Inquiry into teenage pregnancy

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A post-nuclear 'family' for post-industrial society?
Integrating the social and the medical in public health
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Health Service problems and the 'problem' of 'teenage pregnancy'

Many issues of practical concern in public health and social policy are artefacts of the routine data collection processes of organizations in those fields. Problems 'constructed' by the health and social care data system then need to be 'solved' by that same system. This, however, is sometimes impossible, as an apparently delimited problem turns out to be one presenting symptom of a complex social dynamic, for which, as Sally Macintyre points out, any potentially effective solution requires remedial/preventive attention to move 'upstream'[1] – '...most of the drivers of population health and of the distribution of health lie outside the NHS' (Macintyre 2000)

In UK public health, high rates of 'teenage pregnancy' are a case in point. John Ryle pointed out over fifty years ago that 'All diseases of high incidence may be said to have a social as well as an individual pathology' (Ryle 1988). And so it is here: in establishing an association between high rates and communities in industrial decline the UK epidemiology suggests a community aetiology. Epidemiology, however, leaves the community aetiology as a 'black box': the input indicators are known, the outcomes are known, but the social processes are not known.

Acknowledging this fact, Tayside Health Board focused 'upstream' and commissioned a pilot study into the general patterns of family and lifestyle in deprived areas of a former industrial centre. Persisting high rates of teenage pregnancy were of primary concern but there was also concern for other phenomena with a possible connection with family functioning: low levels of breast feeding, a high prevalence of smoking, high rates of acute hospital admissions, and a majority of newborn babies being registered to unmarried parents.

Method

The commission was specifically for sociological research, not socio-medical research. Given the openness of the problem definition, the overall approach adopted was grounded theory, the method key informant interviewing. Interviewees were selected on theoretical sampling criteria. The aim was to produce an ethnographical sketch or model of the social context of some family/health problems intractable to the solution systems – a model which

[1] 'There is a need to move away from the almost exclusive focus of research on individual risk, towards the social structures and processes within which ill-health originates, and which will often be more amenable to modification.' (Lancet 1994)

was theoretically rich, but also practical, in pointing towards profitable avenues for follow-up research.

Results

Until recently, the governing theory of health and illness required health problems being investigated with UK health service research funding to be constructed in a form amenable to health service solutions ('effectiveness', 'measurable health gain'), and thus utilisable by doctors. Time pressures and acquired attitudes to the scientific value of publications also ensure that efficient dissemination of research results still depends on keeping within the conventions of medical writing. The Tayside family research results were accordingly cast into one of the most established forms in medical science reporting, the 'clinical entity' (Guttentag 1949), the form given to a newly-identified disease/medical condition. Arguing analogically from physical pathology to social pathology, 'distributed parenting' in clinical entity terms is –

- *an acquired constitutional disease of the reproductive system of a deindustrialised community,*
- *caused by redundancy, dyseducation, and a maladaptive culture,*
- *manifest in asocial conceptions, asocial parenting, hypertrophy of the peer group and the division of parenting labour with the extended family, public and commercial agencies,*
- *issuing from a structurally deranged family role system,*
- *leading to functional disorders in mental health, substance dependence, financial problems and 'copelessness'.* (Ryan 1999)

Discussion and Implications

Every choice of method involves trade-offs. It was to maximise dissemination in the field of public health medicine that distributed parenting was presented as a pathology of the nuclear family. However, recasting the overall ecology of family life in poor communities in the terms of historical and comparative sociology allows a different diagnosis or - more properly - a different hypothesis[2]: 'It is from the "maybe" and "perhaps" of speculative statement that future hypotheses are generated. If a scientific paper points forward, it must point at the unknown' (Skelton and Edwards 2000). As a hypothetical model, 'distributed parenting' functions to organise perception in a world in which we cannot yet find our way about; it shines a beam, structuring if still only suggestive, into the future.

As a strategy, distributed parenting is rational in the use of resources, saving costs by spreading the tasks of parenting across a larger range of more or less willing co-parents than was the case with the division of labour within the

[2] Pilot studies perhaps partake more of the nature of clinical than of laboratory medicine, the premium being on hypothesis generation: '...the logic of good physicians is applied by generation, testing, and acceptance or rejection of diagnostic hypotheses throughout the data collection process. The number of hypotheses formed will vary with the educational level of the problem solver, his experience, and whether his specialty matches the nature of the case.' (Cutler 1987)

nuclear family based on the male breadwinner wage. The reason why this strategy has become salient at this historical point is the clear link between the deindustrialising of the UK and the loss of the male breadwinner wage as the basis of the social mobility strategies of achievement-oriented working class families. The moral basis of a competitive/solidaristic society has gone. Today, the individualisation of success (signalled by the younger generations' preoccupation with 'fame'), the relative decline in boys' educational achievement, the rise of single parent families, continuing high rates of teenage pregnancy, addictions and self-harm, these are all testimony to the same socially disintegratory dynamic within post-industrial society. We are living through the deindustrial revolution.

