Proceedings of the 1998 Konopka Lectureship

Henry W. Foster, Jr., M.D.
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The Konopka Institute
Division of General Pediatrics & Adolescent Health
University of Minnesota
The Gisela Konopka Lectureship was established with the support of Dr. Konopka's friends and colleagues to honor her and her achievements on the occasion of her retirement after 30 years of contribution to the University of Minnesota. It carries on the important, unique tradition of integrating theory and practice and humanizing services for children and youth.

Dr. Konopka has been the moving force behind numerous innovative methods in practice and research in social work and youth services. She is a pioneer in the area of making scholarly knowledge about youth available to those who need it most—the practitioners. It has been her unerring devotion to making human services humane that has characterized her outstanding career.

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Taming the Tempest of Teen Pregnancy

Henry W. Foster, Jr., M.D.

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Gisela Konopka, D.S.W., Professor and Director Emerita, Center for Youth Development and Research, delivered the following remarks as introduction to *Best Practices for Improving Adolescent Health*, a 20th anniversary celebration of the Konopka Lectureship and the University of Minnesota’s Adolescent Health Program.

**Priorities for Working with Youth in the 21st Century**

*by*

Gisela Konopka

Twenty years seems to be a long time ago. I am very moved about your coming today. I want to thank you, all of you who do the actual work with young people, and all of you who have helped to make this event possible every year. I especially thank Bob Blum and those who work with him.

My subject is to talk about priorities for youth work in the 21st century. I do not know how the 21st century will look. I have never believed in those “futurists.” Yet, I assume that our adolescents then will not be so different from what they are today. In my very long life, I have seen adolescents in many countries, living also in various cultures and in a variety of conditions. Certainly there were differences but, basically, all of them are people like all of us. Yet philosophy and political goals of various societies have always influenced responses to the next generation. Therefore, I can only say what I see here today and what should be our continuous tasks as adults in relation to adolescents.

First of all, we need not only to have but to promote an attitude of respect for them, not present them to be in an “awful transition stage,” something “in between” and actually, as dangerous. We need to recognize them as being in a time of strong life force, in great need of friends of their own age, of widening of experiences, of a thirst for adventure. We need to destroy the present prejudices against them and the growing distrust against adolescents. When we work with a new generation, we have to clear our own
values. If we want hardened soldiers as in the time of Sparta, we will destroy their sensitivities, will give them no tender moments. If want them to be like the Nazis, we will teach them to only obey orders and not think for themselves. I hope that these are not the values we want to promote. So, we have to:

1. Demonstrate that we can work with them.

   We must listen to them and in anything that we call youth work to include them. Youth participation, being part of any project, is most important.

2. We may not need a lot of new programs but we need a thorough look at any organization or project. We need especially a thorough investigation of the places where young people are kept—delinquency institutions, prisons, mental health institutions, etc. Right now we are calling only for punishment which is sometimes called “rehabilitation.” Instead, we need to create places of feeling, learning new skills, emotional and otherwise, learning new satisfactions and especially mutual respect.

3. We need to learn about good practices and promote those. We need to evaluate existing youth work according to a clear philosophy and an understanding of the needs of adolescents.

   I would like to give examples of what I am talking about, and I would prefer to have young people speak for themselves. Yet, I cannot do this in this short time but I can plead with everyone for really listening to them and feeling with them.

   We must understand what lies often behind an attitude of bravado and not caring. A 15-year-old in a group home once wrote:
"There deep down underground, 
ever to be shown
these feelings are deep in me 
ever to be known."

The great poet, Langston Hughes, said it even more strongly:

"Because my mouth
Is wide with laughter
And my throat
Is deep with song
You do not think
I suffer after
I have held my pain
So long!"

I have recently spoken with some 14-year-olds to prepare for my remarks. I asked them, among other things, what they would want to say to people, what they would consider the most important things they would change for young people. Their answers were "respect young people... most times they just judge things by number, by our ages... it doesn't depend on age, what you think but what you know, how much you comprehend."

To summarize, I quote first Alan Paton who stood often alone against apartheid. He wrote:

"It is my own belief that the only power which can resist the power of fear is the power of love."

