tainted by their long use as curse words. Adults are beginning to use them more easily but they are not felt to be a proper medium of instruction for children. Medical terms are too forbidding and polysyllabic. In any event, nonlabelling and mislabelling may result with profound consequences".

Sexual instruction, or non-instruction, is part of the cultural patterning of children. The quality of instruction is strongly influenced by the concept of childhood innocence which is rooted in cultural thought. This concept is in essence, relatively new and may well have evolved as a means towards protecting children from exploitation such as the sexual abuses of incest, assault and prostitution.

PHASE II - THE TWILIGHT ZONE - ADOLESCENCE

At puberty the process continues. The ever increasing need for thoughtful honest guidance and direction at this time is essential - yet, many children continue to be socially conditioned to refrain from conscious consideration of the physical and emotional changes occurring to them.

Erikson (1950), in turn, points out that a child must turn from the exclusive pre-genital attachment to his parents to the slow process of becoming a parent and a carrier of tradition. This process of detachment from parent, according to Erikson, is greatly accelerated when parents and other adults provide very little sex education for children, and the information gap between the parent and child is filled by the child's friends, acquaintances, and the media. This can result in a young person having to face sex-related responsibilities before being adequately prepared for them.

Besides the need for sex education and information, adolescents on the threshold of new and bewildering emotions, and relationships

with peers of the opposite sex, require concrete guidelines and 'visible' role models, both in reality (from parents, teachers and others, etc.) and through the media (films, books, etc.) These should provide them with standards and rewards for acceptable sex-related behaviour. When these are found wanting, they once again turn to their equally ill-prepared contemporaries for direction. The entrance into what Winslow (1968) refers to as, the Adolescent Social System, can cause additional stresses as the individual seeks to determine his status within this group. As a consequence, non-institutional behaviour as a means to interpersonal rewards may result. Another point of note is the tendency of young children, before puberty and early adolescence, to separate into the same sex groups. While this may not be so rigidly adhered to today as in the past, it still persists significantly enough to have a profound effect on definitions of masculinity and femininity, as well as relationships between the sexes. Exchange of sex information still remains somewhat clandestine and cloaked in guilt. Even though communications between peer group members are relatively more open than are those between parents and child, much of what is said is incorrect and misleading. Jules Henry (quoted in Skolnick 1973:187) sees a hope for a change in this situation for today's youth. His following statement can be applied to Canadian youth as well as to American youth:

> ...the teenage world in America has been exposed to extra-ordinary changes in sex attitudes, culture, generation conflict, women's and gay liberation, as well as by countermovements of all these. The whole pattern of dating, going steady, and early marriage seems to be altered - to what extent we don't yet know. It appears, however, that teenagers today are in the process of being liberated from the rigid mating and dating codes of the last two decades, and all the tensions they entailed, and are beginning to face problems involved in making personal choices without the guidance of strict rules.

PHASE PII - THE DOUBLE BIND - YOUNG ADULTHOOD

On reaching legal majority and a higher level of independence for choice or role, position and societal involvement, people remain, in effect, the product of the socialization process through which they have passed from their birth.

Contact with many others, professing different ideologies and standards for sex-related behaviour, can result in emotional confusion and cast doubt upon what was previously considered adequate for all future functioning.

The credibility of past "teachers" and role models comes into serious question as more and more young people complain about the inadequacy of their preparation for independence, interpersonal sex-related relationships and parenthood. It is at this age that criticisms become stronger and more vocal. On the one hand, they are expected to assume total responsibility for their actions and yet they have not been adequately prepared to assume such responsibilities.

Other profound influences on the sex-related attitudes and behaviour of this group are (a) medical advancement reducing infant mortality and increasing life spans, (b) contraceptive development and changes in attitudes and laws government abortions and (c) technological advances and educational opportunities providing women with greater choices for careers, encouraging them to develop their mental capacities and talents.

Women no longer are expected to devote their lives to only child rearing. Motherhood is a matter of choice rather than an inevitable consequence of being female.

A major consequence of these changes is, however, that the young person today is in a double bind, having to resolve many conflicts between ideas and ideals rooted in youth with the challenges of new innovations and attitudes. Until this plateau is reached and equilibrium established with the current environment, she remains at high risk for an unwanted pregnancy and faces potential social stigmatization and sanctions.

