High rates and high costs of adolescent pregnancy and school dropout have resulted in the development of many prevention programs; however, little is known about the long-range effectiveness of efforts. Empirical research is needed to document behavioral outcomes over extended periods of time.

I interviewed eight young white women who were my students in a dropout and pregnancy prevention program in the 1980s. Retrospective qualitative interviews were used to encourage them to talk about how their experiences in the program impacted education, pregnancy, employment, and relationships. Participants' health risk behaviors (HRBs), both past and present, were also reported. This study provides greater understanding of the major factors that contributed to each adolescent's high-risk status.

The participants identified these five program processes the greatest impact: (1) boosting self-esteem, (2) accessing resources, (3) supporting group members, (4) volunteering to help in the community, and (5) applying education.
The key finding of this study is: Caring is essential for the survival of these young women. The "Upward Spiral of Caring" is a model that portrays the stages that the participants described as they became involved in the program. Unconditional acceptance led to a sense of belonging. Volunteering gave them opportunities to experience accomplishment and recognition. Each person learned to care for herself, others, and the community, working together to boost self-esteem. In turn, positive self-esteem positively impacted individuals' actions, such as school attendance and academic achievement.

The program had two goals: to increase graduation and decrease pregnancy. Of the eight participants, seven earned a high school diploma or GED and none became pregnant while enrolled in the program. Today, all have experienced serious illness and/or injury. Half have psychological problems, and half have made suicide attempts. Seven used alcohol and/or drugs excessively as adolescents, and now those who use alcohol do so responsibly, except for one who continues to have all six HRBs.

The contribution of this study was to place marginalized young women at the center of inquiry. This study is an unique combination of critical inquiry, grounded theory, qualitative case study methodology, and a health education perspective. Recommendations for program development and future research were made.
Life Stories of High-Risk White Female Teens:
Qualitative Retrospective Interviews with Adolescents Ten Years
After Participation in a Dropout and Pregnancy Prevention Program
by
Tamara Lee Shaub

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I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

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Tamara Lee Shaub, Author
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CHAPTER I: INTRODUCTION

Teenage pregnancy and school dropout are complex interrelated phenomena occurring in epidemic proportions. Awareness of social and economic issues related to teenage pregnancy has resulted in the development of many programs. Although many prevention programs have been initiated, very little is known about their effectiveness over time. Empirical studies are needed to assess programs' far-reaching effects on participants' lives. No qualitative studies have been conducted that identify, from the student's perspective, the factors that initially placed her at risk and then follow the high-risk individual over a long period of time to determine lasting program influences.

I interviewed eight young white women who were my students in a dropout and pregnancy prevention program in the 1980s to discover their perceptions of long-term program impact. Retrospective qualitative interviews were used to encourage them to talk about their experiences. The main contribution of this study was to place these young women at the center of inquiry so that their lives become visible and their voices heard.

The National Research Council (Hayes, 1987) identified three programs that have documented reductions in pregnancy: contraceptive services, school-based clinics, and the Teen Outreach Program [TOP]. Teen Outreach had its beginnings in a St. Louis inner city school in 1978. At that time, Brenda Hostetler was the director of an adolescent parenting program. A group of girls asked her, "There are all these programs for girls
after they have a baby--why don't we start a program to keep them from getting pregnant in the first place?" Brenda Hostetler started the first Teen Outreach Program with this group of 13 girls. The girls named the program, decided the structure, and suggested topics, speakers, and activities. Teen Outreach was initiated and planned by students, and to this day its expansion across the nation is largely attributed to its student-centeredness.

Research Questions

How has a pregnancy and dropout prevention impacted participants' lives over the past 10 years? More specifically, what were the residual effects on personal choices and behaviors related to education, pregnancy, employment, and relationships?

The study sought to answer the research question from the participants' perspectives. The study was organized around three major axes: (1) participants' perceptions of long-term program impact; (2) participants' reports of past and present personal health risk behaviors; and (3) participants' oral histories which explored their thoughts and feelings about their experiences. The emphasis was on each participant's insights into her major life events and her interpretations of the ways in which the program impacted her life.

Limitations

Researcher bias was the main limitation. I, the researcher, was the TOP teacher, and I selected the study participants. My relationships with them could potentially bias my findings. Since I was their teacher and friend, I might have the tendency to see them as
more successful than they truly are. Due to our friendship, it was possible they might try to please me, or tell me what they thought I wanted to hear, or omit information that would portray them negatively.

However, potential biases were offset by the historical relationship enhancing the richness of the data. Because of our personal relationships over the past 10 years I was well acquainted with the participants, their families, and their problems. The participants were more willing to disclose intimate details of their lives to someone they knew and trusted.

Participant bias was problematic due to the retrospective nature of the study and memory recall. This study documented the participants' reports of their experiences, which were subjective interpretations that may or may not reflect any objective reality.

Several measures were taken to counter bias. The taped interviews were transcribed verbatim by a professional transcriber. I chose not to use any participants' comments about me personally. I eliminated from the analysis "glowing" and over-emotional reports. Incorporated into the study design were fail-safe methods using outside raters. Three professional peers read the participants' transcripts and identified major themes. Each colleague brought to the analysis her particular perspective. Discussing their interpretations gave me valuable insights into the meanings they perceived from the vantage point of their area of expertise.
Definitions of Terms

For the purposes of this study, the following definitions are provided:

high-risk students: those who are unlikely to graduate from high school due to one or more risk factors

dropout: a student who leaves school for any reason, except death, before graduation and does not transfer to another school

program: a set of procedures intended to be implemented as a total package and capable of replication

alternative program: offers educational experiences other than those provided by traditional schools

health risk factors: attitudes or behaviors detrimental to well-being

health risk behaviors: voluntary actions that threaten self-esteem, harm health, and increase the likelihood of illness, injury, or death

Qualitative Research Paradigm

To answer the research question regarding long-term impact of a pregnancy and dropout prevention program, I chose to use a qualitative paradigm. Qualitative research deals with complex, multiple, socially constructed realities or "qualities" (Glesne & Peshkin; 1992; Lincoln & Guba, 1985). The fundamental purpose of qualitative research is to obtain "intelligibility," that is, to perceive the meanings of individuals' viewpoints on issues (Steckler, McLeroy, Goodman, Bird, & McCormick, 1992). Qualitative research
explores the meaning of social phenomena (Rosenberg, 1988). This particular research explored the phenomena of young women's perceptions of program impact.

Under the umbrella of qualitative research are many philosophical orientations. This study was eclectic, applying multiple theories and methods: phenomenology; constructionist theory; grounded theory; case study methodology; and critical inquiry. A health education perspective was the unifying theme throughout this study.

Theoretical Framework

Critical Inquiry

Critical inquiry provided the overall theoretical framework. The primary purpose of this approach was to analyze how gender has affected the lives of these marginalized women. Critical inquiry, as it was applied in this study, examined a woman's subjective sense of herself and explored the meanings in ordinary women's everyday lives. Furthermore, the critical inquiry approach was used to show how these women have been oppressed and to tell how they have resisted and survived.

Constructionist Theory

According to Ubbes (1997), postpositivist research utilizes interpretative epistemologies, for example, phenomenology. To make the connection between constructionist theory and health education, Ubbes recommended "systems thinking." Ubbes asserted that rather than isolating a person and her health issues, the individual must
be seen in the context of larger systems. When at-risk behaviors are decontextualized we do not consider the context in which these behaviors are culturally generated and maintained. Ubbes suggested an approach that views persons with a whole perspective. Applying constructionist theory, health educators can help learners construct meaning out of their health-related behaviors.

Health Education Perspective

This research examined the Teen Outreach Program from a health education perspective, reporting students' health risk behaviors at the time of their participation in the program when they were in high school in the 1980s, as well as current health risk behaviors. Our society's conceptions of health have evolved considerably over the centuries, from concerns about sanitation, hygiene, and quarantine, to the current emphasis on fitness and wellness. Health is defined here as a state of optimal social, physical, intellectual, emotional, and spiritual well-being.

In the past, women's health has not been well defined and has focused on reproductive functions. Many aspects of women's health have been omitted. Definitions are needed that express the totality of women's health, such as van der Kwaak's,

...the entire range of issues which touch on illness, sickness, disease, wellness, well-being as well as those activities of prevention, diagnosing, healing, caring, and curing. Woman's health is her total well-being, not determined solely by biological factors and reproduction, but also by effects of work load, nutrition, [and] stress (van der Kwaak, 1991, in Koblinsky, Timyan, and Gay, 1993, p. 35).
Health education is a process in which health education professionals provide learning experiences to help individuals improve their health and quality of life. Health education involves planned, sequential, and comprehensive instruction to influence health knowledge, attitudes, and behavior. Health education gives people a knowledge base that enables them to make informed decisions. Through the educational process, individuals learn to accept responsibility for their own health. Health education at its best creates a foundation for making healthy choices for a lifetime (Ames et al., 1992). The purpose of health education is to empower people through the development of knowledge, motivation, and skills—ultimately reducing personal health risks and optimizing health.

The field of health education has several basic assumptions, for instance, that health education programs are holistic, addressing the whole person, as well as ecologic, taking into consideration the complexities of life in the 1990s. It is assumed that diseases, particularly chronic conditions, are multicausal and multifactorial, therefore prevention efforts must have multiple approaches. Health education professionals are respectful of an individual's autonomy and do not engage in victim blaming. It is believed that active, rather than passive, participation of the learners is more likely to produce lasting behavioral changes (Green & Kreuter, 1991).

Another chief assumption of the discipline of health education is that individuals have the right to make their own health decisions and to choose their personal lifestyles. The profession believes in voluntary participation of individuals in determining their own health practices (Green & Kreuter, 1991). Health education is designed to facilitate voluntary actions conducive to health; moreover, voluntary connotes of the person's free
will, with full understanding, and without coercion. Another fundamental concept regards lifestyle as an individual's personal behavior patterns related to health (Green & Kreuter, 1991).

Health Education Evaluation

Evaluation in health education involves making a judgment about whether or not learning has occurred or health behavior changes have been made. The purpose of evaluation in health education is to provide feedback so that we know that health programs are effective. Evaluation aids us in determining whether program goals and objectives have been reached. Health education evaluations serve the primary function of developing and improving quality school health education programs (Deeds, 1992).

According to Steckler, McLeroy, Goodman, Bird, and McCormick (1992), health education programs are complex phenomena requiring the utilization of multiple methods to evaluate them. Furthermore, group members' perceptions of program impact and consequences largely determine how and why programs are effective or not effective (Steckler et al., 1992).

While quantitative evaluations provide numerical data to demonstrate improvements in knowledge, skills, and attitudes, qualitative evaluations tend to be more subjective, and may include participants' thoughts, feelings, and experiences. With qualitative methods it is possible to describe outliers, idiosyncracies, or more unusual cases.
Kamen (1997) discussed the vital role of impact research in the survival of health education as a profession. Impact research is important because it has practical application and a high likelihood of leading to a solution of a problem. According to Kamen, as a profession we have a responsibility to pursue the studies that have the highest potential for impact.
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Figure 1. School Health Promotion Components and Outcomes.
Theoretical Models

Kolbe (1986) provided a model for the evaluation of comprehensive school health education [CSHE] programs. The Kolbe model identified eight main comprehensive school health education program components: (1) school health services, (2) school health education, (3) school health environment, (4) integrated school and community health promotion efforts, (5) school physical education, (6) school food service, (7) school counseling, (8) school site health promotion program for faculty and staff.

This study was concerned with Kolbe's second program component, school health education. Comprehensive school health education contains 10 nationally recognized content areas: community health, consumer health, environmental health, family life, mental and emotional health, injury prevention and safety, nutrition, personal health, prevention and control of disease, and substance use and abuse (Joint Committee on Health Education Terminology, 1990).

Kolbe's CHSE components are used to evaluate immediate, short-term, and long-term program outcomes to assess behavior change, improvement in health status, cognitive performance, and educational achievement. The vertical arrows between program components show the interdependence of program components. Other arrows show various ways in which immediate, short-term, and long-term outcomes are related to program components. In part, the Kolbe model was used to design my research instrument, the interview questions. I asked the participants questions that revealed long-term program impact, for example, questions about past and present health risk behaviors.
During the analysis stage, I looked for ways that program components were interrelated, and for specific ways that Teen Outreach Program components impacted health behaviors.

Adolescent Pregnancy: Anatomy of a Social Problem in Search of Comprehensive Solutions, a 1987 Children's Defense Fund [CDF] report, identified categories of adolescents' life experiences: education, health, work, social responsibility/awareness, and personal growth [see Appendix A]. The categories were correlated on a matrix with prevention program components: information/decision-making, supports/opportunities, assessment/guidance/referral, and desired outcomes. Outcomes were high school diplomas, basic competencies, good health, a job, community involvement, citizenship, and a strong positive self concept. These CDF categories and components also aided me in designing the interview questions, for example, I asked questions regarding educational achievement, health behaviors, work experiences, and volunteer service. The outcomes criteria was also used to analyze the data.
Figure 2. Theoretical and Methodological Approaches for Health Education Evaluation.

Figure 2 illustrates how multiple theories and methods were applied to perform a Health Education Evaluation of the Teen Outreach Program. A Health Education Perspective was used to evaluate health risk behaviors and outcomes. Theoretical Models provided the overall framework. Constructionist Theory was used to construct context and meaning of participants' experiences. This included a Qualitative Paradigm used to explore the phenomena of participants' perspectives and Phenomenology for interview methods and data interpretation. Critical Inquiry was used for social critique. Constructionist Theory and Critical Inquiry fed contextualization and social critique into the Health Education Evaluation.
Positionality

Positionality is an important aspect of qualitative research. My positionality determines who I am as a researcher and what kinds of questions I ask. A fundamental assumption is that a researcher's position affects how she identifies, addresses, and understands the issues. As for my positionality, I am a white, middle-class, 50-year-old, married woman born and raised in the Pacific Northwestern region of the United States. In many ways I represent the norm. Because I am white and middle class, I am a member of the dominant culture. Being white and middle class are part of my cultural capital. Earning an advanced degree is my intellectual capital. I have had the privilege of choosing among several professions and I have worked in the fields of public relations and education [acceptable positions for those of my race, gender, and class]. Currently, I am a counselor/instructor with the Educational Opportunities Program at Oregon State University where I work with minority students to help them reach their educational goals.

How does my positionality affect my vision as a researcher? I must constantly be aware of my tendency to see others with a white middle-class mindset. I must realize how internalized domination causes me to think that white middle class is the norm. I desire to use the power and privilege of my position to liberate the oppressed and to enact change in society.

A Priori Assertions

Prior to officially beginning the interviews I identified 18 initial assertions [see Appendix B for the list of initial assertions]. My education and experience as a health
educator predisposed me to expect certain outcomes. Throughout the study I remained ever mindful of this "conceptual baggage" which might possibly lead me to draw erroneous conclusions (Kirby and McKenna, 1989). For example, I made the assertion that those who experienced violence or were abused as children would be likely to repeat the cycle of violence and abuse. As another example, I asserted that those participants undergoing psychiatric care or therapeutic counseling would tend to be better adjusted, more functional adults than those not seeking professional help for their emotional problems.

Summary
Chapter I discussed the problem of our profession's lack of knowledge regarding participants' perceptions of long-term impact of programs designed to prevent teen pregnancy and school dropout. To answer the research question from the participants' perspectives, thereby creating an insider's view of their world, a qualitative paradigm was used. I applied several qualitative theoretical and methodological traditions, most importantly phenomenology, grounded theory, and critical inquiry. A health education perspective was also employed, making use of a theoretical model commonly used for planning and evaluating comprehensive school health education programs. My positionality as a researcher and a priori assertions were presented.
CHAPTER II: LITERATURE REVIEW

Chapter I established the need for research on long-term impact of efforts to reduce teen pregnancy and school dropout. The purpose of this study was to discover individual participants' perceptions so as to reveal lasting program effects. Chapter II reviews the relevant literature concerning school dropout and adolescent pregnancy in the United States, characteristics of high-risk students, the incidence of high-risk behaviors, and the results of related studies. This chapter explains how this study supports results of similar studies and contributes to our knowledge concerning high-risk female adolescents and the impact of a model prevention program on their lives.