Fear is the base of hate and we have to help our young people not to be afraid. If their life is only gray and ugly, fear mounts. We have to let them see that variety in people is enjoyable. It enriches life. Variety gives life the vibrancy we need. But we also know that all human beings have much in common.
Let us be gentle with our young ones instead of constantly criticizing and chiding them. We will have less violence. Let us give our young people joy and beauty and stimulation instead of dreary places in which to grow up and no experience of the beauty of the arts, poetry, music and dance.

And, finally, give them HOPE again. The sulleness I meet often comes from the feeling that there is nothing to look forward to. We can’t lie to them about the harsh reality in which many of them live. But we can let them become strong in the knowledge that they can be part of shaping a better future.

The major priority is the enhancement of gentle strength in each one of our young people.

I know we sometimes feel discouraged because we do not always see success. Let me read to you from a writing of Irving Stone that has helped me when I felt like giving up:

“Are you suffering a little from disillusion, Gene?”
“Yes, to be frank with you.”
“But that is perfectly natural... The idealist is always torn between disillusion and inner resolve. One of the bitterest lessons I had to learn, Gene, was that the job always has to be done over again, every day.”
“...You mean that no matter how completely a work is accomplished ... it does not stay accomplished?”
“If it did, we all would be living in a Utopia now.”
“But if a man (woman) knows that to be true, how can he continue?”
“Because, if he doesn’t carry on, if he does not renew his efforts, every day of his life, then only the grasping and evil people remain active.”

Irving Stone, ADVERSARY IN THE HOUSE

So—we must carry on.
Taming the Tempest of Teen Pregnancy
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The challenges facing our youth are greater today than perhaps ever before. And of these challenges, teen pregnancy is most paramount. Teen pregnancy, like so many youth behaviors, has its roots in the social health of young people. So much of what has a negative affect on health outcomes is not medical but rather social and behavioral in its underpinnings; medical sociologists have understood this for a long time—we’ve lagged in the medical field.

Non-medical Barriers to Optimal Health Outcome

Why is it important to understand the generic determinants or antecedents that cause adverse health care outcome? So much of what influences health care outcome is not medical. Social expectations and behavior are often underpinnings of negative health outcomes. It is, therefore, axiomatic that all who are associated with health care fully comprehend this fundamental concept.

Medical sociologists speak of two major non-medical barriers to health care which are characterized as “attitudinal” barriers and “organizational” barriers. Attitudinal barriers prevent individuals from becoming motivated to seek needed health services. Organizational barriers prevent motivated individuals from utilizing those services they know they need. Attitudinal barriers include ignorance, fatalism, mores, superstition and fear. Organizational barriers include lack of finance, health insurance, transportation, health care providers, health care facilities, and the like.

The extent to which these non-medical barriers, along with medical barriers, operate for an individual or for groups determines health risk status. Health risk status and the quality of service provided determine health care outcome. Very clearly, an individual at low risk who receives superlative care will have the best chance of living a healthy life free of the need for serious medical intervention.
Likewise, individuals at high risk who receive substandard care are most likely to have poor health and need serious medical intervention. As physicians, we must contribute to lowering risk factors, both medical and non-medical, while increasing the quality health services provided.

**Inadequate Appreciation of Public Health**

In addressing teen pregnancy and so many other health problems with their roots in adolescent behavior, it is essential that we embrace an appreciation of the public health approach to solving social problems that so often are disguised as medical problems.

This broader view of public health is well championed by Dr. Julio Frenk in his brilliant paper, “The New Public Health,” that views public health from a Jeffersonian "holistic" perspective. Dr. Frank says “Health is a crossroads. It is where biological and social actors—the individual and the community, the social and the economic policy—all converge.” We must comprehend this fundamental premise, for if not, we will fail miserably in addressing not only teen pregnancy but all of America’s health needs. Public health has made major contributions to the health of our nation. Its epidemiological population-based approach to solving health problems is essential to maximizing good outcome and cost efficiency.