PHASE IV - THE DOWNWARD SPIRAL - UNWANTED PREGNANCY AND/OR MOTHERHOOD

Pregnancy outside marriage is seen by many as a gross violation of societal norms. "Tolerance" of sexual intercourse does not provide for the acceptance of single motherhood, or as Malinowski (1930:37) states

> Marriage cannot be defined as the licensing of sexual intercourse, but rather as the licensing of parenthood.

A satisfactory resolution of an illegitimate pregnancy is primarily dependent on the type, quality and extent of interpersonal relationships with significant others and their intervention on behalf of the pregnant girl.

Attitudinal and economic constraints do not at present allow for the flexible, individualized programming necessary to meet the physical and psychological needs of this group. Passage through an illegitimate pregnancy is, in reality, a "hopscotch" process passing from one crisis to another. Appropriate interventions at any one of these crisis points could greatly reduce the potential for high risk physical and emotional conditions which are all too

common to the single pregnant girl and her offspring.

DISCUSSION

The four phases serve to illustrate the problems associated with attempting to socialize youth towards accepting and functioning appropriately within the sex-related behavioural norms.

From birth there is a steady build up of pressures placed on youth to conform to what are often ill-expressed, rigid codes of behaviour inconsistently subscribed to by many of their "teachers" and role models. Unfortunately, many adults are themselves the victims of this socializing process, having had little access in their youth to sex-related information and sex education programs. A large part of their experience has been gained through being "thrown to the wolves", and they have had to find their own way to live within the system. So much of what is natural to life remains cloaked in secrecy and censure. The result is an over-imaginative distortion of the truth, and an over-emphasis of sex by the imposition of sexual connotations on totally unrelated objects, notably by advertising and the entertainment media. This sexual stimulation is allowed, but if an illegitimate pregnancy results the "victim" is condemned.

CONCLUSION

This study is an attempt to clarify the major basic underlying problems associated with single pregnant girls in the City of St. John's, Newfoundland. The data collected can be applied to many other

areas of this Province as many of the subjects were "immigrants" to the city from other regions. The findings are based mainly on the feelings, fears and perceptions of the young girls themselves. The professional and non-professionally concerned persons who were interviewed did add considerably to the overall picture of the true social status of the girl who becomes pregnant outside marriage.

The major factors determining the eventual outcome of these pregnancies for the mother, her child and involved others, were the expected and experienced social responses to the illegitimate pregnancy.

The theory generated by the data is presented to alert responsible people to the dangers of these biased social attitudes and prejudices for the well being of those under their care, who face adult situations for which they have not been prepared. This is not to say that such attitudes are deliberate or meant as punitive. The socialization needs of the young in this highly complex world are often overwhelming and not necessarily aided by technological and communications developments of the last two decades. Past values are constantly being challenged by differing belief systems imposed upon the social environments by these advances.

Compromises must be made by all concerned, both by the young and their elders. A major effort must be made to reduce the pressures imposed by prejudicial social climates that continue to prevail. Young people need to be encouraged to place more trust in significant adults without fear of stigmatization and sanctions. Where this cannot be achieved within the home environment, special settings

should be developed, i.e. schools and residences etc. to ensure a comfortable and optinal passage through the child-bearing cycle.

The Church, including the Roman Catholic denomination, must be prepared to recognize that the existing trend (as demonstrated in this study) towards abortion as the most desirous of options available for the outcome of a single pregnancy, is a reflection of the strength of the anticipated negative social responses, rather than through fear of retaliation or censure from the Church. Neither eternal damnation, excommunication, or the interpretation of abortion as murder appears to concern them as much as do the attitudes and opinions of their parents, neighbours and friends. The effects of decisions made while under duress or extreme stress, in terms of future relationships within the church, plus the real possibility of an emergence of latent feelings of guilt or regret, must remain an important concern. Should these problems occur, the young woman will need sympathetic understanding and counselling from church representatives and others if she is to satisfactorily resolve these problems.

Success in diminishing the strains and stresses on single girls, and everyone involved requires, therefore, whole community effort. No one group is untouched by this phenomenon. Whatever energies are expended to meet these needs means a reduction of resources available for other purposes. Every individual, when helpless, has the right to care from others, but 'helplessness' resulting from ignorance and neglect is very costly to all concerned.

Would it not serve a better purpose to prepare today's youth in a practical way to assume more responsibility for their own

behaviour? This preparation would be based on the imparting of factual knowledge and an honest appraisal of what options are available to the resolution of problems, including the implications of these various choices for their future functioning and status within their own social environments.