Contextualization

To contextualize this study, I present a review of the literature dating back to the 1980s when these eight young women were attending high school. In qualitative research it is critical to interpret the participants' words and actions in light of the time period and cultural context in which they lived. Contextualization is the process of interpreting data within the context in which it was gathered.

Historian Elliot West (1996) told the story of what it has been like for children to grow up in 20th century America. In the last two decades, according to West, the greatest changes have occurred in the composition of the American family. The nuclear family--a husband, wife, and one to two children--is much less common. Other trends were a rising divorce rate, increased births to unmarried and teen parents, an increase in
single parent families, and increases in mothers working outside the home. The "normal" family of the 1990s is characterized by children living with one parent, or a home where both parents work and children spend more time at day care or with babysitters than with their parents. When parents cannot afford child care, older siblings often may have the responsibility of caring for younger children, or they may be "latchkey" children who must spend time all alone. At an early age, many children are forced into adult roles and responsibilities. Neil Postman has referred to this phenomena as the "disappearance of childhood" (in West, p. 261).

More young people are in the workplace than ever before. Typically they work waitressing, cashiering, and cooking at fast food restaurants, cleaning hotel rooms, or selling merchandise in department stores. To earn money to purchase things they want, one-half to two-thirds of high school students work from 15 to 20 hours each week, causing concern over how working affects school performance and SAT [Scholastic Aptitude Test] scores.

Media advertising targets the young and there is growing concern about the exploitation of the youthful consumer market, especially by the tobacco industry. Fast food places have become popular since they first appeared in the early 1960s, and with fast food consumption has come concern over the health effects of diets high in fat, calories, cholesterol, chemical additives, and preservatives.
1980s High-Risk Adolescents

School Dropout in the 1980s

A dropout, for the purposes of this study, was defined as a student who leaves school before graduation for any reason, except death, and does not transfer to another school. Natriello (1987) observed two main aspects of the dropout phenomenon: (1) patterns of dropping out among American youth, and (2) programs and policies developed to reduce the incidence of dropping out. Several longitudinal studies were conducted in the 1980s to determine patterns of dropping out. Ekstrom, Goertz, Pollack, and Rock (1986), reviewing previous research, reported that socioeconomic status [SES] and race/ethnicity were the strongest predictors of school dropout. In addition, dropout occurred more often among Hispanics than among blacks and more often among blacks than whites. Furthermore, other background factors associated with dropout included coming from a single-parent family, coming from a large family, and living in the South or a large city. Using the data base from High School and Beyond [HS&B] of the NCES, Ekstrom et al. found that the most frequently reported reasons students gave for leaving school were dislike of school and poor grades, suggesting that one-third of all dropouts left school because they failed to achieve in school and/or they felt alienated from school.

Also analyzing HS&B data, Wehlage, Rutter, Smith, Lesko, and Fernandez (1989) concluded that dropouts were not satisfied with their schooling. These students saw school as a place where they got into trouble: truancy, suspension, detention, probation. For some, working at minimum wage or caring for their children was more attractive than staying in school. About half of all female dropouts left school because of pregnancy
and/or marriage. The authors reasoned that dropping out was an act of rejection of the school as an institution. They proposed that new research examine not only the characteristics of the dropout, but also those institutional characteristics that negatively impact the marginal student.

Fine and Rosenberg (1991) argued that dropping out must be recognized not as the aberrant behavior of the "bad student," but rather as a voice which critiques the American educational and economic systems. The authors stated that the "typical dropout" is a social construction, employed to reinforce the ideology that education is the path to equal opportunity, thereby releasing schools of their responsibility. Further, prevailing ideologies portray the dropout as a "loser"—deviant, unmotivated, lazy, inadequate. However, empirical data has demonstrated that many students who leave school are intellectually above-average students who are critical of meritocratic ideology and aware of gender/race/class discrimination in school and the work force. The researchers concluded that for many adolescents dropping out is "an act of resistance" (p. 267). Rather than blaming the victim, Fine and Rosenberg suggested that we ask what social and economic factors have placed her at risk.

Social Indicators Affecting School Dropout

Many social indicators in the 1980s bore witness to the pressures placed on American youth at that time. Haberman (1988) reported that 25 percent of children lived in poverty. Twenty percent of all children lived with a single parent. Fifteen percent had parents who were teenagers themselves and 10 percent had parents who were illiterate
(Haberman, 1988). The young were adversely affected by a number of social ills: high crime rates, drug abuse, and an epidemic level of mental health problems (Comer, 1985). Since 1960, teenage drug use increased 6,000 percent, teenage homicides 200 percent, juvenile delinquency 130 percent, and teenage pregnancy more than 100 percent (Haberman, 1988). In 1965, 15 percent of adolescent girls who gave birth were unwed; in the 1980s, more than 50 percent were not married and 19 percent of all children born in America were illegitimate (London, 1987).

Poverty was shown to have a negative effect on school performance and retention. The study by Ekstrom and colleagues (1986) revealed that socioeconomic status was the strongest predictor of school dropout. Dropout rates among the economically disadvantaged were significantly higher than the national dropout rate of 25 percent. In some inner cities almost half of the students were leaving school (Kunisawa, 1988). Research revealed that dropping out of school affected a person's earning potential and the opportunity to escape poverty. Olneck (1989) calculated that a high school dropout would earn 16 to 18 percent less income over a lifetime than a high school graduate of comparable ability and socioeconomic background; in addition, graduating increased the prospect of escaping poverty by 50 percent.

The Relationship Between Teen Pregnancy and School Dropout

The relationship between teen pregnancy and dropout has been well documented. Teen pregnancy was the main reason why girls dropped out of school. Four out of five girls who became pregnant in high school dropped out (Hahn, 1987). Teens who had a
baby were more likely to drop out of school; teens who dropped out of school were more likely to become pregnant (Ascher, 1985). Teenage girls with poor academic skills were five times as likely to become mothers before the age of sixteen as those with average or above average academic skills (Children's Defense Fund, 1986). A 1986 Harris poll found that teenagers, both girls and boys, were most likely to be at risk of becoming unwed parents if they had low self-esteem and poor academic skills (Wattleton, 1987). There existed a negative relationship between teenage sexual behavior and school performance. A 1986 Louis Harris poll conducted for Planned Parenthood found that adolescents who were sexually active earned lower grades in school than sexually inactive teens (McClellan, 1987). According to the National Research Council study issued in 1987, children of teenage parents scored lower, performed less well, were more likely to drop out of school than children of older parents, and were more likely to exhibit behavioral problems (Hayes, 1987).

Reasons for School Dropout

A synthesis of research findings by Hahn (1987) reported the following reasons for leaving school: poor academic performance, suspension, attraction of work or military service, learning disabilities or emotional problems, language difficulties, pregnancy, dislike of school. Academic difficulty was a primary reason for dropping out of school; furthermore, students who did not perform well experienced school as an unpleasant place to be and therefore dropped out.
Characteristics of At-Risk Teens

At-risk teens may have shared common characteristics. A Harris poll conducted in 1987 identified these characteristics of the population at risk for teen pregnancy: coming from a home of lower socio-economic status, having below average grades or not attending school at all, being unemployed, living with only one parent, and having parents that are not college graduates (Wattleton, 1987). As possible reasons for high-risk behaviors, Ostow (1988) suggested the following predisposing adolescent developmental factors:

- immaturity, impulsiveness, susceptibility to peer influence, rebelliousness against normative values and authority
- ignorance, misinformation, and community or peer mythology, particularly with respect to contraception and reproduction
- limited current satisfactions, academic failure and boredom in malperforming schools, low self-esteem, and a pessimistic image of the future (p. 76).

Glenn (1989) identified five behaviors of high-risk youth: underachievement, pregnancy, crime, chemical dependency, and suicide. Glenn also established what he termed the "significant seven" characteristics of high-risk individuals: weak perceptions of personal capabilities, weak perceptions of personal significance, weak perceptions of personal power, weak intrapersonal skills, weak interpersonal skills, weak systemic skills, and weak judgmental skills. He also theorized that low-risk individuals displayed strong perceptions and skills.

Research Findings in Self-Esteem

Abraham Maslow (1970), in his foundational work on the hierarchy of needs,
established that basic needs for safety and security, love, and belonging must be met before the higher levels of self-esteem and self-actualization are attainable. Coopersmith (1967), who from 1959 to 1965 conducted an extensive study of the antecedents, correlates, and consequences of self-esteem, clarified the meaning of the term "self-esteem":

the evaluation which the individual makes and customarily maintains with regard to himself: it expresses an attitude of approval or disapproval, and indicates the extent to which the individual believes himself to be capable, significant, successful, and worthy. In short, self-esteem is a personal judgment of worthiness (p. 5).

Coopersmith further proposed that power, competence, and virtue form the bases of esteem.

Mecca (1990), using the results of 20,000 research studies as a data base, identified four basic ingredients of the esteeming environment: belonging, significance, effort acknowledged, and competence recognized. Clemes and Bean (1990) listed four conditions of high self-esteem: connectiveness, uniqueness, modeling, and power. Reasoner (1982) stated that self-esteem could be promoted by establishing the classroom conditions essential to the development of five characteristics: a sense of security, a sense of self-concept, a sense of belonging, a sense of purpose, and a sense of personal competence.

Other research findings have confirmed that the best way to enhance positive self-esteem is to acquire and to demonstrate competence. Holly (1987) in surveying cross-lag correlational studies, found indications that self-esteem is not a cause of academic success but an effect, that is, feelings of competence usually precede increases in self-esteem.
According to Conrath (1986), children demonstrating low self-esteem had a deep sense of personal impotency, helplessness, and lack of self-worth. In locus-of-control studies, these children were termed externalizers--those who perceive the world as outside their control and responsibility; as opposed to internalizers--those who have confidence in themselves and feel control over their own lives. Conrath established that enhancement of self-esteem may be accomplished by gaining confidence in one's abilities. He recognized that a sense of control over one's life is developed through experiencing success. He noted that nothing justifies a feeling of competence more than having actually demonstrated competence, thus his solution to problems of low self-esteem involved helping students to set meaningful and attainable goals.

Alternative Programs for At-Risk Students

The serious dropout problem resulted in the development of various alternative approaches to education from the late 1960s to the present. Keeping students in school has become a major challenge for the public education system, and as a result school districts have developed alternative programming to serve high-risk and other populations. According to the U.S. Department of Justice, an alternative program:

embraces subject matter and/or teaching methodology that is not generally offered to students in traditional school settings, which includes the student as an integral part of the planning team. The term includes the use of program methods and materials that facilitate student success and are relevant to students' needs and interests (U.S. Department of Justice, 1980, p. 11).
Young (1990) researched the background of public alternative education in America. Historically, alternative programs have stressed self-esteem and interpersonal relationships. This emphasis on affective education is a key ingredient in the effectiveness of these programs. Due to concern for the whole student, alternative programs have a long history of dealing with issues related to teens—drug and alcohol abuse, child abuse, assertiveness training, teen pregnancy, and child care (Young, 1990). Numerous options within alternative education have offered a variety of programs, including schools within schools. The creation of a school within a school was proposed by the 1989 Carnegie Report, *Turning Points: Preparing American Youth for the 21st Century*, whose Task Force on Education of Young Adolescents recommended

> . . . dividing large, impersonal schools into smaller 'communities for learning,' where stable, close, and mutually respectful relationships with adults and peers can be forged, . . . young adolescents have a great need for intimacy, yet we put them in large impersonal schools, . . . Young adolescents need increased autonomy and they need to make their own decisions (quoted in Young, 1990, pp. 125-126).

**Effective Public School Alternative Programming**

Traditionally, alternative programs accommodated the special needs of at-risk students. In two studies (1982 and 1984) describing eight alternative schools, Foley identified the ingredients of effective programs: positive student-teacher relationships, student-centered curriculum, varied roles for teachers, noncompetitive classrooms, clear mission, and small class or school size. Wehlage (1983), in a study of six alternative schools, recognized similar characteristics: smallness, program autonomy, empowerment, teacher optimism, family atmosphere, and experiential curriculum.
Young (1990) synthesized research findings and compiled this criteria for effective alternative programming: "smallness, concern for the whole student, supportive environment, sense of community, and a clear mission" (p. 46). Furthermore, Wehlage and colleagues (1989) discovered that emphasis on self-esteem, personal problems, and connecting school to the outside lives of students were prime factors of effective programs. Moreover, they found that these programs not only created a positive atmosphere, but they also required performance within a supportive environment. For alternative programs to be successful, students must be held accountable to high standards of behavior and performance.

Teen Outreach Program

Teen Outreach began in 1978 in an inner-city high school in St. Louis. Teen Outreach was a spinoff of Brenda Hostetler's adolescent parenting program. To find out the names of pregnant girls in the school, Brenda called together a group of girls who were not pregnant. That group of 13 girls wanted to start a program to help girls not to become pregnant (Brenda Hostetler, personal communication, July 5, 1997). Teen Outreach was first funded and developed as a service project of the Association of Junior Leagues of St. Louis. From its inception in the 1970s, Teen Outreach was replicated at eight sites, growing to a total of 108 sites in 39 cities. After seven years of operation by the Junior League of St. Louis, Teen Outreach became a collaborative effort of the American Association of School Administrators and the Association of Junior Leagues International in New York City. Now Teen Outreach is owned by the Cornerstone Group
and is currently operating with 3210 students at 88 sites in 36 communities nationwide, according to Linda Bell (personal communication, April 15, 1996).

Teen Outreach was a school-based dropout and pregnancy prevention program with two main goals:

1. to increase the numbers of students graduating from high school; and
2. to decrease the numbers of teen pregnancies.

To accomplish its goals, the program combined life skills training, peer group discussions, and community volunteer service. As described by the National Research Council, Teen Outreach was a life options type program seeking to boost self-esteem and increase decision-making skills (Hayes, 1987). The Teen Outreach Program Curriculum Guide (1988) included experiential lesson plans and covered the following topics: decision making, goal setting, problem solving, understanding yourself, values, life planning, communication, life pressures, family, relationships, human growth and development, parenting, and community resources. According to Jackie Faber, national director of TOP replication, these topics were the same as those in the Children's Defense Fund model [see Appendix A] (personal communication, July 5, 1997). The curriculum guide provided a general framework for the program, but no two program sites were the same due to the different needs and interests of each particular group. Differences also existed among sites because of school district requirements and the level of involvement of the local Junior League.

The effectiveness of Teen Outreach was documented by several quantitative studies. The National Research Council (Hayes, 1987) named three programs that have
documented reductions in pregnancy: contraceptive services, school-based clinics, and the Teen Outreach Program. Results of four consecutive years of data indicated that Teen Outreach reduced rates of teen pregnancy, course failure, and dropout by approximately 30 to 50 percent relative to matched comparison groups of students (Philliber & Allen, 1989). A summary of the fifth year of evaluation reported that Teen Outreach students had significantly lower rates of school dropout, suspension, course failure, arrest, sexual intercourse, and pregnancy (Allen & Philliber, 1989).

The purpose of the study by Allen and Philliber (1988) was to identify Teen Outreach 'active ingredients' -- the student, facilitator, and program characteristics related to the success of Teen Outreach at a given site. The study found that the quality of the volunteer work was highly significant related to the success of the program as rated by the students. In other words, how meaningful students found their volunteer work and the degree to which it engaged student interest appeared highly relevant to program success. The results suggested that as Teen Outreach was replicated, efforts needed to be geared towards making the classroom and volunteer experiences as meaningful and engaging to students as possible.