With the disappearance of male breadwinner wage-packets from millions of child-rearing households, the costs of parenting now fall ever more on mothers. However, mothers find themselves pushed into the labour market by the historical decline in value of the contribution from the state family support system coinciding with a rise in the real costs of children (their dependence prolonged by the collapse of youth labour markets, the necessary human capital investment raised as employment competition intensifies and the demands of service sector work include more higher-level skills, the socially compulsory expenditure on children-as-consumers driven up by the competitive materialism of youth culture, etc.). How to square the earning vs. parenting circle? One answer in the UK is *'share out the parenting'.*

In distributed parenting in economically marginalised districts with minimal earning opportunities we see the resourceful adaptation of working class child-rearing traditions to new circumstances. However, generalising the argument to suggest that distributed parenting may be an evolutionary break within British society rather than a 'pathology' of 'the underclass' has been prompted by the self-evident fact that British deindustrialisation has brought an acute rise in the opportunity costs of a) having a child, and b) intensively parenting one's own child, to all levels of the socio-economic system. While this means that mothers of all classes are prepared to accept supplementary parenting where they can find it (e.g. breadwinner-wage professional women who organise a miscellany of paid and unpaid sub-contractors to help them bring up their children, in some cases expending the entirety of their earnings for years to ensure motherhood does not push them off the career ladder), some of the poorest families have it thrust upon them. The obligation to parent does not go by default, but gets assumed by the state, whose agents and agencies take a leading role, more or less directly, in the parenting function.

While it needs further investigation, the balance between state and family seems to be the crucial factor. In weak state/strongly familistic societies (Italy, Spain) a precipitate drop in fertility has been the response to the economic demotion of men; in strong state/weakly familistic societies (UK, Scandinavia) distributed parenting appears to moderate the impact of the raised opportunity costs of parenting on fertility. The natural experiment opportunely provided by German reunification adds weight to the hypothesis: fertility crashed in eastern Germany after its incorporation into a society with a strong male breadwinner ideology but without the required number of male jobs with

breadwinner wages (Adler 1997). Historical differences in the socio-institutional context have thus conditioned the response to the same socio-economic factors differently in each society, with radically different outcomes for both demography and family structure. It is these outcomes which then become the proximate drivers for public health issues.

At the dawn of the industrial revolution even the most scientific physicians were aware of the significance of social context: 'Medicine is a social science in its very bone and marrow' (Virchow 1849). Because contexts change, social science concepts, unlike biological concepts, are historical. They require to be glossed. The acceleration of history requires them to be glossed ever more frequently. At some point in the historical process medicine may well find that it has made a choice. To recover its social science heritage. Or to become marginal to public health.

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7 February 2013

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Annex A

'Teenage pregnancy as a community symptom'

Summary of presentation by Joyce Wilkinson and Desmond Ryan
at a symposium

Putting teenage pregnancies in their contexts

Royal Institute of Public Health and Hygiene/Society of Public Health
7 November 2000

Why is teenage pregnancy so highly associated with deprived social environments? What is it about living in a poor community that makes its young people take more risks with unprotected sex? If a high local rate of teenage pregnancy is one end of an investigatory thread leading us from the sexual to the social, where do we end up if we follow it? Some answers to these questions come from exploratory ethnographic research carried out in the poorest areas of a former industrial town in Scotland. We present them as representative case studies, illustrated with quotations from our interviews.

FIVE CASE STUDIES

1. 'Young mother' vs. 'early mother': Annie is eighteen and had her son Angus when she was seventeen. She was engaged to Angus's father Alastair at the time of the birth, and they have since got married. They live together in a council flat for which they were given priority when Angus developed respiratory problems in their damp bed-sit in the private sector. Annie's mother lives nearby, as does her elder sister, unmarried with two young children. Alastair works as a delivery driver.