CHAPTER 7

"We cannot be just unless we are kindhearted"
Vaurenargues (1715-47)

RECOMMENDATIONS

The literature (see Chapter II) provides many suggestions for corrective measures needed to ensure the achievement of the desired status and behaviour for today's young people. These include open honest communications between parent-and-child and other adults and child. Included should be appropriate information and sex education programs, elimination of secrecy and distortions of the truth with relation to human sexuality and reproduction. Others advocate readily accessible contraceptive information and services to those who become sexually active regardless of age and marital status. Such advocacy includes abortion programs for those who are not prepared to carry their pregnancies to term.

The fact of the matter remains, however, that, despite the initiation of many of these measures some in toto, and others in part, in many communities illegitimate pregnancies, especially amongst teenagers, are on the increase. Total prevention of these pregnancies is not a realistic proposition. Even in history[1] when abstinence of sexual intercourse before marriage was the rule and culprits heavily punished (some were put to death), illegitimate pregnancies continued to occur. Energies must be clearly directed therefore, without

prejudice, to meeting the physical and psychosocial needs of single pregnant girls and all others affected by such pregnancy. This is essential, not only for the well being of the mother and her child, but also for the well being of the community itself. Those ill-prepared for motherhood and parenthood have a very costly effect upon community resources. Programs to date have not succeeded in eliminating or reducing the problems faced by a single pregnant girl. Social responses, real or anticipated, precipitate the girl in directions and along pathways not conducive to reaching an optimal healthy pregancy outcome.

Young people are not often consulted as to their perceptions of what they consider to be relevant to their needs within the context of health and social welfare programs. These services are developed and administered by adults. They have the money, the professional preparation and the authority to plan such interventions. The question remains, however, why do so many young people not use these services? Some of the answers are found in Chapter VI (the section on punishment p. 94. Other answers are provided by sociologists, physicians and health workers, clergy, teachers, social workers and so on. While their perceptions remain valid, the real insight as to the reasons for the non use of services must come from those most in need of them.

The following recommendations come from all the sources mentioned above including those made by the subjects in this study.

(a) That professional resource persons demonstrating expertise, commitment and empathy, be readily accessible to the single pregnant girl, her partner, parents and other involved persons

where and whenever they are most needed. Privacy and maintenance of confidentiality must be assured. This can be achieved by:

(i) a 24 hour telephone service

(ii) the permanent stationing of the community nurse in one area thus allowing time for her clients to develop trust in her judgment and ability to solve health and social problems. She, and other appropriate resource persons, when needed, should be provided with sufficient physical space in this district to be used for private counselling, group programming, pre-natal, post-natal, and well-child clinics, plus any other services deemed feasible to meet the needs of this population.

(b) That in addition to the above recommendation, a pregnancy or mother allowance should be implemented by the Provincial Department of Health. While this may be considered very costly, the long term effects of this measure, as has been found in Britain, Scandinavia and other countries, is a reduction in the incidence of high risk situations and conditions among this population due to registration of early pregnancy. This allowance is given only after the mothers have registered at a pre-natal clinic. Should they fail to keep any future appointments at the clinic they are visited by a nurse or nurse-midwife to ensure that they are physically well and not in any particular need.

There remains the possibility of a single pregnant girl preferring to remain anonymous and therefore not registering at

these clinics, yet the available money should provide for many, sufficient incentive to seek assistance early and consistently throughout her pregnancy.

(c) That while abstinence from sexual intercourse is a sure way to prevent unwanted pregnancies, proper use of contraceptives will achieve the same purpose if consistently used. Sexual activity amongst unmarried women, especially teenagers, is, however, a reality and is steadily increasing. Contraceptives should therefore be made available to this population if they indicate that they do not intend to cease being sexually active. Arguments asserting that the prescribing of contraceptives provides an 'open-gate' to promiscuity have not been substantiated.[2] The risk of this occurring is far less than are the physical, emotional and social risks of an unwanted pregnancy for the mother and her child.

(d) That the legal age of consent for receiving medical treatment should be reduced. As indicated by the study more than half the subjects were below 19 years of age.

The need for parental consent was a major inhibiting factor to their early request for health care. Such delays are costly not only to the health of the mother and her child, but to the community at large. It must bear the cost and maintenance of those who develop physical and psychosocial complications, many of which are preventable if interventions occur in the early stages of pregnancy.