A study by Allen, Philliber, and Hoggson (1990) found that Teen Outreach sites which highly utilized the volunteer service component reported lower levels of student problem behaviors (school dropout, suspension, and pregnancy). The results of this study indicated that Teen Outreach sites were most successful when the volunteer component was more intensively implemented (i.e., when students worked a large number of volunteer hours). An important feature of all the volunteer work was that students
verified that it was meaningful to them. The researchers reported that the volunteer service had the potential to empower students by offering them the opportunity to be help-givers rather than only help-receivers (Bronfenbrenner, 1979; Rappaport, 1987). They explained that the "helper-therapy" principle, introduced by Riessman (1965) suggested that helping other people can be therapeutic and can lead to personal growth, particularly for persons in disempowered groups.

Philliber (1996) published a 10-year TOP summary, including 4,367 students enrolled in the program 1984-1994. These data show an 8% lower rate of course failure in school, an 18% lower rate of school suspension, a 33% lower rate of pregnancy, and a 60% lower rate of school dropout among TO students than among comparison students.

[The Teen Outreach Program specific site will be described in generic terms to protect the anonymity of the participants.]

Multi High School, Centertown, USA

The program site where I worked was the Centertown Teen Outreach Program. One of seven original replication sites, the Centertown program was a joint effort of the local Junior League and Centertown Public Schools. Centertown is a community in the Pacific Northwest with a population of 50,000 in a major agricultural area. Centertown leads the state's standard metropolitan statistical areas (SMSAs) in a number of demographic categories. It is the first in percentage of racial minorities, percentage of unemployed, and percentage of families living below the poverty level. Centertown is last
in per capita income and the percentage of high school graduates. Almost half of the students participate in the federal government's free or reduced-price lunch program and 33 percent of the students live in single-parent families. Both males and females, and African American, Native American, and Mexican American students were involved in the program. Centertown County had the highest teen pregnancy rate in the state during the 1980s.

Multi is a large mainstream public high school with a multiethnic student body of 1,600. In 1989 the State Office of Superintendent of Public Instruction identified the high school as having the highest dropout rate (54 percent) in the state. School district officials, using other methods to calculate the data, determined that the dropout rate was nine to thirteen percent.

At the Centertown site, administrators, teachers, and counselors referred students to the Teen Outreach Program. The school produced a computer-generated list of students who were failing their classes and/or had attendance problems, then counselors indicated the students they believed would benefit from the program. I contacted each prospective student by phone to set up an interview appointment. During the interview, I explained the requirements regarding attendance and participation at group meetings. In keeping with school district policy, 50 hours had to be completed to earn one credit per trimester. Earning the 50 hours was accomplished by attending two-hour group meetings after school twice a week; in addition, they participated in at least 12 hours of individual or group volunteer projects per term. Participation in the program was voluntary. Students signed a contract to indicate their agreement to fulfill the requirements.
At the first meeting of each new term the group decided the speakers and topics that interested them, typically including job interviews, career planning, self-esteem, teen pregnancy, teen parenting, birth control, abortion, date rape, birth defects, AIDS, sexually transmitted diseases, domestic violence, suicide, smoking, drugs, drugs and the law, alcoholism. Speakers also came from organizations such as Alateen, Ala-non, and the Battered Womens' Shelter.

At the beginning of the term the group brainstormed and voted on the group volunteer projects they wanted to do. Through volunteering students found they could make meaningful contributions to their community. In individual volunteer job placements, feelings of achievement came from learning to do new tasks, for example, filing or making copies in an office. Examples of group volunteer projects included playing with children at day care centers, visiting the elderly in nursing homes, raking leaves at a restored mansion museum, stacking wood at a mountain camp, the Great American Smokeout for the American Cancer Society, fundraising for the March of Dimes, planting flowers and pulling weeds on the Parkway, wrapping and distributing presents with Operation Santa Claus, serving Thanksgiving dinner at the Union Gospel Mission, putting on a Valentine's Day party at the juvenile offenders' group home, checking coats at the Red Cross Ball, and serving the Passover Meal at Temple Israel. Volunteer experiences involved students in their community and familiarized students with community resources.

From 1984 to 1989 the program at Multi High School received much recognition and many honors. The students appeared numerous times in newspaper articles and on the
local television news. In 1987 the group received the Governor's Award for Outstanding Volunteer Service by a Youth Organization. Two students and I traveled to the state capitol to attend a reception at the Governor's Mansion. The Multi site was chosen as one of the four top dropout prevention programs in the state. In a nationwide competition in 1988, Teen Outreach students wrote about how the program had affected their lives. Among over 3,000 students, a Multi student was chosen to make a speech at the annual national conference. The Multi program was featured in a television documentary that was aired nationwide on a major network.

My 1991 research was a phenomenological study of the Teen Outreach Program which identified, from the students' perspectives, the essential components of the program. I interviewed eight white female participants, asking each one an open-ended question: "What were the most important parts of Teen Outreach to you?" The essential components identified were: (1) supportive environment, (2) peer group discussions, (3) speakers and information, (4) volunteer work, and (5) positive self-esteem development. The former research focused exclusively on the program, and personal information about the participants was not included. The present research documented personal information, such as health risk behaviors, and laid the groundwork for future longitudinal research.

1990s High-Risk Adolescents

School Dropout in the 1990s.

Significant numbers of students dropping out of school continues to be a serious problem in American society. Because of irregularities in definitions of "dropout" and
various methods of calculating the figures, comparing dropout statistics among schools and geographic regions is difficult. In the 1990s, a dropout has been redefined as persons who have neither completed the 12th grade nor received a general equivalency diploma [GED]. According to the National Center for Education Statistics ([NCES], 1992) of the U.S. Department of Education, data show a clear increase in dropout rates from about 1 percent in grade 7 to about 6 percent in grades 10, 11, and 12, with a cohort group dropout rate for grades 7 through 12 of approximately 23 percent. Conflicting with NCES data, the U.S. Bureau of the Census reported that the dropout rate had decreased from 10.6 percent in 1985 to 9.2 percent in 1992.

Adolescent Sexual Activity in the 1990s

Adolescent sexual activity has greatly increased over the past three decades, and approximately 1 million teen pregnancies occur each year. Now nearly 70 percent of high school seniors engage in sexual intercourse prior to graduation (Centers for Disease Control, 1995). Trends in sexual behavior indicate that the percentage of adolescents reporting sexual intercourse is increasing, and also that the age of first intercourse is decreasing. According to the Alan Guttmacher Institute (1991), about 19 percent of unmarried women aged 15 had sexual intercourse in 1982; by 1988, the percentage had increased to 27 percent. In addition, in 1988, 75 percent of unmarried men aged 17 had been sexually active, up from 56 percent in 1982.

Increases in sexual activity since the 1970s have contributed to the incidence of sexually transmitted diseases and unintended pregnancies (CDC, 1995). Sexually active
young people who engage in unprotected sexual intercourse may experience adverse effects. Adolescents who are sexually active have high rates of STDs and HIV. One out of eight adolescents has an STD each year, and greater than 80 percent of all AIDS cases occurs among those less than 29 years of age, with about one-fifth of all persons with AIDS are in their 20s. Considering that the incubation period between HIV infection and onset of AIDS is 10 years, many 20 to 29 year-old-persons with AIDS might have been infected as teenagers (CDC, 1995). Consequences of adolescent pregnancy may negatively affect the mother's health, education, and economic status over her life span (CDC, 1995).

The National Center for Health Statistics (1993) reported that birth rates for adolescents increased from 1990 to 1991, with the rate for younger teens [15 to 17 years old] increasing more than 3 percent and the rate for older teens [18 to 19 years old] increasing almost 7 percent. Between 1986 and 1991 the birth rates increased 27 percent for younger teens and 19 percent for older teens. From 1970 to 1991 the percent of live births to unmarried women increased to 30 percent, nearly three-fold. In this same time period, the percent of live births to unmarried white women quadrupled to 22 percent (NCHS, 1993, pp. 11, 14, 15).

Adolescent Risk Behaviors

Risk behaviors are voluntary actions that threaten self-esteem, harm health, and increase the likelihood of illness, injury, and premature death (CDC, 1993). Risk behaviors usually are established during youth; persist into adulthood; are interrelated;
contribute simultaneously to poor health, education, and social outcomes; and are
preventable. The CDC identified six categories of risk behaviors in today's students:

1. Behaviors that result in unintentional and intentional illness and injury
   resulting from violence, homicide, suicide (for example, motor vehicle
   accidents, fires, drownings, domestic violence, child abuse)
2. Tobacco use
3. Alcohol and other drug use
4. Sexual behaviors that result in HIV infection, other STDs, and
   unintended pregnancy
5. Dietary patterns that contribute to disease
6. Insufficient physical activity (CDC, 1993)

Burns (1994) defined an "at-risk" person as one who faces two obstacles to
development--inner obstacles of unmet needs, and outer obstacles of environmental stress.
According to Burns, a "high-risk" person is an "at-risk" person with three added factors:
low self-image, lack of support, and lack of coping skills (1994).

A 1996 report by the National Highway Traffic Safety Administration summarized
major findings regarding youthful risk-taking behaviors. The younger the onset of the
risky behavior, the greater the likelihood that the unhealthy behaviors will continue over
time. Among some young people, sensation-seeking is high. Youth tend to engage in
risky behaviors and perceive themselves as invulnerable. Teens may disregard warnings
concerning negative consequences. Knowledge about associated risks is not always a
predictor of whether or not youth will engage in unhealthy behaviors, rather young people
are more influenced by peers and immediate social benefits and costs. Health education
sometimes utilizes a social influence strategy to curb problem behaviors. The question of
how to influence youthful behaviors in the context of these risk factors presents a major
challenge to health education professionals.
Risk and Protective Factors for Alcohol and Drug Prevention

Hawkins, Catalano, and Miller defined adolescent drug abuse as:

The frequent use of alcohol or other drugs during the teenage years or the use of alcohol or other drugs in a manner that is associated with problems and dysfunctions (1992, p. 64).

These researchers suggested that the most effective strategies for the prevention of adolescent alcohol or other drug problems are through a risk-focused approach that reduces, mitigates, or eliminates its precursors. Contextual factors are societal and cultural, including:

1. Laws and norms favorable toward behavior
2. Availability
3. Extreme economic deprivation
4. Neighborhood disorganization

Personal factors are within the individual and their interpersonal environment, and include:

5. Physiological/Genetic
6. Family alcohol and drug behavior and attitudes
7. Poor and inconsistent family management
8. Family conflict
9. Low bonding to family
10. Early and persistent problem behaviors
11. Academic failure
12. Low degree of commitment to school
13. Peer rejection in elementary grades
14. Association with drug-using peers
15. Alienation and rebelliousness
16. Attitudes favorable to drug use
17. Early onset of drug use (Hawkins et al., 1992, pp.65-85)

Hawkins and colleagues suggested that multi component intervention strategies seek to reduce multiple risk factors and enhance protective factors (1992). The effects of
risk exposures may be moderated or mediated by protective factors. The researchers recommend prevention approaches that target early risk factors:

1. Early childhood and family support programs
2. Programs for parents of children and adolescents
3. Social competence skills training
4. Academic achievement promotion
   a. alterations in classroom instructional practices
   b. tutoring
5. Organizational changes in schools
6. Youth involvement in alternative activities
7. Comprehensive risk-focused programs (Hawkins et al., 1992)

Physical Activity and Health in the 1990s

The Surgeon General's Report on Physical Activity and Health (1996) stated that 60 percent of Americans are not regularly active, and 25 percent are inactive. Physical activity declines during adolescence. Nearly half of youths 12-21 years of age are not regularly physically active, with one-fourth reporting no vigorous activity. Approximately one-fourth engage in light to moderate activity every day. About 14 percent of young people do not engage in either vigorous or light-to-moderate physical activity, and this report of inactivity is higher among females than males, and among black females than white females. Among high school students, daily physical education classes have declined from 42 percent in 1991 to 25 percent in 1995. Participation in physical activity declines dramatically as grade or age increase. Regular physical activity reduces the risk of dying from heart disease, the leading cause of death in the U.S. Physical activity reduces the risk of developing diabetes, hypertension, and colon cancer; improves mental health; fosters healthy bones, muscles, and joints; helps maintain independence in the
elderly. Physical activity also promotes quality of life by preventing and controlling injury, disease, or disability. The key finding of the Surgeon General's Report was that the health of all people—all ages, female and male—benefit from regular, moderate physical activity [such as 30 minutes of walking, gardening, or yard work]. The Surgeon General also encouraged health professionals to be good role models of healthful living.

In a study of over 900 high school girls in rural South Carolina, Bungum and Vincent (1996) found that the white females were significantly more active than the African American females. One-half of the white female students and one-third of the African American female students engaged in exercise sufficient to produce health benefits.

Related Studies of At-Risk Individuals

Longitudinal studies that follow high-risk individuals over a long period of time are relatively recent, primarily done by researchers in the fields of psychiatry, psychology, sociology (Werner & Smith, 1992). The majority of longitudinal research encompassing the life span has largely focused on males, childhood, and adolescence. Research beginning at birth or extending beyond 20 years of age is rare. Few studies have tracked high-risk individuals into adulthood to observe the long-term effects of adversity in those early formative years. Some studies are retrospective, looking back to see the effects of traumatic childhood experiences; while others are prospective, looking forward to trace individuals with certain risk factors to determine outcomes. Retrospective case studies generally document risk factors, while prospective longitudinal studies tend to report short
and long-term outcomes. Currently in the resilience literature there is a trend toward prospective studies with greater emphasis on the positive, rather than negative, factors that enable successful adjustment despite childhood adversities. Subjects may come from clinic populations or birth or community cohort. There are marked differences in researchers' definitions of terms, measurements, time periods in subjects' lives, as well as variations among ethnic groups and cultural contexts (Werner & Smith, 1992). Some research focuses on factors within the individual or in the family, while others focus on those in a broader social context (Bronfenbrenner, 1979).

The Kauia Longitudinal Study by Werner and Smith (1992) traced the long-term impact of risk factors and stressful life events in the development of Asian American children in Hawaii. This 30-year study, from 1955 to 1985, followed 505 individuals from pregnancy, birth, infancy, childhood through adulthood to determine the long-range effects of perinatal stress, chronic poverty, and discordant family environments. Of this birth cohort, one in three children was born into a high-risk environment with odds against their successful development. The researchers found that two out of three in the high-risk group developed serious learning or behavior problems by age 10, or had a history of pregnancies, delinquencies, or mental health problems by age 18. However, one out of three from the high-risk group, even though growing up in disadvantaged, adverse home situations, were able to become confident, competent, caring young adults. So the researchers identified the positive factors that enabled some of these children to be stress-resistant and to become well-adjusted adults. These factors they called protective, meaning mechanisms that buffer a person's reaction to a situation that ordinarily might
cause maladaptive outcomes. They termed these children resilient, defined as having the ability to rebound from adversities without psychological harm. The main components of the 30-year study were three interrelated life events: work, marriage, and parenthood.

The concept of the "psychologically invulnerable child" was introduced by Anthony in the 1970s to describe children who were able to achieve competence and emotional health despite adverse home life (Anthony & Cohler, 1987). Anthony studied adult children of psychotic parents and found that a significant number of the resilient individuals reported that they tended to withdraw from their parents when difficult interrelationships occurred, a finding also confirmed by Werner and Smith (1992). Anthony (1987) stated that resiliency models may offer more long-term benefits than prevention models that target vulnerability because they focus on the development of a person's creative capacity to be resilient.

Werner (1990) reported that resilient children were able to identify at least one prosocial, positive adult who unconditionally accepted them for who they are. Often this is a teacher--someone who is interested in the child and builds a close and trusting relationship. In this way, teachers become role models for students, reassuring them that they are important and worthy of someone's attention, respect, and time (Deiro, 1996). Valliant's (1981) research revealed a child's need for a "constant and crucial" attachment figure in the lives of children.

Furstenberg, Brooks-Gunn, and Morgan (1987) followed 289 Black teen mothers from the time of their first prenatal exam to 16 years after childbirth when they were about 32 years old. Furstenberg and associates found that for many their situation had greatly
improved. About 25% had moved up from poverty to the middle class; most of those working were regularly employed; and only one-fourth were on welfare. Furstenberg et al. focused on two indicators: financial independence and low fertility. Factors that determined the mothers' later success were parental education, small family size of less than four children, and not having been on welfare as a child. Parental education was also correlated with educational performance and aspiration of the daughter. The keys to financial independence were graduation from high school, restriction of further childbearing, and/or a stable marriage (Furstenberg et al., 1987).