Given enough maturity, being of teen age is not the problem. Harping on about 'teenage' pregnancy distracts from the real problem, unpreparedness. Mother and child do better if their circumstances are right: materially, socially, humanly. Annie would be a case of 'teenage pregnancy' in the statistics, but in fact her baby was wanted and planned, and arrives in a social situation where potential risks come more from the deprived environment than from the unpreparedness of the parent(s). She is a 'young mother' rather than an 'early mother'.

In low-opportunity communities babies are clear social assets. Since they are far from being the obstacles to high earnings and promotion they have become for educationally qualified career women, nothing is gained by putting off having them. Here, also, motherhood is the high-status position: once you have a baby you can give up being a slapper and everybody has to take you seriously. For both young and early mothers, great excitement surrounds the baby as a bearer of consumer statements: the pram, the clothes, the toys, early transition to solid food and independence:- all are assessed as indicators of parenting success, and bring positive social recognition – perhaps, for some young women, for the first time in their lives.

[Illustrative quotations]

2. Excluding schools: Betty is seventeen and had Bessie when she was sixteen and a half. She hated secondary school, finding the subjects irrelevant and the teachers uncaring, only concerned with their own agenda. TV and video distractions, no access to a table, and the lack of quiet space made doing her homework almost impossible. She skived off her last two years, with the collusion of her mother (who also had hated school) and egged on by peers, missing, among other things, her personal and sex education classes, and, with no exams, ended up working in a shop. The school took minimal steps to make her attend.

Disaffection with school and mutual misunderstanding appear to feed into a spiral of hopelessness and poor achievement for pupils and a less than ideal work situation for their teachers. The fact that schools require to achieve competitive standards set by central government puts considerable pressure upon staff and does not enable them to take account of the difficulties faced by individual pupils, many of whom are lacking in motivation and are unsupported by families. More and more pupils are excluded from school or 'managed' on a part-time basis. Close links between conditions at home and success in school are apparent. The contrast between early mothers and those young women for whom schooling seems to offer a route to an alternative future is stark.
[Illustrative quotations]

3. Alcohol abuse: Chrissie is 21 and has a one year old son, having had an abortion at 15, largely because her parents would have been unable to give her any help if she had had the baby. She had never told the lad involved that she was pregnant; it happened at a party, when both of them were drunk.

Booze is plentiful, cheap, and easily acquired by the under age. Sociability in these communities is bathed in alcohol. As a primary ingredient in a high-profile lifestyle and in the exchange of hospitality, high alcohol intake is sewn into the basic framework of social life. Hence many decisions about drink are situationally determined, all but removed from individuals' own control. To say 'no' is threatening. This is especially true for men, and for those younger teenagers who need to over-assert their identity as 'adult' as they disengage from school (and frequently also from home) and find uncertain anchorages on training schemes and in low-paid jobs. On closer examination, many questions about risky sex turn out to be questions about alcohol management.
[Illustrative quotations]

4. Absent fathers: Denise is 17 and her daughter is 18 months. She never knew her own father, and her mother had various men in the house while she was growing up, but none with whom she formed any bond. She didn't get on with the adults and they left her to get on with things herself, putting her out from the house when she was just 16. She has no respect for the lad who fathered her baby and he has faded from the scene. She keeps up with a few of the others from the special school for pregnant school-age girls, but has nothing in common with them and is beginning to get isolated and depressed.

Historically, most families in British industrial communities had a marked division of labour: women ran the home, males' family contribution was overwhelmingly seen as to be the provider. With the loss of industry the economic base for social mobility strategies based on investing family financial and cultural resources in the future has gone. The loss of industry and its breadwinner wages has therefore also put a full stop to this model of family, at the same time putting a big question mark over fatherhood. Loss of financial support exacerbates household poverty, but there are also significant consequences for children of growing up without a consistent adult male in the home. Traditional father functions of protection, supervision, discipline and adult gender role modelling are not being fully picked up by the surrogate parenting systems: sexual risk-taking by the young appears to be one consequence. The fact that children are poorly controlled now has no impact on the achievable future: 'whatever you do makes no difference' is a widespread view. 'Families' increasingly become day-to-day survival units ('female families'), not strategic investment units – for where is the capital, and/or the return?
[Illustrative quotations]

5. Peer group dependency: Elaine is 15 and has been a member of a fairly wild group of girls since she was 11. They go around together, smoke and drink, wear the same designer labels, use the same buzz-words, and are disruptive in school, abusing teachers and slagging off anyone who tries to do well. Once they poured orange juice over two other girls on the bus, because 'one of them had a high voice'. Recently she was involved in a drunken mass attack on the home of one girl in her class who was staying on for a further year, shouting abuse, tipping over the dust-bins and throwing stones at the windows. The police had to be called. Pressure to display the badges of adult status, notable to become sexually active, pervades these groups. Drunken week-end parties when someone's parents are away are the high point of this lifestyle.