(e) That single parents should be given every opportunity to complete their formal education or job training. The number of Day Care centres for care of their children should be increased. This will allow for the self-improvement of the young mother leading to self-support and great self-respect. The $750,000 required for welfare payments to single parents in 1976 (see Appendix D) could be substantially reduced or diverted to support the above programs.

(f) That the provincial government take steps to remove from the statutes the word - 'illegitimate'.

FOOTNOTES

[1] John Fowles (1969) in his novel "The French Lieutenant's Woman" describes and documents throughout the work many true examples of "Victorian morality", which strongly influenced attitudes and values still adhered to today. The differing standards for sex behaviour of the middle as opposed to the poorer classes are graphically described by him. Today's affluence and the influences of many varied value systems have succeeded in narrowing these two class distinctions.

[2] A search through the literature did not identify any sources to substantiate such claims.

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APPENDIX A

RATIO OF GUIDANCE COUNSELLORS TO STUDENTS IN THE SCHOOL DISTRICT OF ST. JOHN'S, NEWFOUNDLAND.

SCHOOLS	GRADE	1975-1976		1976-1977		TOTALS	COUNSELLORS
		M	F	M	F		
Mount Pearl	10	65	70	62	66	263	1 guidance counsellor
	11	50	55	60	71	236	
		115	125	122	137	499	
St. Boniface	10	19	17	9	18	63	Vice-Principal
	11	21	23	17	16	77	
		40	40	26	34	140	
Bishops	10	157	154	149	138	598	1 guidance counsellor
	11	155	139	132	141	567	
		312	293	281	279	1165	
Booth	10	81	115	82	99	377	Principal plus Vice-Principal
	11	103	95	80	118	398	
		184	210	162	217	773	
Prince of Wales	10	213	186	210	202	811	1 guidance counsellor
	11	187	190	174	178	729	
		400	376	374	380	1540	
St. Kevin's Bell Island	10	36	52	44	41	173	Principal
	11	20	38	25	39	122	
		56	90	69	80	295	
St. Kevins Goulds	10	22	31	24	26	103	part-time guidance counsellor
	11	--	--	24	24	48	
		22	31	48	50	151	
Holy Spirit Manuels	10	--	--	36	30	66	Principal
	11	--	--	--	--		
		--	--	36	30	66	
Beaconsfield	10	129	148	116	132	525	1 guidance counsellor
	11	128	158	107	139	532	
		257	306	223	271	1057	
Brother Rice	10	286	—	274	--	560	1 guidance counsellor
	11	273	—	281	—	554	
		559	--	555	--	1114	
Gonzaga	10	270	—	273	--	543	1 guidance counsellor
	11	260	—	249	—	509	
		530	--	522	--	1052	

RATIO OF GUIDANCE COUNSELLORS TO STUDENTS
IN THE SCHOOL DISTRICT OF ST. JOHN'S, NEWFOUNDLAND.

SCHOOLS	GRADE	1975-1976		1976-1977		TOTAL	COUNSELLORS
		M	F	M	F		
Holy Heart	10	—	542	—	559	1101	1 guidance counsellor
	11	—	495	—	479	974	
		—	1037	—	1038	2075	
Pentecostal Eugene Vaters	10	22	16	16	18	72	Teacher
	11	7	16	21	16	60	
		29	32	37	34	132	
Seventh Day Adventist	10	5	9	8	10	32	Principal
	11	8	4	5	8	25	
		13	13	13	18	57	

The tabulated data from the accompanying table shows a ratio of one guidance counsellor to 1214 high school students in the St. John's School District. 1626 high school students do not have access to a professional guidance counsellor in their schools.

APPENDIX B

The materials listed under Appendix B all pertain to the content of Chapter I. This chapter discusses earlier attempts to initiate this study through the auspices of the Avalon Consolidated School Board and the Roman Catholic School Board. This course failed. The close relationship between the contents of items I and V requires that they be listed under one appendix.

I - Letter to the Superintendents of the Avalon Consolidated School Board and the Roman Catholic School Board requesting permission to conduct this research.

II - Letter from Dr. Boyd Suttie to the above School Boards

III - Reply from the Superintendent of the Avalon Consolidated School Board

IV - Reply from the Superintendent of the Roman Catholic School Board

V - Questionnaire submitted to the above School Boards

APPENDIX B-I

Memorial University of Newfoundland
School of Nursing
December 16, 1975

Avalon Consolidated School Board
10 Barter's Hill
St. John's, Newfoundland

ATTENTION: Mr. Kelland

Dear Madam/Sir:

The welfare of the pregnant teenager in Newfoundland in terms of their physical, psychological and social needs is of concern to the health, educational and social professions in Newfoundland.