Today, everyone is enamored with high-tech medicine, and indeed, it is very fascinating and necessary. In the larger scheme of things, its aggregate contribution to overall health of the country is believed, by some, to be overrated. I refer you to a letter that appeared in *Science*, Vol. 263, No. 3, December 1993, written by Richard Lamm, former Governor of Colorado. In his letter, Lamm challenges Dr. Michael E. Deakey’s belief that the increase in life expectancy and the reduction of premature mortality are due to medical research. Lamm says such a belief is self-serving and mostly wrong. While Governor Lamm acknowledges that medical research has done some truly wondrous things, he attributes increased life expectancy to the public health system.
Like Victor Fuchs, Governor Lamm asserts that when the state of medical science and other health determinant variables are constant, the contribution of high tech medical procedures to positive health outcomes is marginal in modern nations. "The great enemies of death and disease in the modern world have been sanitation, pasteurization, chlorination, refrigeration, sterilization, soap, diet, screen doors, and the high standard of living," says Lamm. Now, I won't become totally immersed in the polemics of this issue because public health and medicine must complement each other. However, such polemics re-emphasize how little we understand or care about behavioral epidemiological population-based research and its positive effects on the country. Both have been neither adequately appreciated nor properly addressed.

**Teen Pregnancy in America**

Let me put into perspective for you the magnitude of teen childbearing in America. All of the news is not bad. The rate of teen births steadily declined during the 1990s in America. The rate of 62.1 live births per 1,000 women ages 15 to 19 years old reported in 1991 was the highest level recorded in 20 years. The rate of 52.9 reported in 1997 represents a three percent decline in one year. However, this rate remains higher than rates reported in the mid-1980s when they were at their lowest point ever (50-51 per 1,000).

More than 1 million teenage pregnancies, most of them unintended, will occur in this country this year, resulting in some 500,000 births and another 500,000 induced abortions. The United States leads all other industrialized nations in this category by a two-fold margin.

Our annual teen pregnancy rate is more than double that of the next nearest western nation which is the United Kingdom at 46 births per 1,000. And, when we consider the Netherlands and Japan with just 10 such pregnancies per 1,000, we can see that the magnitude of our problem is tenfold or more than 1,000% higher than where it ought to
be. It is also important to appreciate that this is a problem that crosscuts all ethnic, economic and social classes. It is most important for this audience to appreciate that considering only the white contribution to our nation’s teen pregnancy rate does not change at all our relative statistical ranking to other western nations. This is not a problem confined to the inner cities, the barrios or Appalachia but is one that affects the entire nation.

It has been incorrectly presumed that other western nations have lower teen birth rates than the United States because of their higher abortion rates. In fact, abortion rates in the United States are substantially higher than those for other western nations. Additionally, in Sweden and France, teenagers become sexually active at an earlier age than do teenagers in our country, yet their pregnancy, birth and abortion rates all remain substantially lower than do ours in America.

One of the oldest methods of problem-solving is by comparison. When someone similar to you has the same challenge that you have but they do a much better job of addressing it, then it behooves you to examine what they are doing that’s different from you. In western European countries, K through 12 family life sexuality education that is both age and grade appropriate exists universally. Teachers there are not harassed and brow-beaten for teaching human biology as are so many teachers here in America. The media there are much more open about discussing issues related to sexually transmitted diseases and contraception. In most countries, contraceptives can be purchased over the counter without prescriptions. There are lessons there for us.

Sexuality and sex education are lacking in our nation both in school and at home. A startling 72% of boys and 63% of girls first learn about sex from someone other than their parents. I do not believe that most people who oppose family life-sex education are evil people. I believe they are parents desperately trying to protect their children. They hold the woefully mistaken notion that learning facts about
human biology is the trigger that causes teens to become interested in sex. They do not comprehend that sexuality is a biological instinct that promotes the perpetuation of the species. No formal education is needed. The obstructionists have got it just backwards; to the contrary, factual knowledge about human biology is needed not to become sexually active. When parents fail to teach children the facts and their own values about sexuality, teenagers fail to learn how to deal with sexual and other stressful situations. It is absolutely essential that teachers receive support from school districts, parents and the community to provide sex education or, if you prefer, family life education.