Society abhors a vacuum. The less intensive socialization by parents is, the more children do it themselves. But they don't do it single-handed. Peers have a very powerful role in the development of all young people today, but especially in areas where home, school, and voluntary agencies have lost commitment to young people; where the jobs are few, casual, and provide little support to fragile identities; and where the media are uncontested in show-casing 'must-have' possessions and 'must-do' styles of behaviour.
As 'parents', however, peers protect their own interests first and foremost: they socialise others to be like themselves. Functionally, these teenage peer groups could be seen as the vigilantes of the socially excluded lifestyle, policing the exit points of communities at the edge in an effort to ensure the social community itself continues to reproduce, that the culture which gives them a place and a voice will survive. While getting pregnant may be a fairly predictable lifestyle accident for teenagers here, actually having the baby may not be without overtones of 'political' resistance.
[Illustrative quotations]

CONCLUSION

If high rates of teenage pregnancy are a symptom of something affecting these communities, what is it? We need to go beyond the surface individual facts to the underlying history which they compose. Viewed in a more global perspective, what we see is restructuring within restructuring: a community where, under the pressures of economic marginalisation, the patterns both of sexual activity and of reproduction have to some considerable degree separated from the patterns prevalent in the wider social system. This separation is congruent with the economic separation. The fact that the early motherhood pattern is more prevalent among those whose socio-economic futures will be to stay where they are and not to ascend the socio-economic ladder suggests that the two different family patterns fit two different life-worlds: early motherhood for the post-industrial socially excluded, delayed (or, increasingly, renounced) motherhood for the career women of the modern service sector. Two classes of women, living in separate economic systems, 'doing family' in different ways.
What is the significance of this separation for British society? Among others, one key question is whether (and how) the 'traditional family functions' are being performed for society by the new family structures and processes which seem to be working among the socially marginal. For families reproduce society as well as themselves.

- With regard to ***socialization of the young***, they are clearly not functioning as the 'personality factories' identified by Talcott Parsons in the 1950s, maximising developmental gains by helping the young to manage the tensions between an intimate private world and the demanding public world of school and peers, work and/or higher education. As we have seen, many youngsters from deprived areas arrive at adolescence encumbered by acute difficulties in self-management in their roles and relationships, whether at home, in school, work, consumption, leisure, or sex. Though they wish to take life by storm, they are not life-ready. Hence 'society' keeps them at the edge, e.g. by failing them in school.

- In addition, these structures appear not to be providing for the ***stabilisation of the personalities of the adults*** as a social mobility-committed couple at the centre of a strategically managed household supported by an emotionally anchored breadwinner. Whatever the real merits of the old working-class family, in the new one mental health problems, addictions, comfort eating, and debt-inducing lifestyles all attest to a shortfall from members' emotional investments in relations between self and others. Inter-personal communication and respect for personal boundaries present as major difficulties in many such homes.

Thus both adolescents and their parents seem to find difficulty in 'getting it together'. The functional load ascribed to the nuclear family in the embourgeoisement/'never had it so good' years is proving beyond the carrying capacity of many families in today's areas of advanced marginalisation.

We suggest that high local rates of teenage pregnancy may be symptomatic of an adaptive transition under way to a 'post-nuclear family' reproduction system, more appropriate to the structure of resources, opportunities, and cultural demands of marginalised post-industrial communities no longer able to hold their competitive position in the mainstream of the global economy.

But the more appropriate the new reproduction system is to the structures of its own community, the further it moves from fitting the needs of the wider society, as it in turn adapts to economic change. Cultural differentiation reinforces spatial separation, creates difference. Those who live in another world become other people.

So this reproduction system is not just about poor teenagers, their babies, their abortions. It is also about how a society handles its historical evolution, a global change which is multi-levelled and complex (sexual, psychological, cultural, educational, material, political, geographical, etc.). For, if indirectly, and unintended, the system is more the creation of those outside these communities than those within. It is those who create macro-environments who hold the power to determine evolution, not the social groups within each local niche, adapting to survive each difficult day.

Annex B

'Distributed Parenting'
Teenage pregnancy in post-industrial areas in a social medicine perspective

A medical theory of social pain

March 2001

http://www.desmondryan.com/dundee/pdfs/DistributedParenting00Full.pdf