Research oriented to a better identification of such needs as determined by the pregnant girl herself and those closely associated with her during her pregnancy is lacking at this time and it is to this purpose that permission is requested to approach the schools for information on this matter.

The major objectives of the research project under development by myself with the close supervision of the M.U.N. medical school is to

a) identify the physical, social and psychological needs of the pregnant teenager still attending high school in St. John's.

b) identify the needs of those most closely associated with the pregnant teenager while she is attending high school in the city of St. John's and after she leaves school.

c) make recommendations to the Provincial Department of Health, another Newfoundland Medical Association, for the establishment of pertinent services and programs designed to meet these identified needs.

Earlier consultation with the guidance counsellors in the high schools in St. John's has led to the development of a questionnaire to be answered by the pregnant teenager under the supervision of the counsellor. The student will remain anonymous and be under no obligation to answer all or any of the questions. Decisions of this nature are to be left to the discretion of both the student and the counsellor. It is hoped that as many students as possible can complete the questionnaire, as the validity of the findings depends largely on the size of the population accepted as representative of the total population of pregnant teenagers in the designated study period.

.....2

The question of parental consent is of major concern. A large percentage of these pregnant teenagers hesitate to inform their parents and deny their pregnancy until it is well advanced. As all pregnant adolescents are considered to be at risk, this delay is serious predisposing the girl and her baby to serious medical, psychological and social complications. Any recommendations from the Board dealing with the parental factor will be most appreciated.

Any further questions pertaining to this matter should be directed to

Dr. B. Suttie or Dr. G. Fodor
c/o Community Medicine
Health Science Complex
Memorial University of Newfoundland

or

Mrs. Hope Toumishey
School of Nursing
Memorial University of Newfoundland

Yours sincerely,

* A similiar letter was sent to Brother Brennan, Superintendent of the Roman Catholic School Board

HT/svc

December 22, 1975

Mr. Newman Kelland,
Superintendent,
Avalon Consolidated School Board,
P.O. Box 1980,
St. John's, Newfoundland.

Dear Mr. Kelland:

Re: Study by Mrs. Hope Toumishey
on Adolescent Pregnancy

I thought I would write to let you know that Mrs. Hope Toumishey of the Faculty of Nursing, Memorial University, is planning to undertake a study aimed at obtaining information vital to the planning of services for the adolescent teenager. This is in accord with the University's firm desire to give service to the community.

Mrs. Toumishey has considerable experience and interest in the problems of the pregnant adolescent and is well aware of the delicacy and sensitivity of the issue. I have every confidence in her, and her proposed activities in this area will be carefully planned, and supervised by senior physicians of the Division of Community Medicine, MUN Medical School.

I think it also fair to say, in my capacity as Associate Deputy Minister of Health, that the Department of Health would find the information as to the needs of these adolescents most useful in helping to provide the best possible response.

I hope that you will be able to accord Mrs. Toumishey every assistance in this worthwhile activity.

Yours sincerely,

BOYD SUTTIE,
Visiting Professor of Community Medicine.

BS/mep

cc: Mrs. Toumishey

APPENDIX B - III

The Avalon Consolidated School Board

P. O. BOX 1980
ST. JOHN'S, NEWFOUNDLAND
A1C 5P8

Chairman: H. W. R. CHANCEY
Vice-Chairman: B. S. BUTTON
Secretary: R. MITCHELL, C.A.
Treasurer: DR. D. H. RENDELL

Superintendent: N. KELLAND, B.A.(Ed.), M.Ed.
Asst. Superintendent: J. J. PARSONS, M.A., M.Ed.
Business Administrator: F. P. POLLETT

March 30th, 1976.

Mrs. Hope Toumishey,
School of Nursing,
Memorial University of Newfoundland,
ST. JOHN'S, Newfoundland,
A1C 5S7.

Dear Mrs. Toumishey,

At the last Board meeting your request to study pregnant teenagers was discussed.

It was felt that the schools would not be the most appropriate place for such a study and, in any case, the number of such cases that come to the attention of our Guidance Counsellors per year is very small, less than four or five. It is suggested that it would be more appropriate if you used a location where there would be larger numbers of such girls available.