Valliant and Valliant (1981) conducted a longitudinal study of 450 males growing up in the 1930s in the Great Depression in high crime neighborhoods in Boston. These individuals were traced from age 14 to age 47, with assessments at 25 and 41. They reported resilience and upward social mobility among many of these subjects, most of them the children of immigrants. Risk variables were poverty or growing up in a multi problem family. Valliant and Milofsky (1980) applied Erickson's model of adult development in the lives of these underprivileged men and compared these findings with similar longitudinal data collected from privileged men from Harvard (Valliant, 1977). The researchers found that the stages in midlife occurred independent of social class [poor or rich] or education [high school or college degree]. Instead, psychological maturity was associated with a child's experiences that contributed to developing trust, autonomy, and initiative.
Resiliency Model

Resiliency is one's ability to rebound during times of adversity. Research by Rutter (1985 and 1989) and Werner (1992) has resulted in developing strategies based on identifying and encouraging resilient characteristics in young people. Deiro (1994) reasoned that the resiliency model requires a paradigm shift. Rather than focusing on "what is wrong with a child," the resiliency model focuses on "what is right with a child." This strategy builds on factors that are a child's innate, positive attributes.

Werner and Smith's (1992) longitudinal data revealed that resiliency may change in every developmental stage in the life span. The researchers found that resilient subjects were independent, achievement-oriented, and expressed satisfaction with their lives. Those persons identified as resilient gave time and energy to help others. Furthermore, the subjects reported that determination and competence were their most important ways to cope with stress.

Our findings . . . suggest that a number of potent protective factors or buffers have a more generalized effect on the life course of vulnerable children than do specific risk factors on stressful life events . . . they offer us a more optimistic outlook (Werner & Smith, 1992, p. 208)

Protective factors within the family included four or less children with a space of at least two years or more between children, close and loving attention of a caretaker during the formative years of life, and structure and rules in the home. Protective factors outside the family were being well-liked by classmates, having at least one close friend, and an
informal network of neighbors and friends available for counsel and support during
difficult times. Resilient children were able to locate many outside resources.

We surmise that boys and girls exposed to adversities in early childhood
are not predestined to grow into adults with failed marriages, criminal
records or psychiatric disorders. At each developmental stage there are
opportunities for protective factors to counterbalance the negative weight
exerted by the adverse experiences (Werner & Smith, 1992, p. 171.)

Longitudinal prospective studies by Rutter (1985) have shown that among children
exposed to potent risk factors, usually less than half develop disabilities or other serious
problems. Rutter (1985) explained that resilience or stress-resistance indicates an
individual's track record of successful adjustment and the expectation of low vulnerability
to future stressors. Rutter (1985) expressed that resistance to stress is not absolute, but
relative; furthermore, an individual's resistance may depend on the individual's constitution
and environment, with the degree of resistance changing over time and circumstances.
Rutter discovered that 25 percent of children growing up in adverse home environments
did not show signs of conduct disorders if they had a good relationship with a parent, as
compared to 75 percent who did not have a good relationship and developed conduct
disorders. Rutter (1989) stated that protective factors are catalytic and may reduce the
impact of the risk factor or inhibit the negative chain reactions often associated with the
risk situation. Possibly, protective factors may lead to new opportunities and may increase
self-esteem and efficacy (Rutter, 1989).

Efforts to engender resilient traits may be required throughout childhood. If a
child bonds to a primary teacher, resiliency may not necessarily be sustained during her
youth. Rutter views resilience and vulnerability as opposite poles of a continuum. Rutter has cautioned that resilience must not be viewed as a permanent attribute. Those people who successfully deal with problems at one point in time may not respond so well when circumstances change. Rutter gave the essential components of resilience: effective planning, positive self-esteem, self-efficacy, and response to key turning points in life.

Garmezy (1985, 1986, 1987) studied resilient children growing up in homes with a mentally ill parent. He identified many of the same protective factors that Werner and Smith (1992) found. Garmezy concluded that the timing of life events was more important in determining if the outcome would be beneficial or not. Garmezy found that the "street-smart" children "worked well, played well, loved well, and hoped well" in spite of the obstacles they faced (p. 513).

To summarize major research findings of Anthony and Cohler, Werner and Smith, Rutter, and Garmezy, many of the children who grew up in disadvantaged situations were able to successfully overcome adversity, even with the odds stacked against them. These children possessed or developed the resources to rebound back. For example, Werner and Smith (1992) found that a stressful environment with many risk factors does not inevitably lead to "poor adaptation." As long as there is a balance between stressful life events and protective factors, successful adaptation is possible. A majority of the highest risk children developed into competent, caring, and confident adults.

Advocates of the resiliency perspective have generated a list of common personality traits or coping skills found in resilient children, such as a sense of humor, confidence, compassion, flexibility, social competence, and problem-solving skills. These
qualities have been shown to help children overcome adversity. Prevention strategies must be developed to cultivate resiliency traits and skills in all children.

Wellness Theory

A wellness theory was developed by Mills, Dunham, and Alpert (1988), who theorized that bonding with prosocial adults promotes resiliency and wellness in a child. This wellness theory was based on the assumption that persons are born with an innate desire to learn, the ability to develop common sense, and the internal motivation to do well. The wellness theory maintains that negative experiences inhibit these innate drives and create negative beliefs about themselves and life. A negative belief system may lead to decreased self-esteem. Over a three year period, Mills (1991) applied the wellness theory to a school-based prevention program with trained teachers. The study revealed that there was a 47 percent reduction in school failure, a 75 percent reduction in discipline referrals, and an 80 percent reduction in teen pregnancy (Mills, 1991). Benard (1991) explained that family protective factors are: caring and support, high expectations, and opportunities for participation. Werner and Smith found that:

There are some lessons these young people can teach us about the need for setting priorities, about critical time periods for prevention and intervention, and about the need for a continuum of care and caring (Werner & Smith, 1992, p. 207).
Caring in Schools

Some educational theorists propose that schools should be places which nurture the emotional needs of students, and they advocate teachers taking an active role in caring for students (Deiro, 1996; Noddings, 1992; Sergiovanni, 1993). At every stage of life people have basic needs to be cared for and to care. We all need to be received, respected, and understood. When students' social and emotional needs are met, academic success is more likely (Deiro, 1996). According to Noddings' theory of moral education, an ethic of caring has four main components: "modeling, dialogue, practice, and confirmation" (Noddings, 1992, p. 22). Noddings argued that students' success in school depends as much on caring for students as it does in promoting academic achievement. Noddings maintained that when schools concentrate on what matters in life--the emotional and social need for caring--then academic success will occur naturally. Noddings stated:

It is obvious that children will work harder and do things--even odd things like adding fractions--for people they love and trust (Noddings, 1988, p. 10).

Noddings recommended that caring be a main topic in education. Noddings also suggested students learning to care through involvement in community volunteer service. For some children, teachers are more important than parents. Teachers must help students "learn how to be recipients of care" (p. 108). The teacher-student relationship is characterized by reciprocity. "There is nothing mushy about caring" stated Noddings (p. 175). Evaluation of caring can be done by looking for the signs that are evident in a healthy family--happy, healthy children; cooperative and considerate behavior; competence; willingness to share,...and a growing ability to sustain intimate relationships.
Deiro (1994; 1996) conducted a qualitative study of mentoring teachers to determine ways to form healthy bonds with students. Deiro observed these strategies:

1. Creating one-to-one time with students
2. Using appropriate self-disclosure
3. Having high expectations of students while conveying a belief in their capabilities
4. Networking with parents, family members, friends, and neighbors of students
5. Building a sense of community among students

Summary

Chapter II presented a review of the literature concerning high-risk adolescents. Research concerning alternative approaches to dropout prevention revealed that effective programs are comprised of similar essential ingredients: smallness, concern for the whole student, supportive environment, sense of community, and a clear mission. Further, it was found that enhancement of self-esteem through competence and empowerment were crucial elements of program effectiveness. The most distinguishing feature of the Teen Outreach Program was student volunteer service. The researchers found that a program's capability to reach its two main goals to retain students and prevent pregnancy was highly correlated to intensive implementation of the volunteer component. Recent research has shown that in order for prevention programs to be effective, both multiple risk factors and multiple protective factors must be addressed.
CHAPTER III: METHODOLOGY

Chapter I established the need for research on long-term impact of programs designed to prevent adolescent pregnancy and school dropout. Chapter II reviewed the relevant literature regarding characteristics of high-risk adolescents, the incidence of high-risk behaviors, as well as results of related studies. Chapter III explains the research strategy for exploring lasting program effects on participants' lives. To begin, I state the research questions, then I give an overview of the research design and its theoretical bases. I describe the process for selecting the research participants. Next, I outline the data collection methods. Then I explain my system for gathering, organizing, and analyzing the data. Finally, Chapter III discusses issues of reliability, validity, bias, generalization, and protection of participants.

Research Questions

Research Question 1: How have young women's experiences in an adolescent pregnancy and dropout prevention program impacted their lives?

Research Question 2: More specifically, were there any lasting influences on personal choices and behaviors regarding pregnancy, education, employment, and relationships?

The primary focus was on participants' perceptions of program effects and their interpretations of significant events in their lives. This research asked: Did the program
figure in any way--positively or negatively--as the participants struggled in making major decisions, overcoming obstacles, or surviving difficult circumstances?

The terminology used in qualitative research varies from researcher to researcher, therefore I give the reader the terms and working definitions that I use. Data refers to transcribed interviews, field notes, and observations. Participants are the persons who participated in this study. Transcript/transcriptions are transcribed data. The narrative refers to this paper, my "story-line," in which you will hear my voice. Participants' voices are direct quotations of their thoughts and feelings. Memos are written records of analysis or abstract thoughts related to forming theory, and diagrams are graphic representations or visual images of relationships among concepts (Strauss & Corbin, 1990).

Qualitative Methodology

To explore answers to these research questions, qualitative methodology, also known as exploratory or interpretive research, was the most appropriate means. The primary goal of this research was to discover the meanings these particular women attribute to their involvement in a pregnancy and dropout prevention program. This research sought to generate suppositions and hypotheses; therefore, exploratory methods were prescribed. To study social phenomena, the qualitative paradigm uses such research methods as interviews, observations, life histories, case studies, participation in activities, and/or analyzing documents (Steckler, et al. 1992). Qualitative designs usually focus on in-depth, long-term interactions of relevant persons in one or many sites (Glesne &
Critical Inquiry

This study also applied critical inquiry to examine significant events in the lives of eight female, former high-risk students. Critical inquiry is particularly concerned with the needs and experiences of people who are oppressed, in this case young women, and seeks to create understanding of their perspective of the world. The contribution of this approach was to place the young women and their viewpoints at the center of research and to critique the influence of gender in their lives. Sexism is the discrimination against and mistreatment of women on the basis of gender. Racism is prejudice against and mistreatment of people on the basis of skin color. Classism is prejudice against and mistreatment of people on the basis of social class. Critical inquiry critiques how the established societal institutions--economic, educational, political, legal, medical, religious--operate to oppress some groups of people to maintain the status quo. Critical inquiry also seeks to discover the ways that the oppressed resist and survive oppression.

Phenomenology

Phenomenology guided this research process. Phenomenology is the philosophical framework that seeks to illuminate the meanings people have on certain issues and to discover how they make sense out of their lives. Berger and Luckman (1966), in The Social Construction of Reality, theorized that the meanings people have about the realities
of their lives are socially constructed. The phenomenological approach emphasizes that our knowledge of objective facts in the real world is conditioned by the social matrix in which it is learned (Glaser & Strauss, 1967). From the phenomenological vantage point, the main goal is to understand and interpret how people use language to construct, or make meaning out of, the world of their social setting (Glesne & Peshkin, 1992). This research utilized phenomenological methodology to explore the phenomena of young women's responses to their experiences. Phenomenology is a philosophical orientation (Strauss & Corbin, 1990). According to Max van Manen (1990, p. 11), "Phenomenological research is the human scientific study of phenomena." Therefore phenomenological inquiry asks what it is like to have a certain experience (van Manen, 1977). Phenomenological research studies a situation rather than a set of preselected variables (Barritt, Bleeker, Beekman, & Mulderij, 1985). Phenomenological approaches do not test hypotheses (van Manen, 1977), nor do they attempt prediction or generalizability (Barritt et al., 1985). Neither does this perspective problem-solve; rather, it asks questions about the meaning and significance of particular phenomena (van Manen, 1990). Phenomenological description aims to elucidate the meaning of lived experience, is validated by lived experience, and validates lived experience (van Manen, 1990). Phenomenology is a way of ordering thoughts that lends itself to such information gathering methods as interviews, oral histories, observations, and reflexivity.

Phenomenological interview methodology involves engaging in purposeful dialogue. What this means is that I, the researcher, talked to women through dialogue. This dialogue involved asking pre-determined questions and listening to the subjective
interpretations and meanings that these young women ascribed to their experiences (Lee, 1996). Thus, long, in-depth interviews were the most appropriate way to explore the meanings of the participants' experiences.

There were several advantages to a semistructured, free-flowing interview style which used open-ended questions. First, it helped to put the participants at ease because, in general, these individuals feel more comfortable speaking, as compared to reading or writing. Secondly, by not confining thinking to a prestructured format, the participants were free to follow directions of personal interest, allowing for creativity and expansion. Thirdly, the face-to-face interview enabled me to ask the participant for immediate clarification or elaboration. Also, I was able to observe emotional responses and body language, which better helped me to interpret the meanings beneath the words they shared with me.

Grounded Theory

This qualitative study also utilized "grounded theory," as conceptualized by Glaser and Strauss (1967). In this theoretical orientation, rather than data following theory, theory follows data. Consequently, theory is grounded in the circumstances of everyday life (Glaser & Strauss, 1967). Grounded theory uses inductive rather than deductive reasoning. Bogdan and Bilkin (1992) explained that in grounded theory the data is analyzed inductively as theory emerges from the bottom up as many pieces of evidence interconnect and converge.
Lather (1991) emphasized the necessity of a reciprocal relationship between data and theory. Beginning with a priori theory, new theory grows from contextual data in a manner that prevents the researcher's predispositions from distorting the logic of the data, thereby reducing the likelihood of theoretical imposition, i.e., the researcher imposing her own personal definitions on the researched (Lather, 1991).

Research Design

Qualitative methodology provided the overall design for the study. To obtain data, I primarily used three traditional qualitative research methods: multicase studies, in-depth interviews, and field note observations and reflections.

Multiple Case Studies

Multiple case research refers to studies that include two or more subjects, settings, or data sets in order to find commonalities and/or differences, which allows the researcher to make comparisons and contrasts among the cases (Bogdan & Bilken, 1992; Yin, 1994). The data were analyzed from two distinct perspectives: within-case and cross-case. Gaining understanding of each participant required a within-case analysis. This analysis helped me discover patterns and characteristics in each individual case. Then, each case required a cross-case analysis to discover both unique and common characteristics. In the next stage, I analyzed data of all participants, comparing them to one another. Finally, I looked for differences and similarities in their perceptions of program impact (Deiro, 1994).
Pilot Study

In order to field test my interview questions, I conducted a pilot study. I contacted three women who had been actively involved in the program. All three agreed to be interviewed. After conducting the interviews and performing a rudimentary analysis, I modified the questions. I did not use the data collected from these three women because I interviewed the same eight participants in my 1991 study.

Participant Selection

Purposive participant selection and sample size were influenced by qualitative methodology. The study included eight white females, ages 21 to 27, who had attended the model program sometime between 1984 and 1989. Principle criteria for selection were participation in the program, availability, and willingness to be interviewed. Participants who were selected were actively involved in the program for at least one year; in addition, individuals were chosen who would best be able to articulate their experiences.

Since this research was a continuation of my previous 1991 study, I interviewed the same eight participants.