On the economic front, preventing teen pregnancy saves money. For every dollar spent on providing basic preventive services like education and contraception, tax payers save an average of $4.40 in costs associated with pregnancy.

Let me touch on one other contributing cause to teen pregnancy and destructive behavior. It is disquieting that nearly two-thirds of teenage mothers are impregnated by men age 20 and over. Men six or more years older than their female consorts cause nearly 400 teen pregnancies everyday. This calls for national and local action focused directly at irresponsible and delinquent fathers. We must mandate a greater focus on males. We have worked to apply these principles to the “I Have A Future Program” which I will discuss momentarily.

The “I Have A Future” Program

Now let me share with you some aspects of a program called “I Have A Future” founded in Nashville in 1987. The conceptualization of this teen pregnancy prevention program actually began in 1980 with a Robert Wood Johnson Foundation initiative. Our initiative drew heavily from a study in 1986 by Leon Dash. Our goal was to develop a program that addressed the social needs of children that, when met, reduce the likelihood of teen pregnancy.
A reporter for the Washington Post, Dash lived incognito for over a year in Anacostia, a very high risk area of our nation's capital. While there, to his utter astonishment, he found 12, 13 and 14 year old girls who were actively trying to get pregnant, often even when the males didn’t want them to do so. What this says so stridently is that we cannot reduce or prevent teen pregnancy without the desire to prevent pregnancy. We, as a nation, are at fault when we allow environments to develop where 12 year-olds can only see their value in having babies.

The United States desperately needs a domestic Marshall Plan: the best teacher-pupil ratios ought to be in the inner city, the barrios and Native American reservations. We must maximize day care. Imagine what having access to these deprived children eight hours a day for five years before they reach the first grade might do. The opportunities are there, we simply have to muster the will to seize them.

The Robert Wood Johnson Foundation program I directed was instrumental in creating school-based comprehensive health programs. While these school-based programs were effective, they didn’t meet the needs of teenagers during the time they were out of school. That led to the community-based intervention as a major unique aspect of the “I Have a Future Program” at Meharry Medical College. It was primarily because of this unique feature that the Carnegie Corporation saw fit to provide funding to test this new concept.

We characterized the community base as a residential venue with several major advantages. The residential setting allows us to more adequately address idle time. Community-based centers such as these are open to all adolescents. The closer proximity of families provides a better opportunity to involve parents and siblings. Finally, the residential setting enables the program to operate within the full range of situations that characterize life in the public housing setting.
"There deep down underground, 
ever to be shown 
these feelings are deep in me 
ever to be known."

The great poet, Langston Hughes, said it even more strongly:

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Fear is the base of hate and we have to help our young people not to be afraid. If their life is only gray and ugly, fear mounts. We have to let them see that variety in people is enjoyable. It enriches life. Variety gives life the vibrancy we need. But we also know that all human beings have much in common.
(3) To increase socially adaptive and appropriate behavior with particular focus on school achievement, vocational development, and delinquency rates, and to enhance adolescents’ ability to overcome environmental barriers to attaining the skills necessary to pursue meaningful employment with a promise of upward mobility;

(4) To engender a more positive self-concept and constructive attitude toward community, family life, and the future; and

(5) To expand educational opportunities for students in the health professions through a community-based program serving high-risk adolescents.

At any given time, there are about 180 youth actively participating in the program and they range in age from 10 through 17. The program is designed to be sensitive to all developmental needs and abilities and the following values permeate all aspects of the program: self-esteem; physical and mental well-being; completion of school; the development of job skills; sexual responsibility; self-control and the ability to handle interpersonal conflict; and the value of helping others.

There are ongoing and planned activities including modules that meet all five of the program’s objectives. Each module includes exercises and presentations to teach an edited version of the Nguzo Saba Seven Principles of Blackness pro-social skills and attitudes which are taught by their Swahili names; values which enrich any culture. These values are unity, self-determination, cooperative work and responsibility, cooperative economics, purpose, creativity and faith.

There are nine modules utilized to carry out the five objectives. I will mention each and give a brief description.