The Board wishes me to advise you that should there be other ways we can help we would certainly be available and should you be able to make recommendations to alleviate the problems such girls have it would be most helpful.

Yours very truly,

N. Kelland,
Superintendent.

NK/cs

Roman Catholic School Board for St. John's

BELVEDERE
BONAVENTURE AVENUE
ST. JOHN'S, NEWFOUNDLAND
AIC 3Z4

April 6, 1976

Mrs. Hope Toumishey
School of Nursing
Memorial University of Newfoundland
St. John's,
Newfoundland

Dear Mrs. Toumishey;

Your survey proposal has been presented to the Board and has been discussed a second time by the guidance personel with this Board. I regret to inform you that their decision is still the same, i.e. they do not wish to participate in such a survey in our schools.

You maybe interested in the reasons which prompted our decision.

1. There was a general reluctance on the part of all our guidance councillors to participate. In spite of the confidentiality and anonymity of the questionaire, it was generally felt that conducting such a survey would encroach upon the privacy of the student in such a delicate situation.

2. Your inquiries have prompted me to examine the procedures used in our high schools in the case of pregnant teenagers. It appears to me that in all cases that are brought to our attention, everything possible is being done for the student. In the vast majority of cases, the students return to school after the birth of the child. While they are at home they are kept up to date on almost a daily basis on the course of studies followed by their classes. All available help is provided to each student to ensure their physical and psychological well-being.

. . . . . ./2

April 6, 1976

Mrs. Hope Toumishey

3. A survey of these students would not provide the kind of information which you are seeking. A better source of information on those students who do not have access to the help they need would be the maternity ward of the city hospitals. Practically all of the girls involved would find their way there eventually. I have been led to believe that the hospitals would be co-operative.

4. Even in the cases of pregnant students who drop out of school before the school authorities know the cause, prudent contacts are made by the school Personnel if they have reason to suspect the reason for the withdrawl from school.

Consequently, in light of the above, the Board has decided not to become involved with this proposed survey. I trust that your contact with the hospitals may provide the opportunity to complete your work as planned.

Sincerely yours,

Bro. A. F. Brennan
Superintendent

AFB/jd

To those filling in this questionnaire.

This questionnaire is designed to find out what you consider to be your greatest needs at this time, during the rest of your pregnancy, and in the future.

Please answer as many questions as you can, remembering that you will remain anonymous and that there is no way in which you will be identified.

The name of the school you attend will not be written on the form and, if you wish, you may place the completed questionnaire in a sealed envelope to be mailed by your counsellor. The guidance counsellor or teacher will also help you with this form if you so prefer.

We hope to determine from your answers what services or programs will be best suited to meet your needs and those of other pregnant teenagers in the future.

Thank you.

Dec. 19/75
amf

Date .....

Age ..... Grade ..... Average marks .....

1. In what month did you have your last menstrual period? .....
2. In what month did you first know you were pregnant? .....
3. Have you seen a doctor since you became pregnant? ..... ☐ Yes ☐ No
4. How many times have you seen a doctor during your pregnancy? .....
5. Have you had any of the following complaints during your pregnancy?
   (Check any of these statements if true)
   - ☐ Headaches
   - ☐ Swelling of your hands, feet or face
   - ☐ Dizziness
   - ☐ Blurred vision
   - ☐ Felt sick to your stomach
   - ☐ Vomited
   - ☐ Aches and/or pains
   - ☐ Any bleeding
   - ☐ Any other problems. If so, please state .....

     .....

     .....
6. Did you tell your doctor about any of these problems when you had them? .. ☐ Yes ☐ No
7. Did the doctor tell you what to do? ..... ☐ Yes ☐ No
8. Were you able to follow his advice? ..... ☐ Yes ☐ No

   If not, what problems did you have? .....

   .....

Using this list, please answer the following questions, numbers 9, 10, 11, and 12.

(a) The father of your baby
(b) Your doctor
(c) A nurse
(d) Your girl friend
(e) The guidance counsellor
(f) A teacher
(g) A priest or minister
(h) A social worker
(i) Your mother
(j) Your father
(k) A sister or brother
(l) Another relative
(m) Any other person

Write in the appropriate letter ( ) from the list above next to the statement in questions 9, 10, 11, and 12. If more than one person, mark in more than one letter.