To obtain a broader base within this group, some participants were selected who had completed their high school education and some who had not, some who had been pregnant and some who had not, ones who had been self-supporting and ones who had not. I chose participants from different years in the program and from different social classes--upper middle class, middle class, working class, and welfare. Each participant defined her social class based on family income at the time she was in high school as well
as their current income level. As self-identified by the participants, one was
upper middle class, two were middle class, five were working class, and none of the young
women was on welfare at the time of the study.

Participant Profiles

Each profile contains pertinent information about the participants, including social
class, reasons for failing grades and/or referral to Teen Outreach, education, employment,
health risk behaviors, pregnancy, relationships, use of community resources, and future
goals and dreams, as reported to me during long, extensive interviews.

Amy is from a working-class family and most of her life she has lived in an
alcoholic, violent home environment. Amy was sexually abused by one of mother's
alcoholic boyfriends. Amy did not perform well academically due to moving around and
attending many different schools. Often she stayed up late at night, slept in, and was tardy
to school. Her low grades were due to low attendance. Amy left school after her junior
year, but returned one year later to graduate. Amy joined the Navy, but was discharged
for health reasons. She attended one term at the community college.

After high school Amy worked at fast food places. Currently, she provides child
care for six nieces and nephews. In high school, her diet was poor and is inadequate
today. She does not exercise sufficiently. Amy has chronic bronchitis that is worsened by
living with people who smoke. She has made four suicide/self-mutilation attempts. She
has never been pregnant. The only community resource she has ever used was a toll-free
crisis line number. To cope with stress, Amy collects Barbie dolls [she has 400] and
writes stories. Amy's dream is to be a published author and Pulitzer Prize winner.

Beth was born into a working-class family. Beth's failing grades were due to her
involvement in a negative peer group. Beth's friends pressured her to skip school, start
smoking, and use alcohol and drugs excessively. Her boyfriend became increasingly
violent toward her. At a turning point, Beth decided to leave that abusive relationship,
change friends, and do well in school. Beth graduated from high school on time and she is
the only one with a college degree (double major in sociology and Spanish, minor in
nutrition). As a teenager, Beth's diet and exercise were inadequate. Now her diet is
adequate, but her exercise is insufficient. Today, Beth does not smoke and she uses
alcohol in moderation. Diabetes during her pregnancy has been her only significant health problem.

In high school she worked as a waitress. After high school, she gained work experience as a WIC certifier and a bank teller. Following graduation from college, Beth started working as an insurance adjustor. Beth and Juan lived together and when Beth became pregnant they married. They have been married six years. Beth became pregnant at 19, and had her first child when she was 20. A second child was born when she was 23. Among the community resources she has used were the health department. Her major goals are to earn a master's degree in sociology and to provide a stable home for her children.

Diane was raised middle class. Her parents divorced when she was 12, and both of them remarried. She failed courses because she thought school was boring. She skipped classes, didn't do the homework, and graduated with a D average. She briefly attended a Christian school and a Bible college and was expelled from both for violating rules.

In high school she worked as a hostess in a restaurant. Later she moved to Canada where she worked as a receptionist for a radio station. All her life Diane has had asthma and allergies. As a teen, her diet and exercise were inadequate and continue to be inadequate today. Other than going to the hospital to deliver her baby, Diane has not used any community resources. She married in 1995, became pregnant in 1996, and is now fulfilling her dream to be a full-time, stay-at-home wife and mother in a traditional middle-class family.

Jane came from a working-class family and today she remains in the working class. Her reason for failing grades were family problems--alcoholism, drug addiction, and violence. She graduated on time with her class and she has attended classes at the community college.

After high school she worked in retail at a department store, a bookstore, and a computer software store. Jane also worked as an activity assistant at the same convalescent home where Teen Outreach participants volunteered. Most recently, she has a job as house manager at a drug and alcohol treatment center.

When she was a teenager, Jane had all six health risk behaviors. She was sexually active and did not always protect against pregnancy and STDs. She smoked and used drugs and alcohol. She also had a poor diet and insufficient exercise. She still uses alcohol occasionally and continues to have a poor diet and insufficient exercise. Jane has had three serious monogamous, heterosexual relationships and has been sexually responsible in protecting against pregnancy and STDs. Currently, she is not involved in a relationship and she is living alone.
Kathy's family background was middle class. Now her income makes her working class. Kathy's failing grades were because of negative peer pressure. Kathy became pregnant at 16, left school, and later earned a GED. She has attended six terms at a community college. In high school, Kathy earned money babysitting. After high school, she worked at a bookstore. Currently, she manages a retail photo lab.

When she was a teenager Kathy had all six health risk behaviors. She used drugs and alcohol. She had unprotected sex with multiple partners. During her pregnancy she was ill. She was hospitalized once for attempted suicide. Kathy has had four pregnancies: one miscarriage, two abortions, and one live birth, a son. Kathy uses alcohol and tobacco occasionally. Her exercise is insufficient, but her diet is adequate.

As a teen parent, Kathy used the most community resources of all the participants. For example, Planned Parenthood, Crisis Pregnancy Center, welfare, food stamps, and medical vouchers. Teen Outreach gave her information about accessing community resources. Kathy's dream is to own her own business and have a husband, a home, and a family.

Mary was raised in a working-class home by an alcoholic mother. As a child, she was sexually abused by her mother's second husband. In high school, Mary had a reputation as a fighter and she assaulted a teacher. She failed courses because of problems in her unpredictable, alcoholic home environment. Mary graduated on time with her class. While in high school, Mary worked distributing Avon products, doing food demonstrations in a grocery store, and selling merchandise at a department store. In more recent years, she sold radio and TV advertising. As a teen, her diet was poor and her exercise was insufficient. She used tobacco, and she abused alcohol and other drugs. She was sexually active, had multiple partners, and she did not consistently use pregnancy or STD protection. Mary had cervical cancer that required 30 surgical procedures over a 10 year period. Doctors told Mary that she would never be able to have children.

Mary eventually stopped smoking and abusing alcohol and other drugs. Some walking is her only form of exercise. Her greatest health problems, other than cancer, have been related to complications with pregnancy. She has been pregnant four times. The first was a tubal pregnancy, and she has given birth to three daughters, including twins. Mary married a man from a middle-class family and now has achieved her dream--to have a "normal" family and own her home. Most recently, Mary has a part-time evening job as a community educator for a lobbying organization. Their combined incomes make them middle class.

Renee is an incest survivor. Renee comes from an upper-middle-class background. Both of her parents are college educated and both have professional positions. Today, Renee is in the working class, though there have been times when she had to use welfare
assistance and at one time she was homeless. She has been married and divorced twice, both times to working-class men. Her current boyfriend is also working class. Renee was referred to the program because she was "getting in trouble" at school--skipping class, smoking, fighting, using bad language, abusing alcohol and drugs, and running away. She was involved with a negative peer group that pressured her to use alcohol and drugs excessively.

Renee graduated on time with her class, and she has attended approximately two years at a community college. In high school, Renee worked as a busgirl, waitress, and a maid at a motel. Following high school, she worked as a cashier at a fast food restaurant. Renee and her husband lived in Germany where he was stationed in the Army. In Germany she had a job designing buttons. Currently, she is working three jobs-- waitressing, delivering newspapers, and cleaning houses--to earn the money to return to college.

As a young person, Renee had all six of the health risk behaviors. She smoked, abused alcohol and drugs, had a poor diet, did not exercise sufficiently, and she engaged in unprotected sex with multiple partners. All her life she has had allergies and asthma. Now she has chronic bronchitis which is worsened by smoking. Today, Renee is the only participant who continues to have all six health risk behaviors. Renee has been pregnant twice, resulting in one abortion and the birth of a son. Her dream is to earn a degree in Spanish and work as a translator for the United Nations.

Sandy is also a survivor of incest. Sandy was born into a working-class family. Sandy's school failure was due to family problems after she reported her father for sexually abusing her. Her entire family disowned her. At 16 she was living on her own, and at that time she left school. As a teen, Sandy had five of the health risk behaviors: alcohol and drug abuse, tobacco use, inadequate diet, risky sex with multiple partners, and four suicide attempts. She reported receiving sufficient exercise in sports and p.e. classes. Today, Sandy continues to smoke. Occasionally she uses alcohol. She does not exercise sufficiently and her diet is poor. Sandy has been in a stable monogamous marriage for six years. Sandy has never been pregnant because she is unable to conceive.

Sandy has had numerous jobs cashiering at minimarts, picking fruit, packing fruit, and doing construction work. At one time she worked as an escort. Currently, she is undergoing treatment for a job-related injury. When she was packing champagne bottles in a winery, one of the bottles exploded, injuring her in the shoulder. The state is providing job retraining for her at the community college to become a legal secretary. Part of her retraining program required her to earn a GED, and she has completed one-half of the exam. Sandy's dream is that someday her father will admit what he did to her.
Data Handling

This section describes the various techniques used in the collection and organization of the data for the study. Lofland and Lofland (1995) describe the qualitative research process of gathering, focusing, and analyzing data. In the gathering or empirical input stage, the researcher collects data by numerous means, primarily interviews, observations, and documents. In the focusing or social science input stage, the researcher asks scientific questions about the data. In the analysis or social science output stage, the researcher presents an analysis of the data. Lofland and Lofland emphasize that the tasks of gathering, focusing, and analyzing may go on simultaneously, overlapping, and interweaving. The researcher is a witness: looking, listening, asking (Lofland & Lofland, 1995). The researcher is the instrument (Eisner, 1991).

Data Collection

Long, extensive interviews were the main source of data collection. These in-person interviews began in March of 1996 and were continued through August of 1996. Two to eight hour face-to-face interviews were conducted with each participant at the location of her choice. They were interviewed in their homes, or their parents' homes, or in a school district conference room.

Before each interview, the consent form [Appendix C] was given to the participant to complete. The consent form includes an explanation of the study, assurance of confidentiality, the name and number of a contact person at the university to answer any questions regarding the research, and the opportunity to withdraw from the study at any
time. After all questions regarding the consent form were answered, the participant and I signed two copies of the form. I gave one form to the participant to keep and I kept the other form. Next, the participant filled out the personal data form [Appendix D]. This form provided information regarding birth date, address, phone number, high school graduation, and year(s) participating in the program. The form also included the name, address and phone number of a friend or relative who would be able to help locate the participant in the future. All forms, tapes, computer disks, and transcriptions were secured in a locked, fireproof file cabinet.

I chatted with each person prior to officially beginning the interview questions. Sometimes, as we chatted, topics covered in the interview questions arose, so we began the interview with one of those topics, such as parenting or work. The interview questions were developed using categories established in Adolescent Pregnancy: Anatomy of a Social Problem in Search of Comprehensive Solutions, a 1987 Children's Defense Fund report [see Appendix A]. The categories were: education, health, work, social responsibility/awareness, and personal growth. These categories were correlated by way of a matrix with prevention program components: information/decision-making, assessment/guidance/referral, supports/opportunities, and desired outcomes.

**Interview Process.**

The interview was conducted with each participant using a copy of the interview coversheet [Appendix E]. I stated the purpose of the study and explained the format for the interview. The interview schedule included 15 minute breaks every one to two hours.
Interviews lasted approximately two to eight hours. The longest interview [about eight hours of taping] occurred when I spent a week with Mary in Indiana.

To probe certain aspects of the participants' experiences, a series of categorized orienting questions were used. Categories included education, work, relationships, race, class, gender issues, parenting, personal growth, and past and present health risk behaviors. Lastly, I asked specific questions about participants' perceptions of program impact. In each interview every interviewee was asked the same questions. However, depending on the flow of the conversation questions were sometimes asked in different sequences. Follow-up questions were asked to clarify responses. In some situations when face-to-face interviews were incomplete, or when it was necessary to ask further questions of all participants, telephone interviews were conducted to obtain additional data.

Other Data Sources

Other sources of data were field note observations and reflections, as well as other pertinent documents--TOP newsletters and the Teen Outreach Curriculum Guide (1988). These sources were used to glean additional information about the program.

In addition, I conducted at least three follow-up interviews by telephone with each person. Information collected by phone was dated and added to the participant's transcript. I communicated with each one by mail from two to five times. After the initial face-to-face interview, I sent each participant a thank you note. Then I mailed a letter offering each one a copy of her transcript, along with an offer of $10 plus postage to anyone willing to make corrections and additions, and return the transcript to me. Three
participants responded to my offer, and after they returned the transcript I sent each a check for $10 along with another thank you note. All additions and corrections were added to each individual's transcript.

To receive feedback after I had analyzed the data, I mailed a condensed version of my findings to two participants. Later I contacted them by phone to obtain their impressions. I also shared the major research findings with three professional peers who offered their insights. I especially benefitted from sharing the data with a woman, a sociologist, children's advocate, and Teen Outreach board member who was closely involved with the Teen Outreach Program at the Centertown site. As each participant's transcription was made, I sent a copy to her, then we discussed them by mail and over the phone. She spent eight to ten hours reading the transcripts. Her contribution was valuable because she gave me her viewpoint as a sociologist.

Procedures

The eight interviews were tape recorded, and these tapes were transcribed verbatim by a professional transcriber. The eight transcriptions were the primary data for the analysis in Chapter IV. In qualitative research it is common procedure to analyze the data as it is collected (Glesne & Peshkin, 1992; Strauss & Corbin, 1990; Miles & Huberman, 1984). This allowed me to adjust the study as I proceeded. Data analysis was guided by my two research questions. I utilized an inductive reasoning process described as "making sense of the field data" (Lincoln & Guba, 1985, p.202). I read and reread the data, coding and recoding as insights emerged. I referred to my initial assertions to
generate questions. I told the stories to my friends, asking for their interpretations of what I told them.

I chose to do the process of categorization by hand. Strauss and Corbin (1990) give step-by-step instructions for analyzing qualitative data. Codification is the process of coding data. Coding involves specific operations in which raw data is broken down, conceptualized, and put together again in creative ways. Open coding is the elementary first step when the researcher assigns conceptual labels to phenomena, i.e., the researcher names the main ideas or events. Categorizing is the process of grouping concepts. A category has characteristics and dimensions [locations on a continuum] (Strauss & Corbin, 1990).

I began analyzing the first transcript with a line-by-line analysis. I identified the major idea of the sentence or paragraph and gave it a label, for example, self-esteem. I wrote the labels directly on each page in the margins, and I proceeded in this manner all through the entire transcript. When I analyzed the second transcript, I identified similarities and differences between the first and second transcript. A similar analysis was applied to observations and field notes. I took the categories from the labels and wrote them up as memos.

In the second step, axial coding was performed involving procedures that put data back together in new ways. Connections were made between categories by applying a coding paradigm in a relational form. In axial coding, a category is a specific phenomenon, with conditions, a context, action/interaction strategies, and consequences. In grounded theory, categories and subcategories are linked in a set of relationships.
THE PARADIGM MODEL

(A) CAUSAL CONDITIONS ➔ (B) PHENOMENON ➔

(C) CONTEXT ➔ (D) INTERVENING CONDITIONS ➔

(E) ACTION/INTERACTION STRATEGIES ➔

(F) CONSEQUENCES.


Figure 3: The Paradigm Model.

The Paradigm Model illustrated above enables systematic thinking about the data. Here coding is more focused and concerned with discovery of relationships in the paradigm model. "The discovery of similarities and differences among and within categories is the heart of grounded theory" (Strauss & Corbin, 1990, p. 111). The researcher is constantly moving between inductive and deductive thinking, constantly proposing, checking, and verifying.

The third step in coding is the systematic process of selecting the central phenomenon, or core category, and relating it to other categories. The "story line" is the narrative in which the researcher describes the research. Strauss and Corbin (1990) gave these five steps in creating grounded theory:

1. explicating the story line
2. relating subsidiary categories around the core category by means of The Paradigm Model
3. relating categories at the dimensional level
4. validating those relationships against data
5. filling in categories that need further development (pp. 117-125)
In reality, the researcher moves back and forth among the five steps. The term process explains why action/interaction routines break down, why problems occur in the course of life events, and why, when looking back at life, one sees growth, development, or movement or, at the other extreme, the failure of growth, a sliding backwards, stagnation, and a failure to change. In order to analyze process, the researcher must show the evolution of events by capturing how and why action and interaction will change, stay the same, or regress; why there is progression of events; or, what allows continuity of action/interaction when facing changing conditions and with what consequences.