(1) The Tutorial/Academic Enrichment Module: improves participants’ study skills;
(2) CHARM (Choosing How to Adorn and Refine Myself) and MATURE (Males Adorning, Thinking and Using Refined Energies): CHARM and MATURE are eight-week programs designed for females and males respectively to improve their personal appearance;

(3) Family Life Education Module: to help youth understand the meaning of family and discuss various roles of family members, learn conflict resolution, discuss family growth and development, and to improve knowledge of sexuality and contraceptives;

(4) Job Readiness Module: The Job Readiness/Job Skills Program is designed to address career development. Part of this module is the teaching of operative English.

(5) "I Have A Future" Youth Entrepreneurial Program: Promotes vocational and career development;

(6) An Alcohol and Drug Abuse Prevention Module: Used to teach problem-solving and decision-making skills as they relate to substance abuse;

(7) Violence/Conflict Resolution

(8) The Body Awareness Resources Network (BARN) Computer Program, a nationally tested module that teaches computer skills and helpful lifestyles to adolescents; and

(9) Recreation, Athletic and Summer Olympic Activities: Increase and sustain male participation in "I Have A Future" activities. Basketball, baseball, karate, and summer Olympics are used to motivate participation, particularly among males.

In my judgment, too many in America have forgotten the kids who live in the inner cities or the barrios. These children can be helped; they are bright but they need someone to invest in them and to believe in their futures so they will have hope. This is precisely what the "I Have A Future" program does. We utilize field trips and travel extensively to expose these youth to an America with which
they are unfamiliar. Travel is enriching and transforms the abstract images they see on television into reality. Last year for spring break we flew 100 of these inner city youth to Los Angeles.

This experience is indelibly etched into their being. As they begin to see America differently, they will begin to believe that they might have a realistic chance to join it and share in its bounty. After accepting the possibility of their inclusion, these youth are then made poignantly aware of three subsequent imperatives: they will have to work very very hard to succeed, their effort is a challenge that they must relish because of its potential rich rewards, and we, the staff of the "I Have A Future" program, will be there to assist them every step of the way to best assure their success.

In the past four years of the program’s 104 high school graduates, 77 have gone on to college—a rate that exceeds the national average. Remarkably, 34 (44%) of these 77 college students are African American males. This is particularly noteworthy given the fact that 87% of the households where these youth reside are single female headed households.

**The National Campaign to Prevent Pregnancy**

In closing, I will share briefly with you some aspects of the National Campaign to Prevent Teen Pregnancy which was created in 1996. This Campaign is a totally private and nonpartisan effort being led by a distinguished Board whose chair is former New Jersey governor, Tom Kean.

The work of the Campaign is being led by four task forces each chaired by a member of the Campaign’s board. The task force members are drawn from all across the nation and bring a wide range of viewpoints and experiences that clearly will enhance the efforts of the Campaign. These four task forces are: 1) Media; 2) Religion and Public Values; 3) State and Local Government; and 4) Effective Programs and Research. My relationship to this Campaign is ad hoc in nature. As a presidential appointee, this is as it should be to assure the nonpartisan construct of this body. I provide input
to the Campaign, serve as a conduit to the President and as a consultant to the CDC, HHS and the NIH.

I can assure you that “Taming the Tempest of Teen Pregnancy” is no easy task, hence we must intensify our efforts. I remain sanguine about the future of our youth as we prepare to enter a new millennium. We have no other choice because the youth of today, for certain, will be our leaders of tomorrow. To assure their future, we must stay the course and this brings to mind one of my favorite quotes:

“Nothing in this world can take the place of persistence. Talent will not; nothing is more common than unsuccessful men with talent. Genius will not; unrewarded genius is almost a proverb. Education will not; the world is full of educated derelicts. Persistence and determination alone are omnipotent. The slogan, ‘press on,’ has solved, and always will solve, the problems of the human race.”

Those are the words of Calvin Coolidge and they are totally applicable to the task that faces us in providing health care for our children. Thomas Jefferson told us over 200 years ago that we must value health—that without health, we have nothing. We haven’t listened well enough. If every criminal has a right to have a lawyer, then certainly every child has a right to have a doctor.