9. Which person on the list was the first person you told about your pregnancy? _____
10. Who on your list now knows about your pregnancy? _____
11. Has anyone on this list made you feel unhappy, scared, guilty or ashamed about your pregnancy? If so, mark in the appropriate letter(s). _____
12. Who on this list has given you the most help during your pregnancy? _____
13. Why do you feel that the persons you have named in question 12 helps you the most? (Check off any of the following statements that you consider to be true).

- ☐ Shows concern for your feelings
- ☐ Listens to you
- ☐ Is available when you need him/her
- ☐ Is willing to talk to the father of your baby
- ☐ Is willing to talk to your parents
- ☐ Makes plans for you and tells you what to do
- ☐ Allows you to make plans for yourself
- ☐ Makes all the arrangements for you to meet others who can help you

NOTE: If you have already told your parents don't answer questions 14 and 15.

14. If you have not told yet told your parents about your pregnancy when do you think you will?

- ☐ today
- ☐ tomorrow
- ☐ next week
- ☐ next month
- ☐ sometime
- ☐ never

15. Why have you not told your parents yet? Do you think that they may: (Check off any of the following statements that you consider to be true).

- ☐ be very upset
- ☐ be very angry
- ☐ be ashamed of you
- ☐ be disappointed in you
- ☐ hurt you
- ☐ threaten the father of your baby
- ☐ forbid you to see the father of your baby again
- ☐ ignore you
- ☐ send you away
- ☐ insist you marry the father of your baby
- ☐ forbid you to marry the father of your baby
- ☐ insist that you have an abortion
- ☐ insist that you give up your baby for adoption

Using this list please answer the following questions, numbers 16, 17, 18 and 19.

(a) Get married
(b) Keep the baby
(c) Have an abortion
(d) Have the baby adopted
(e) Stay in school as long as possible before the baby is born
(f) Leave school until the baby is born
(g) Stay at home until the baby is born
(h) Leave the city until the baby is born
(i) Want you to decide for yourself what to do
(j) Never to see the father of your baby again
(k) Don't know

Write in the appropriate letter(s) from the list above next to the statement(s) in questions 16, 17, 18, and 19.

16. If one or both of your parents know you are pregnant, what do they want you to do ---------- ____

17. What does the father of your baby want you to do? ---------- ____

18. What do you want to do? ---------- ____

19. If none of the above statements in the list apply to you please state why.

.....

.....

20. What do you plan to do after the baby is born?

☐ Return to school
☐ Enter the University
☐ Get a job
☐ Get married
☐ Stay at home
☐ Have not thought about it yet
☐ Any other plans. If so please state them .....

.....

.....

21. Do you know what body changes to expect during your pregnancy? ☐ Yes ☐ No

22. Do you understand why these changes are occuring? ☐ Yes ☐ No

23. Do you know what to expect during labour and delivery of the baby? ☐ Yes ☐ No

24. Do you know how to take care of your body's needs during this pregnancy such as diet, rest, exercise, etc.? ☐ Yes ☐ No

25. Did you acquire this knowledge before you became pregnant or after? ☐ Yes ☐ No

26. Where did you gain this knowledge? (Check more than one answer if appropriate)

☐ School programs: ☐ Sex Education ☐ Biology Course
☐ Other programs, if so what .....
.....

☐ Club or group meetings
☐ Parents
☐ Friends
☐ Books
☐ Films
☐ T.V.
☐ Family Planning Center
☐ Anywhere else, if so where .....
.....

☐ Do not remember where

27. Do you know that there are special classes for pregnant adults and teenagers at St. Clare's and Grace Hospitals as well as at the Public Health Department on Harvey Road? ☐ Yes ☐ No

28. Do you know that there is a special clinic at the Grace Hospital where you can receive medical care and special counselling while you are pregnant? ☐ Yes ☐ No

29. Now that you know about these places, do you think you will visit them? ☐ Yes ☐ No

30. If you knew about those programs before, did you visit any of them? If so, which ones .....
.....

31. If you do not what to use these programs, is is because: (Check off any of the following statements if you consider them to be true)

- ☐ You don't know the people working in them
- ☐ Too many people involved in the program
- ☐ Some of the women attending are married
- ☐ Many of the women attending are older than you
- ☐ You are not sure what the program is all about
- ☐ Someone you know might see you there
- ☐ They are in a hospital or public building
- ☐ Any other reason, if so, please state .....