In theoretical sampling, I studied the participants' transcripts to see when a phenomena was repeatedly present or noticeably absent. I wrote memos and created figures to show relationships among concepts.

When the categorization was complete, the data was arranged in a logical and meaningful manner. After the complete analysis of the data, I summarized the findings and drew conclusions. Then I reread the review of the literature in Chapter II to determine how the new data and findings confirmed and/or added to the existing body of knowledge.

Reliability

Reliability refers to the consistency or repeatability of the study. In qualitative studies the researcher is the primary instrument, therefore it would be difficult for another researcher to repeat the study exactly since no two persons are the same. To ensure a degree of consistency in data gathering, a copy of the interview coversheet was used with each participant. However, the subject had the freedom to offer additional information or
to pursue topics of personal interest. So while the questions remained constant, it was impossible, even undesirable, to predetermine an interviewee's responses or the direction of the interview.

McLaughlin (1986) stated that a finding which can also be found by another researcher is likely a dependable one. For this reason, I asked three professional peers to read the transcripts, identify themes, and codify the data to produce confirmation or denial. Each read through the transcripts and conducted a line-by-line analysis. We discussed our findings until we reached consensus. We agreed on the coding scheme I had developed. I was also able to incorporate their insights into the major findings.

Validity

Validity, in qualitative research, as explained by Acker, Barry, and Esseveld (1983), is about truthfulness. In other words, how do we know what we say is true? According to Lather (1991), the best way to obtain validity is to construct research designs that include deeper reflection and rigorous self-reflexivity. Validity in qualitative research can be assessed utilizing specific techniques: reflexivity, "member checks," and triangulation (Lincoln and Guba, 1985). Reflexivity refers to the researcher's subjective reflections on the data, usually recorded as field notes in a notebook. "Member checks" simply entail reprocessing descriptions and analyses through the participants in order to receive their feedback and to monitor for validity. Triangulation is used to establish data credibility and trustworthiness, involving the use of multiple data sources, methods, and
theories (Yin, 1994; Lather, 1986). To achieve validity, I incorporated multiple sources, multiple theories, and multiple methods of data collection into the study design.

To do member checks during the analysis process, each participant was offered a copy of her interview transcription. By telephone I talked over my findings with the participants to receive feedback and validation. In addition, to ensure quality control and to safeguard against researcher bias, I discussed the analysis and findings with three colleagues as discussed above. I taught these colleagues how to code the data, and then I compared my coding with theirs. Basically we were in agreement.

The reader is cautioned to interpret these findings in light of the fact that they are based on self-report data, e.g., participants may underreport drug use. Consequently, in interpreting these findings, the validity of self-report data must be taken into account. Findings must be considered exploratory, not confirmatory.

**Generalization**

These findings are specific to the individuals in the study and may not be generalizable to the whole population. Qualitative research tends to be more about uniqueness than generalization. Rather than generalization, there may be transferability from one context to another context, from this situation to a similar situation (Lincoln & Guba, 1985). The only legitimate generalization is based on "the vicarious experience of the reader" (Lincoln & Guba, 1985, p. 65).
Protection of Participants

The main risks for the participant involved disclosure of personal information. Confidentiality was assured through the use of pseudonyms and assigned participant identification numbers. A "link file" was used to associate participants' names with their identification numbers, and with all tapes, transcriptions, and other documents. The link file was kept in a locked location separate from the informed consent documents. When the research was completed the link file was destroyed. To further maintain anonymity, the specific program site was not named.

Summary

Chapter III presented the research strategy. The qualitative research process was influenced by phenomenological methodology. The sample size was intentionally small in order to produce depth as opposed to breadth. The primary sources of data collection were the long interviews with the participants. The extensive interviews were transcribed; these transcriptions formed the main data for analysis. The Paradigm Model by Strauss and Corbin (1990) was used to analyze the data. Reliability, validity, generalization, and measures taken to protect each participants' identity were described.
CHAPTER IV: PRESENTATION AND ANALYSIS OF THE DATA

Our need to gain more complete knowledge of high-risk students and to assess the long-term impact of prevention programs was established in previous chapters. This qualitative multiple-case study offers an in-depth understanding of eight young women who participated in a dropout and pregnancy prevention program in the 1980s, and now examines significant life events--education, pregnancy, employment and relationships--potentially related to long-term program impact. Now Chapter IV presents the analysis of the data and major research findings. First, I restate the overarching research question, explain the process I used, and then answer the question with relevant data, using matrices to organize and display the data. The same process was used to answer the second research question with its subset questions regarding education, pregnancy, employment, and relationships. I, as the research instrument, interpreted their words to answer the questions. The analysis was restricted to impact directly associated with the program. The participants' own words about their experiences are showcased here. Health risk behaviors, both past and present, are recorded. This chapter contains participants' responses to specific interview questions which provided the data on which findings are based. Finally, Chapter IV draws conclusions about lasting program impact.
Research Question 1

Research Question 1: How has a pregnancy and dropout prevention program impacted participants' lives over the past 10 years?

In order to answer the research question, while keeping in mind that this study focuses on participants' perceptions of program impact, I developed open-ended interview questions [Appendix E]. These questions asked the participants for their views regarding their experiences in the program. Each participant responded to every interview question, and some offered additional information. Participants were periodically recontacted by phone to update and clarify certain responses.

Participants' Perceptions of Program Impact

The primary purpose of this research was to determine the participants' perceptions of program impact and to allow them to express the ways the program helped them. During the interviews, I asked each person specific questions about their experiences in the program. Select, relevant, participant responses appear in the data boxes [see Appendix F]. The participants' own words provided the data that I used to create a theoretical model depicting their collective experiences in the program. "The Upward Spiral of Caring" [see Figure 4 on following page], is a model illustrating how the participants expressed impact of the Teen Outreach Program on their lives. The major findings of this study, grounded in the data, are portrayed in this model.
Figure 4: The Upward Spiral of Caring.
The "Upward Spiral of Caring" is a model that illustrates the stages participants described as they became more involved in the program. They described how they felt unconditionally accepted in Teen Outreach, leading to a sense of belonging in the group. Volunteering gave them opportunities to contribute to their community and to experience feelings of accomplishment. They received both individual praise and group recognition for their efforts. Each person learned to care for herself, others, and the community, all working together to boost self-esteem. The resultant feelings of acceptance and belonging inspired a willingness to strive to accomplish more, producing further praise and recognition, and giving rise to increased care for self, others, and community. This created higher levels of self-esteem, in turn, positively affecting individuals' actions, such as school attendance, academic achievement, and HRBs.

To determine how the Teen Outreach Program impacted their lives, participants were asked to review the past 10 years and consider what the program meant to them. As a group, the participants identified five main program processes as having the greatest impact: (1) boosting self-esteem, (2) accessing community resources, (3) supporting group members, (4) volunteering to help, and (5) applying education. The participants' exact relevant quotations are located in the data boxes in Appendix F. Table 1 shows which participants talked about each process. The x's represent tally marks.
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<th></th>
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<th>Volunteering</th>
<th>Support</th>
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<td>X</td>
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<td>3. Diane</td>
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<td></td>
<td>X</td>
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<td></td>
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<td>4. Jane</td>
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<td></td>
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<td>X</td>
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<td>8. Sandy</td>
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Table 1: Tallies of Participants' Comments about Program Processes.

Figure 5 [see following page] shows how the prevention program processes named by the participants influenced immediate, short-term, and long-term program impact. I compared participants' reports of impact with program goals. Figure 5 also shows the interrelationships among program processes, as well as among immediate, short-term, and long-term impact. Immediate program impact, while they were enrolled in the program, was no school dropout and no teenage pregnancy. Short-term impact was demonstrated by increased high school graduation, reduced teenage pregnancy, and the reduction of health-related behaviors. Long-term program impact was evaluated by assessing educational achievement and overall wellness.
<table>
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<td></td>
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<td></td>
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<tr>
<td>education</td>
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</table>

* In order of importance as identified by participants

Adapted from Kolbe's (1986) Model, School Health Promotion Components and Outcomes.

Figure 5: Prevention Program Immediate, Short-term, and Long-term Impact
Arrows between program processes indicate the connections between boosting self-esteem, accessing resources, volunteering, supporting each other, and applying education. The impact of these program processes on school retention and teen pregnancy, as well as the ultimate influences on long-term educational achievement and overall wellness are also illustrated.

The following section explains how the program processes of boosting self-esteem, accessing resources, supporting each other, volunteering to help in the community, and applying education—were derived directly from and confirmed by the data.

**Boosting Self-Esteem**

The participants said that an increase in self-esteem was the most important impact of their Teen Outreach experience. Renee's statement, "It boosted my self-esteem," gave me the name of this process. Also, Amy spoke about how the program helped raise her self-esteem by saying, "Making you feel OK about yourself." Jane explained that the program:

Gave me a sense of self-worth. How you treated us. You treated us like we were worth something. You gave a lot of yourself to a lot of us. It gave me a piece of myself. It helped me explore who I was. I learned I wasn't who my father said I was. I wasn't who my teachers said I was. Teen Outreach laid a foundation of good. I'm a different person because of Teen Outreach. I'm a lot more confident in who I am and how I look than when I was a freshman.

Beth similarly said,

It helped my self-image and self-esteem and gave me positive reinforcement. Instead of focusing on the negative, like some of my friends, it gave me a more positive whole outlook.
Kathy said that helping others resulted in higher self-esteem, "Helping the less fortunate raised my self-esteem. It made me feel really good about myself." Kathy continued talking about her experience—"...to work with the public building up your self-esteem. Teen Outreach makes you a stronger, more confident person.

Sandy expressed that within the group she felt comfortable just being herself, by saying, "I could be more natural, I could just be me."

**Accessing Resources**

The program also impacted students by providing useful information about community resources. Renee said that Teen Outreach most impacted her by:

> . . . giving me valuable information and resources. . . . All the information, I had so many resources from the time in Teen Outreach. I even to this day will go back and try and remember what did that person say about such and such, and oh, I remember that in Teen Outreach.

Amy also mentioned learning about resources, "Speakers letting us know resources."

Beth commented that, "Speakers exposed us to a variety of issues." Kathy gained information that she used about community resources:

> I learned about programs to tap into resources, like APPP [Adolescent Pregnancy and Parenting Program]. Teen Outreach opened a lot of doors for me. It put me in touch with my community.

Mary said that she was able to use the information about how to access resources, stating:

> I learned how to network and use resources, different people to help me when I needed it. I didn’t learn about these resources in my other classes. . . . I called three places. I was trying to find a place to live so I could get away from my mother. I called First Love, CRC [Crisis Residential Center], and a crisis line. I learned about AA, Alateen, Alanon, and I went to some of their meetings.
Mary also said that knowing about resources helped her to refer friends with problems to appropriate services rather than attempting to take care of the problems herself:

Suicide resource, not myself, but I've talked other people out of it, is an example of how Teen Outreach changed me. I would hook them up to people who could help them instead of trying to handle it myself.

Even though Amy never shared with the group about the alcoholic household she grew up in, she still listened and gleaned information that was helpful to her:

In Teen Outreach we had speakers and we talked a lot about alcoholism and dysfunctional families. I never talked about it. I even called one of those hotlines one time. My parents came home and I had to hang up real quick and act normal.

Amy's calling the hotline is an important act because it is the only time in her life she has reached out to ask for help.

Renee said that she was able to recognize the warning signals of a potential abuser by remembering what she had learned from her favorite guest speaker:

I remember even to this day when Beth Wilson came and talked about the Battered Women's Shelter and told us all these warning signals of potential abusers. She gave us information on violence steps. Abuse usually starts with saying bad things about women, like calling women bad names, and then I think it goes on to being insulting but not... like appearing funny, like joking about something female, like oh you little fatty or something, making little personal remarks about you, whatever your personal fault he may think you have or something. And that was when he was calling me a fatty [when I was six months pregnant]. He knew I was really upset about it... which is probably very normal but I was really sensitive about it. He was so extremely manipulative to where I would feel sorry for him and he was the victim... I was so blind to it for a long time.
Beth was able to leave a violent boyfriend because she was put in touch with the appropriate resource, as she tells her story:

I remember also that you helped me by taking me to visit a woman whose name was also Beth at an abuse-she worked with abused women in abusive relationships and it was really helpful and insightful... we dissolved our relationship at that point and it was a big turning point in my life also where after that I started to make a lot of positive changes in my life.

**Participants’ Use of Community Resources.**

As I predicted a priori [see Appendix B], the persons who used the most community health resources would be the ones who became pregnant as teens, kept the baby, and dropped out of school.

Prior to her enrollment in the program, Kathy, at 13 years old, was the first to become pregnant. That pregnancy ended in miscarriage. Then she became pregnant at 16, dropped out of school, and gave birth to her son. Kathy's family refused to help her, so she felt she had no other alternative but welfare. She moved to the poor part of town where she could afford an apartment. Kathy was by far the heaviest user of community resources, including Planned Parenthood, a food bank, and a women's clinic.

Renee, who used the second most resources, also became pregnant as a teenager at 18. She used many of the same services that Kathy used, such as Planned Parenthood and a women's clinic. Diane reported that the only community resource she has used was the hospital where she gave birth to her daughter.
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* indicates learned about in Teen Outreach

Table 2: Participants' Use of Community Resources, High School to Present.
Supporting Each Other

"Support" was the response given by six participants when they were asked what aspect Teen Outreach helped them the most. This support enabled them to make it during a difficult time. Renee talked this way about the supportive environment: "...just having support and someone available that you knew would stand behind you or support you or give you ideas or be your friend." Teen Outreach gave Renee a "sense of belonging," an essential ingredient of peer group support. Sandy said that Teen Outreach was like a family, another important element of peer group support. Sandy shared how Teen Outreach became like a family to her:

When my entire family disowned and turned against me Teen Outreach was like a family to me. The Teen Outreach group was my second family since I had no family life. It was kind of like family taking the empty spot. It helped me through a lot.

Mary said she appreciated the personal relationships formed in the program "I had a personal relationship with you and other students in the group." Kathy described the support she experienced, "Support from you, support from students in the group, a strong group." Sandy said, "I learned that people can be there to help you when you are down. Amy said, "Letting you know other people have problems and they’ve survived too."

Half of the participants stated that the main way they benefitted from the Teen Outreach Program was by learning to relate to many different kinds of people. Amy said, "I learned it's OK to be different and I learned to talk to different types of people."
Participants shared how being in the program helped them to understand and appreciate people they otherwise might not have had the opportunity to get to know. Diane said:

The thing that helped me the most was just the kind of people that were in the class, that you wouldn't normally talk to or hang around with. Because there were all different types in the class, I think helped stretch your thinking a little bit about people. You learned that they have feelings too and problems and just because they are not the way you are, necessarily doesn't mean they are not important.

Diane saw other group members as different than herself.

On the other hand, Renee saw the group as "people who were very similar to me," explaining:

A lot of people would probably call them losers because they were kids with a lot of problems and difficulties. Not one racial background or economic group. They were all very different. Just kids who for whatever reason were alienated. Not people who didn't have any friends, but people who couldn't go with the structure of regular school, kids using drugs, kids skipping, kids causing problems, kids with attitude problems.

Diane commented that she learned compassion:

Being in the group made me more compassionate towards people. Most of the people were troubled and had problems. I learned there was another side of people.

Becoming "more compassionate" was the most important part of Diane's experience in Teen Outreach. Diane learned to be empathetic toward people different than herself.

Similarly, Mary recalled that she learned to be compassionate when she was the teaching assistant for the 9th and 10th grade group:

I learned compassion. In Teen Outreach I sat and looked at these other kids that were in there with me and then... especially when I was helping out with the younger kids, I probably learned more from watching them from anything else. Just listening to their lives, it really showed me how common those kind of problems are.
While there were many different kinds of people in the group, they often shared common problems--problems with family, friends, school, drugs.

Volunteering to Help

Over half of the participants' responded that volunteering impacted their lives.

Beth said that the volunteer part prepared her for work, "I volunteered at the hospital for the kidney dialysis unit and part of my job was to help do clerical work." Jane said that volunteering at the nursing home provided her with the opportunity to be hired:

Volunteering led me to other opportunities and gave me experiences, like volunteering at the nursing home helping with activities. Because I volunteered I got the job I have now. Teen Outreach emotionally prepared me for the job I have now. I'm an activity assistant at the convalescent home's special care unit--people with Alzheimer's and dementia.

Kathy spoke about the ways that volunteering helped her to care for others and gave her work experience:

Before Teen Outreach I didn't have any job skills--just babysitting. After Teen Outreach I learned job skills like social work. I liked working with the kids, to day cares, nursing homes, Operation Santa Claus, worked with people. That gave me the confidence to go and get a job... In a nutshell Teen Outreach gave me a sense of community. I felt more connected to people around me and not so egocentric. I learned about other's needs and helping others.

Renee said that volunteering gave her valuable work experience--

We did so many different volunteer projects. It was like an introduction to a number of different jobs. ... I also had a volunteer job at the convention center. I learned how to use the coffee machine and how to make copies on the copy machine and how to answer the phone appropriately, but most importantly I think I learned how to be in the business environment. Those skills are extremely important and you don't learn them in school.
Sandy stated that she learned to care through volunteering:

Working with the dogs, it was almost like working with homeless children. You want to help them as much as you can and so that taught me to care about other people and other things.

Jane explained how Teen Outreach trained her to be a life-long volunteer:

I've been involved in AIDS education ever since Teen Outreach. I did AIDS peer education for the Red Cross. Now I volunteer with Care Bearers. We provide help for people with AIDS. I have a patient that I check in on to see if he needs anything. We do things like picking up groceries. I also do office work. I volunteered for World AIDS Day December 1st. They had a vigil at the cathedral. I put up the display.

Mary also volunteers today: "I volunteer at my church. I'm in charge of communications--doing the newsletter and bulletin board."

Kathy is yet another life-time volunteer:

Teen Outreach was good practice for real life. Volunteering carried over later. When I lived by an elderly couple I offered to do daily-like things, like waxing the car, doing errands. I get pleasure out of helping people. People gave to me, so I'm giving back. Now I volunteer for Matthew's school. I'm a den mother for his Cub Scout troop. During the recent flood disaster I volunteered to help flood victims by delivering supplies to them. I volunteered at the co-op day care at the community college. I'm a member of Amnesty International.

**Applying Education**

Kathy, Beth, and Mary talked about how they were able to apply the "education part" [formal curriculum] of the program. Kathy said that she learned how to take care of a baby, which helped her to care for her son: "The education part--we learned baby care, it helped me for taking care of Matthew."
Beth talked about learning how to look at something from several different viewpoints, which is related to decision-making and problem-solving, part of the Teen Outreach curriculum, to quote Beth:

I'm able to analyze situations. I learned there's more than one way of looking at things. I can see things from another standpoint.

Mary talked about how learning about alcohol and drug abuse helped her to change her behaviors—"I learned the terms and signs of drug and alcohol abuse and codependency. I progressively lost abusing alcohol and drugs. It didn't happen all at once."

Mary also said, "I learned what made me a healthy person and not a sick person." Similarly, Beth said, "I learned the difference between a healthy and a unhealthy relationship. My husband and I, I think that we have a healthy relationship."

Other Comments

Some participant comments did not fit into any of the other categories. For example, Jane said that Teen Outreach got her out of the house and it gave her some place to go besides home. Jane also said, "I'm a different person because of Teen Outreach." Kathy stated similarly, "Teen Outreach made me the person I am today." Mary said, "Teen Outreach was the major turning point in my life." Beth added, "It was a big turning point in my life also, where, after that I started to make a lot of positive changes in my life." Jane, Kathy, and Mary each said that I was a positive role model for them. Kathy
remarked, "Teen Outreach is good practice for real life," a statement that reflects the "real world" educational experience provided in the program.

Research Question 2

Research Question 2: What were the participants' perceptions of long-term program impact on education, pregnancy, employment and relationships?

What were the participants' ideas about any lasting program effects as they reflected back over the past 10 years? In addition, I also wanted to compare past health risk behaviors with current health risk behaviors. I underscore that Teen Outreach is not a traditional school health education program, even though some health topics are included in the curriculum.

My second question was addressed in a manner similar to the first research question. I constructed open-ended interview questions that would produce responses to the aforementioned issues. Participants' self-reports provided the data which would answer the research questions. Tables were developed to organize, summarize, and compare relevant data concerning participants' educational achievements, pregnancies, employment, and relationships, as well as health risk behaviors.

Program Impact on Education

All of the students were referred to the program because of school failure and/or low attendance. Nevertheless, almost all have made progress in reaching their educational goals. The participants said that family problems (divorce, remarriage, alcohol and drug
abuse, partying, violence, and physical, mental, and sexual abuse) were the main cause of failing grades. Also, "not caring" and "getting into trouble" were given as reasons for poor school performance.

High School Graduation. (Table 3)

Seven of the eight participants reported that they have completed their high school education. All but Sandy have earned a high school diploma or GED [graduate equivalent diploma]. Five of the students--Beth, Diane, Jane, Mary and Renee--graduated from high school on time (i.e., within four years). Amy, Kathy, and Sandy dropped out of school. Amy returned to school the next year to complete graduation requirements, Kathy earned a GED, and Sandy has passed half of the requirements for the GED and plans to complete the remaining part soon. All used credits which they earned in Teen Outreach--one credit per term--to apply toward high school graduation. Thus, Teen Outreach directly impacted the students in two main ways--by encouraging them to remain in school and by giving them the opportunity to earn credits to satisfy graduation requirements.
<table>
<thead>
<tr>
<th>Person</th>
<th>High School Graduation</th>
<th>Description/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Amy</td>
<td>YES</td>
<td>Dropped out 1 year; returned to graduate</td>
</tr>
<tr>
<td>2. Beth</td>
<td>YES</td>
<td>Graduated on time</td>
</tr>
<tr>
<td>3. Diane</td>
<td>YES</td>
<td>Graduated on time</td>
</tr>
<tr>
<td>4. Jane</td>
<td>YES</td>
<td>Graduated on time</td>
</tr>
<tr>
<td>5. Kathy</td>
<td>YES</td>
<td>GED</td>
</tr>
<tr>
<td>6. Mary</td>
<td>YES</td>
<td>Graduated on time</td>
</tr>
<tr>
<td>7. Renee</td>
<td>YES</td>
<td>Graduated on time</td>
</tr>
<tr>
<td>8. Sandy</td>
<td></td>
<td>GED; one-half of exam completed</td>
</tr>
</tbody>
</table>

Table 3: Participants' High School Graduation.

Program Impact on Pregnancy: Participants’ Pregnancies Before Program, During Program, and After Program (Table 4)

None of the participants became pregnant while they were enrolled in the program. Kathy was the only participant who had been pregnant prior to enrollment in Teen Outreach and her pregnancy ended in miscarriage. Half of the participants became pregnant following their participation in Teen Outreach. All together, Beth, Kathy, Mary and Renee had a total of 13 pregnancies, with 6 pregnancies occurring in participants aged 20 years or older, and 5 occurring among participants aged 19 years or younger. Of these 5 teen pregnancies, 2 resulted in live births to Beth and Kathy, 1 resulted in miscarriage for Kathy, and 3 ended in abortion, 2 for Kathy and 1 for Renee. Out of the total of 13
pregnancies, there were 7 live births, 1 miscarriage, 3 abortions, and 1 tubular pregnancy surgically removed. All of the infants were kept by the birth mother, i.e., no infants were relinquished for adoption. Three out of eight of the participants--Amy, Jane, and Sandy--have not yet been pregnant. Amy is not sexually active. Jane has practiced safer sex and used methods to prevent pregnancy and STDs. Sandy is unable to conceive.

<table>
<thead>
<tr>
<th>Person</th>
<th>Before Program</th>
<th>During Program</th>
<th>After Program</th>
<th>#</th>
<th>Age</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Amy</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2. Beth</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>2</td>
<td>19,23</td>
<td>2 live births</td>
</tr>
<tr>
<td>3. Diane</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>1</td>
<td>26</td>
<td>1 live birth</td>
</tr>
<tr>
<td>4. Jane</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5. Kathy</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>4</td>
<td>13,16, 17,20</td>
<td>1 miscarriage/ 1 live birth/ 2 abortions</td>
</tr>
<tr>
<td>6. Mary</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>4</td>
<td>20,21, 26</td>
<td>1 tubal pregnancy/ 1 live birth, 1 set of live twins</td>
</tr>
<tr>
<td>7. Renee</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>2</td>
<td>18,20</td>
<td>1 live birth/ 1 abortion</td>
</tr>
<tr>
<td>8. Sandy</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 4: Participants’ Pregnancies Before Program, During Program, and After Program.
Program Impact on Employment (Table H in Appendix)

Participants reported that they had very few work skills prior to participating in Teen Outreach. Some of them made comments about specific work skills they learned in the program. To Beth, learning about the job interview process was the most valuable part:

I remember learning about interviews, learning about the interview process. I remember talking about what is appropriate to wear to an interview, what behaviors are appropriate, what kinds of questions and responses are necessary and I remember talking a lot about punctuality and about responsibility and consideration, a lot of positive aspects of work.

Kathy recalled that before being in the program she had no work skills:

Before Teen Outreach I didn't have any job skills -- just babysitting. After Teen Outreach I learned job skills like social work. I liked working with the kids, to day cares, nursing homes, Operation Santa Claus, worked with people. That gave me the confidence to go and get a job...to work with the public building up your self-esteem, talking with people.

Jane said she was most helped by gaining communication skills, both with individuals and with groups:

I learned to communicate better with people and peers. I learned a lot of public speaking skills. Presentations, things like that. There was a lot of work in groups, a lot of brainstorming and stuff like that were kind of jobs to function with a group of people instead of just independently too.

Renee explained how volunteering introduced her to the business world. Renee benefitted from group volunteer projects as well as her individual volunteer job placement at the convention center, as she remembers:

We did so many different volunteer projects. It was like an introduction to a number of different jobs. ...I also had a volunteer job at the convention center. I learned how to use the coffee machine and how to make copies on the copy machine and how to answer phones appropriately, but most
importantly I think I learned how to be in the business environment. Those skills are extremely important and you don't learn them in school.

Beth described her individual volunteer job at the hospital:

I volunteered at the hospital for the kidney dialysis unit and part of my job was to help do clerical work. I made labels and I filed and things like that. I liked it. I liked the atmosphere and I liked being there and it was peaceful.

Sandy talked about how volunteering exposed her to many experiences:

I think it showed me a different life, going to the nursing homes and different places.

Teen Outreach had a direct effect on the employment of three participants. For the past two years, Jane has been working as an activity assistant in the same nursing home where Teen Outreach students volunteered. Most recently she accepted a position as house manager for a drug and alcohol treatment center. Jane said, "Because I volunteered at the convalescent home I got the job I have now. . . . Teen Outreach prepared me emotionally for the job I have now and my new job." Kathy said that Teen Outreach gave her the confidence to apply for a job as a wineries tour guide:

I got some jobs through the college that I never would have gone for before, like I did a tour bus through the wine country. I was a tour guide and I would talk into the microphone.

Kathy's been working for two years developing film in a photo lab where she is now the manager. Someday she hopes to own her own photo lab business.

Mary said that in Teen Outreach learning how to network and access resources was valuable. To seek help for her infant's physical disability, she found the appropriate
resources herself. This led to a job as a community educator for the Citizen's Action Coalition (a lobbying organization to reduce medical costs for the disabled).

Renee said that through volunteering she learned how to work in the business world. In the program, students volunteered at over 40 agencies and businesses. In addition to learning job skills, participants' stated that they gained other important things from volunteering: knowledge about community resources, feeling of self-worth, competence, practical experience and a sense of accomplishment. All have had various work experiences and are currently supporting themselves, though there is no direct relationship between these work experiences and Teen Outreach.

Program Impact on Relationships

Relationships--with family members, friends, husbands, lovers, and children--was the topic that participants most wanted to talk about and spend the most time on during the interviews. Relationships have shaped their lives and they tended to define themselves in terms of their relationships. Decisions they have made regarding relationships have had greater consequences on their lives than those regarding education and work and, what has gone on in their intimate relationships has affected education and work. Their primary relationships within their families affected other relationships with friends, lovers, and partners. This discussion is limited to specific ways that participants' relationships were related to program effects. The stories of their lives are basically the stories of their relationships.
Renee said,

And that was when he was calling me a fatty [when I was six months pregnant]. He knew I was really upset about it . . . which is probably very normal but I was really sensitive about it. He was so extremely manipulative to where I would feel sorry for him and he was the victim. . . . I was so blind to it for a long time. The information from everything, from Beth, I remember her, she was probably one of my favorites. All the information, I had so many resources from the time in Teen Outreach. I even to this day will go back and try and remember what did that person say about such and such, and oh, I remember that in Teen Outreach.

Beth was able to leave a violent boyfriend because she was put in touch with the appropriate resources, as she tells her story:

I was involved in an extended relationship but when it started out it wasn't abusive but not far into the relationship Richard started to be very possessive and always wanted me to be with him and it escalated enough until it was physical. I was 15, we were both 15, it was a really difficult situation and it finally escalated to the point that he was abusive to me at school. Somebody saw it and that is when it began to end and he was expelled from school so there wasn't the opportunity to see him at school anymore and also my mother forbade me to see him and it was difficult to break off the relationship but with a lot of pressure and help from others the relationship was dissolved and I remember also that Tamara, you helped me by taking me to visit a woman whose name was also Beth at an abuse--She worked with abused women in abusive relationships and it was really helpful and insightful and since then I have gone on to have healthy relationships and as far as Richard was concerned I haven't seen him for about five years, but we dissolved our relationship at that point and it was a big turning point in my life also where after that I started to make a lot of positive changes in my life. It did make me more aware of warning signals in men, but it wasn't really something that I had ever thought about before because my parents had a healthy relationship and I hadn't been around any type of abuse before so it was never something that I would have looked for in a man before. But afterwards especially as an adult woman even talking with friends or things like that it is something that I really keep in the back of my mind.

Amy learned from the speakers in Teen Outreach about issues related to codependency and dysfunctional families. When Amy told her mom that their family is
dysfunctional, her mom said, "We're not dysfunctional because we function—we work, get paid, pay bills." There are six brothers and sisters, "most have different fathers and different last names." Even though she remains in the dysfunctional home, she has information that helps her understand that the alcoholism is not her fault.

Like Amy, Mary learned about alcohol abuse and was able to benefit from community resources. In Ala-non meetings she, too, realized that she was not responsible for her mother's alcoholism, nor did she need to enable her mother any longer.

Beth had a violent relationship with her boyfriend, Richard, and they used alcohol and drugs excessively. Richard became verbally and physically abusive and the violence escalated. With the help of Beth's mother, the school principal, the director of the Battered Women's Shelter, and a teacher [myself], Beth was able to end that relationship. From that experience she says she learned the difference between a healthy and unhealthy relationship, which enabled her to make healthy choices about men. A turning point in Beth's life was when she decided that it was time for her to make major changes, including the need to change friends and stop drinking excessively. Subsequently, she earned better grades and was placed in the college prep classes. Beth says of Juan, "He is protective, but he is not possessive or abusive. . . . it's a good relationship and a healthy relationship."

Health Risk Behaviors [HRBs] [Tables 5 and 6]

The Centers for Disease Control [CDC] identified six categories of health risk behaviors [HRBs] among adolescents: 1. Illness/Injury, intentional and unintentional; 2.