32. If there were a program <u>just for pregnant teenagers</u> would you attend it? --- ☐ Yes ☐ No

33. If yes, where would you like such a program to be located?

- ☐ In a hospital
- ☐ In a school
- ☐ In a private building
- ☐ Somewhere else, if so please state where .....

.....

34. Would you attend special programs for pregnant teenagers such as: (Check off those programs you would like to attend)

- ☐ An opportunity to meet with other pregnant teenagers
- ☐ An opportunity for both you and the father of your baby to attend together for help and information
- ☐ To prepare you to know what to expect during your pregnancy such as - body changes, labour and the delivery of the baby, etc.
- ☐ To teach you how to take care of your health during your pregnancy
- ☐ To inform you about birth control if you so wished
- ☐ To help you keep up with your schoolwork after you leave school until you return
- ☐ To help you after the baby is born

35. Would you use a 24-hour telephone service providing you with the opportunity to talk to someone when you needed help or advice? ---------- ☐ Yes ☐ No

36. Do you have any suggestions concerning the kind of help you and other pregnant teenagers really need? Please express yourself quite freely. We want to help you and other teenagers as much as possible.

APPENDIX C

PREGNANCY TEST

NAME _____ DATE _____

ADDRESS _____

PHONE _____ AGE _____ PLEASE INDICATE: Married ____
Single ____
HOW DID YOU HEAR ABOUT THE TESTING SERVICE? _____ Separated ____
Divorced ____

DATE OF LAST PERIOD _____

METHOD OF BIRTH CONTROL USED REGULARLY:

Foam ____ Rhythm ____ Pill ____ Condom ____ I.U.D. ____

Diaphragm ____ Withdrawal ____ Other ____ None ____

METHOD OF BIRTH CONTROL USED AT TIME OF SUSPECTED PREGNANCY _____

OFFICE USE ONLY

RESULTS OF PREGNANCY TEST: Negative ____ Positive ____

IF POSITIVE, WAS IT A PLANNED PREGNANCY? _____

WAS THIS CLIENT REFERRED? _____

IF YES - PRENATAL ____

ADOPTION ____

ABORTION ____

OTHER ____

APPENDIX D

RATE OF ILLEGITIMATE BIRTHS PER 100 LIVE BIRTHS IN ST. ANTHONY, NEWFOUNDLAND 1975

1975 - FULL YEAR

AGE	Single G1	G2	G3	7G3	Married G1	G2	G3	G4	G5	G6	7G6	Total
13	2											2
14												-
15	6				1							5
16	15				4	2						21
17	15	1			2	3						26
18	21	4		1	9	6	2					43
19	21	3			8	2			1			41
20-24	19	9	1	-	33	41	24	15	3		3	148
25-29	1	3			11	19	20	16	9	3	3	85
30's	1				3	6	3	6	6	16	16	57
40's							1				5	6
Total	101	20	1	1	71	83	52	37	19	19	27	431

In 1975 - 28.5% of all live-births were registered as illegitimate.

APPENDIX E

Statistical breakdown of single girls served by Planned Parenthood Association (St. John's) - February-July 1977

	Feb.	March	April	May	June	July	Total
Number of pregnancy tests performed.	20	19	16	21	29	29	134
Test results:							
positive	12	9	8	9	5	14	57
negative	8	10	8	12	24	15	77
to retest	--	--	4	4	7	4	14
Contraceptive use.							
failure	3	3	2	1	2	3	14
no method	9	7	6	8	3	11	35
Decisions for outcome							
adoption	1		1	1			3
marriage	1			2			3
single parent			1				1
abortion -(Nfld)	5	1	5	3	3	7	24
-away	2	4	1	1		3	10
unknown	3	2		2	2	4	13
Referrals to P.P.A. by:							
doctors	6	5	8	3	10	6	38
friends	7	9	6	12	16	18	68
media	1		1	2	2	4	10
educational programs	3	3	1	4	1		12

STATISTICS: AMOUNT OF MONEY SPENT FOR SOCIAL ASSISTANCE FOR UNWED MOTHERS IN NEWFOUNDLAND FOR THE MONTHS OF MARCH 1974 - 1977.

March 1974 - $170,794.00
March 1975 - $208,605.00
March 1976 - $265,746.00
March 1977 - $347,850.00

Case Loads for March 1974 - 1191
1975 - 1260
1976 - 1531
1977 - 1814

The number of new and reopened cases from November 1, 1975 to October 31, 1976 was 837 cases at a cost of $750,000.00