**Participants’ Past Health Risk Behaviors.** During their adolescence most of these former high-risk students had all or most of these HRBs. Most noteworthy is that half of the participants' reported that they previously had all six risk factors [Kathy, Mary, Renee, Sandy]. Not one of the eight had an adequate diet. Seven of the eight participants used alcohol and tobacco when they were teenagers, and six did not exercise sufficiently. Six were sexually active, nor did they consistently use protection against pregnancy or sexually transmitted diseases. Over half had serious illnesses or injuries. Only two gained sufficient exercise through physical education classes and sports.

<table>
<thead>
<tr>
<th>Illness/Injury</th>
<th>Tobacco</th>
<th>Alcohol/Drug Use</th>
<th>Sex Behaviors</th>
<th>Poor Diet</th>
<th>Insufficient Exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Amy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Beth</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3. Diane</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4. Jane</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5. Kathy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>6. Mary</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>7. Renee</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>8. Sandy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

| 5/8 | 7/8 | 7/8 | 6/8 | 8/8 | 6/8 |

Table 5: Participants’ Past Health Risk Behaviors.
**Present Health Risk Behaviors.** In 1997, a decade later, the HRBs picture has changed somewhat: All report having had a serious illness or injury (unintentional or intentional). No one exercises sufficiently, with minimal walking [15 minutes to 1 hour] being the only form of exercise reported. All report moderate alcohol use, drinking within limits at special occasions and never driving while under the influence. Except for Amy, all are sexually active but within monogamous relationships. All demonstrate sexual responsibility by using varying methods to guard against unplanned pregnancy and STDs. Five have poor dietary patterns, while three report adequate diets. Renee and Sandy continue to smoke daily. Jane sometimes smokes and Diane smokes only occasionally at parties.

<table>
<thead>
<tr>
<th>Illness/Injury</th>
<th>Tobacco</th>
<th>Alcohol/Drug Use</th>
<th>Sex Behaviors</th>
<th>Poor Diet</th>
<th>Insufficient Exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Amy</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2. Beth</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3. Diane</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4. Jane</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5. Kathy</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>6. Mary</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>7. Renee</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>8. Sandy</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

| 8/8 | 4/8 | 4/8 | 1/8 | 5/8 | 8/8 |

Table 6: Participants’ Present Health Risk Behaviors.
Summary of Life Stories

The long-range desired program goal of virtually all prevention programs is to produce good citizens who are contributing members of society. As a whole, these young women have overcome difficult situations that existed in their homes when they were children—parental divorce, remarriage, alcoholism, violence, neglect, drug addiction, poverty, as well as mental, physical, and sexual abuse. As children, they survived difficult circumstances; moreover, most of them have moved beyond the pathologies existing in their families and have ultimately succeeded in not repeating the same self- and other-destructive patterns. These individuals have stated with the stories of their lives that they are making conscious efforts not to repeat the negative attitudes and behaviors that adversely affected them growing up. Each parent expressed the determination to give her own children a more safe and healthy childhood than she herself had, as Mary commented, "I want them to grow up normal." All are now productive adults: educating themselves, working, and raising children. Today they are concentrating on contributing to others: family, church, volunteer community service. They are proud of their achievements: graduating from high school, overcoming alcohol and/or drug abuse, supporting themselves and their families, and getting along better with relatives.

Research Findings

These research findings confirm that the program's immediate goals of increasing the numbers of students achieving high school graduation and decreasing the numbers of
teen pregnancies were met in nearly every case. With the exception of Sandy, who has yet to complete half of the GED exam, everyone has earned a high school diploma. None of the participants became pregnant while enrolled in the program. This study revealed that the immediate goals were met in almost every case. As students, all of them earned credits in Teen Outreach to apply toward high school graduation.

**Application of The Paradigm Model**

To perform a deeper analysis, portray the larger picture, and form grounded theory, I applied The Paradigm Model (Strauss & Corbin, 1990). In The Paradigm Model, (A) causal conditions were trauma [parental divorce and remarriage; violence; emotional, physical, or sexual abuse and/or negative peer group]; (B) phenomenon was high-risk status; (C) context of the 1980s and 1990s [rising divorce rate; increasing sexual activity; increases in births to unmarried women; more mothers working outside the home; latchkey children; norms promoting alcohol and drug abuse]; (D) intervention of the Teen Outreach Program; (E) action/interaction were program processes [boosting self-esteem; accessing resources; supporting each other; volunteering to help in the community; applying education]; (F) consequences were high school graduation and reduced teen pregnancy. I plugged these phenomena into The Paradigm Model, as shown:
THE PARADIGM MODEL

A) TRAUMA AND/OR NEGATIVE PEER GROUP \( \rightarrow \) (B) HIGH-RISK STATUS

(C) CONTEXT OF THE 1980s AND 1990s \( \rightarrow \) (D) INTERVENTION OF TEEN OUTREACH PROGRAM \( \rightarrow \) (E) BOOSTING SELF-ESTEEM, ACCESSING RESOURCES, SUPPORTING EACH OTHER, VOLUNTEERING TO HELP IN THE COMMUNITY, APPLYING EDUCATION \( \rightarrow \) (F) HIGH SCHOOL GRADUATION, REDUCED TEEN PREGNANCY

Figure 6: Application of The Paradigm Model

Critical Inquiry Analysis

To answer the research question and reach a deeper understanding of the participants' perceptions of long-term program impact, this study also applied critical inquiry to examine how systems of oppression have affected these young women and contributed to their high-risk status. To explore these issues, I inquired of the data: In what ways has oppression been manifested in their lives? How did participants respond to oppression? How have they resisted and survived?

Sexism is the prejudice against and mistreatment of women on the basis of gender. The abuse of women is possible due to male dominance and privilege in both the public and private domains. Among the young women in this study, sexism is apparent in the forms of discrimination, the double standard, scripts of subservience, and abuse--verbal, physical, emotional, and sexual. The most obvious example of sexual abuse is incest, in this case, a father's sexual relationship with his daughter, as happened to both Renee and Sandy. At the time of their high-risk status, each was openly rebelling and acting out the
rage she felt toward her father. When Sandy reported her father to a school counselor, her father denied it, and the family disowned her. At 16 she was living on her own. She became involved with alcohol, drugs, and risky sex. Depressed, Sandy made three suicide attempts. At the present time she is no longer depressed, but she is unable to become pregnant and doctors have told her there is no physiological reason why she is unable to conceive.

Only in the past two years has Renee been able to face the reality of her father's incestuous relationship with her. Renee's father sexually abused her for as long as she can remember. When her father remarried, his sexual advances were transferred to Renee's stepsister. Renee then felt ugly and rejected, so she rebelled. Renee has been clinically depressed and suicidal. For the past two years Renee has been under psychiatric care. Just recently, with the help of her psychiatrist, Renee is beginning to deal with the consequences of sexual abuse. Renee's son is also in counseling to help him deal with his mother's depression.

Violence against women is further evidence of sexism in a misogynist, male-dominated society. Beth described what she learned from her experience in a violent relationship:

It did make me more aware of warning signals in men, but it wasn't really something that I had ever thought about before because my parents had a healthy relationship and I hadn't been around any type of abuse before so it was never something that I would have looked for in a man before. But afterwards especially as an adult woman even talking with friends or things like that it is something that I really keep in the back of my mind.
Beth's experience with violence increased her awareness of the "warning signals" in potential abusers. Talking with other women has also caused her to realize the prevalence of violence against women. Renee remembered how her husband's verbal and emotional abuse escalated. It began with jokes and put downs and he became increasingly manipulative, controlling, and isolating. Renee recognized the symptoms of a potential abuser from the description given by a speaker in Teen Outreach and was able to leave the situation before it escalated further.

Sandy has been discriminated against as a woman during her fight with the state over her job-related injury. Medical doctors have not taken her seriously and the state's reluctance to help her has made it difficult for her to get proper treatment and just compensation. After fighting the system on her own for two years, she engaged a (male) lawyer to fight the battle for her, so now she is beginning to receive what is rightfully hers.

Jane explains the abuse she has experienced from the people in her life:

It took me a lot of shit from men, from Brandon, from Norman, from my dad, from a lot of shit from my family, a lot of shit from people that I knew.

Kathy sees sexism in the unfairness of the double standard:

... boys have more freedom as far as their behavior goes. Boys have more leeway. Like if a boy did half the things I did, it's just boys will be boys, boys will be restless, and it's like OK for them. But like for me, you're like labeled.

During the interview I asked, "What do you like least about being a woman?"

Jane responded, "Cramps and chauvinists." Her answer was representative of the
answers that other participants made. Over half responded "menstruation," indicating that, by in large, they have internalized negative scripts about this natural bodily function.

Resistance Strategies

As a group the participants used several strategies to resist oppression and survive: denial, fantasy, psychosomatic illness, avoidance, positive self-talk, and voice.

Jane has come to the place in her life where she is happy living alone and content without a man:

I was glad he was out of my life. I was glad that I didn't have to spend any more time in a negative relationship because it got real negative in the end and I realized that, you know, . . . . I had a whole lot to offer and he gave up a whole lot and I think that is probably the point that it clicked, is that, you know, I am ok by myself. I'd rather be with someone for the right reasons than be alone, than be with someone for the wrong. I am proudest [that] everything I have gotten I have gotten for myself. Nobody has given me anything. My car, I went out and paid for. I paid myself through school. . . . Everything I have done I have gone out and gotten myself.

When I asked Diane what coping strategies she used, she stated:

I have always coped well with things, so I don't really have any strategies, it just comes naturally to me to deal with things. It doesn't seem to stick with me, I get over it quick. [His wife] never had kids before so he would always cater to her even if it meant hurting us. So a lot of that adjustment period when they were married was hard because I felt resentful sometimes but now I don't. I am a very resilient person. Things kind of just bounce off me. . . . I am not the kind of person . . . they have something bad happen or traumatic happen to them. They hold on it forever and it affect them and I am just not like that. I have never been like that.
Participants' Social Class [Appendix H]

Amy, Beth, Jane, Mary, and Sandy reported that they came from working class families. Diane and Kathy grew up in middle class families. Renee's background is upper middle class and she grew up in affluence. Both of Renee's parents are college educated and hold professional positions. Renee has married twice, both times to working class men, and currently she is divorcing her second husband. She mainly supports herself as a waitress. At the time she is working three jobs--waitressing, delivering newspapers, and cleaning houses--trying to earn the money to continue her education at the community college in the city where she now resides. She must pay one term's tuition in order to be reinstated for financial aid. While Renee grew up in an upper middle-class environment, her choices and circumstances have made her working class. When she was a single parent and homeless she used public assistance.

Similar to Renee, Kathy was raised middle class. In the home she was brought up in, both of her parents were professionals and held college degrees. As a teen parent Kathy was on welfare for four years. On her own, two years ago Kathy moved with her son, Matthew, to a city 350 miles away from Centertown. Currently, she is a single parent supporting Matthew and herself. She claims she is "working class aspiring to middle class."

Of note, while both Renee and Kathy were raised upper middle class and middle class, respectively, they are the only ones who have required public assistance. They both became pregnant as teens--Kathy at 14 and Renee at 19 years of age. While they each...
have received some monetary help from their families, their families have been unwilling to totally support them financially.

Beth had working class beginnings. Her mother was a traditional stay-at-home mom. Beth is the only one with a college degree and she is the only one with a professional position. She works as an insurance adjuster, and her income has made the family middle class and enabled them to buy a home. Juan, her husband, is not interested in going to college and he has a job as a laborer in a cement plant. Beth's mother-in-law cares for their two children while they are at work. When Beth has paid back all her loans she plans to return to school to earn a master's degree in Sociology. Beth's college education and career have moved her from the working class up to the middle class.

Mary grew up in a single parent working class home. Her mother was on welfare in Mary's early years, and later she supported them working as a cocktail waitress. Mary married into a middle class family and her husband, Mark, has a management position with a large corporation. When they first moved to Indiana to be near Mark's family, they lived with Mark's parents for two years. Recently they bought their first house. At the time of our interview, she worked at home making items to sell at local bazaars. Currently she started a job two evenings a week as a community educator for the Citizen's Action Coalition, a lobbying organization to gain reasonable medical and utility costs for the disabled. Mary was a stay-at-home mom.

Diane grew up in a middle-class home, her mother's second marriage was to a middle-class man, and she married a middle-class man. Diane has achieved her goal to be a stay-at-home wife and mother. Today, Mary and Beth are middle class. Diane
maintained her middle-class status by marriage, Mary married into a middle-class family, and Beth earned her way into the middle class by acquiring a college degree and beginning a professional career. Diane and Mary are the only ones with a traditional nuclear family, with the role of the mother caring for the children at home and the father working to support the family. Beth also has a nuclear family, but she is the primary breadwinner.

All from working class backgrounds--Amy, Jane and Sandy--continue to be in the working class. Amy has never married and she still lives with her family. Jane has also remained single, and now she supports herself working at an alcohol and drug treatment facility. When Jane can afford it, she has her own apartment. When she can't accord it, she moves back into her parents' home. Sandy grew up in a working class family where the mother worked in a fruit warehouse to support her husband and their six children. At times when her husband has been laid off from construction work, she is the sole support of the family.

Summary

The major finding of this study is that learning to care for self, others, and community is essential for the survival of these women. The participants named the following program processes as having the greatest impact: boosting self-esteem, accessing resources, supporting each other, volunteering to help in the community, and applying education. The participants said that Teen Outreach provided support and a "family" to help them through a difficult period in their lives. The most direct program effects occurred in two cases of resisting physical and emotional abuse. Due to the information
participants learned from a counselor at the Battered Women's Shelter, the two young women were able to leave abusive relationships. The program directly affected the relationships of five participants. Planned Parenthood was the community resource most used by the participants. All who were sexually active as teens received health care at Planned Parenthood. The two participants who were pregnant as teens used the greatest number of community resources; moreover, these resources ultimately enabled these young women to become self-supporting and no longer in need of public assistance. Through guest speakers and volunteer experiences, participants learned about resources available to them in the community, for example, the Adolescent Pregnancy and Parenting Program. Volunteering gave them opportunities to learn job skills and to enhance self-esteem.

In regard to the health risk behaviors, behavior change has occurred with more responsible use of alcohol and responsible sexual activity. From a health education perspective, the health risk behaviors of greatest concern are inadequate diet in most and insufficient exercise of all. Sexism has been manifested in their lives--in the forms of discrimination, abuse, and violence. The women have opposed oppression through various strategies of resistance. Of the factors race, class, and gender, the most defining aspect of their lives has been gender.
This study purposed to expand our understanding of high-risk female adolescents and to evaluate the long-term impact of a dropout and pregnancy prevention program. Through the use of face-to-face, in-depth, retrospective qualitative interviews, this study examined participants' major life events associated with education, pregnancy, employment, and relationships. Participants' past and present health risk behaviors were compared, both individually and as a group. This chapter explains how this study supports results of similar studies and contributes to our knowledge concerning high-risk female adolescents and the impact of a model prevention program on their lives. Chapter V contains a discussion related to the literature review, conclusions regarding major findings, and recommendations for program development and future research.

Discussion

Participants' Perceptions of Program Impact. Collectively, the participants identified these five main program processes as having the greatest impact: (1) boosting self-esteem, (2) accessing resources, (3) supporting each other, (4) volunteering to help in the community, and (5) applying education. The program processes named by the participants were derived directly from and confirmed by the data. Exact participants' quotations may be seen in the data boxes [see Appendix G].

Boosting Self-esteem. Heightened self-esteem was evidenced as participants expressed feeling better about themselves due to volunteer experiences. Volunteering was
an important part of Teen Outreach because students learned that by helping others they could feel better about themselves. Volunteering produced feelings of importance as students felt wanted and needed, and when they realized that they were able to make a difference. Students were aware that volunteering involved doing good things, perhaps cultivating a sense of virtue.

Coopersmith (1967) found that virtue was a basis for self-esteem. Other theorists (Reasoner, 1982; Conrath, 1986; Holly, 1987) have proposed that self-esteem is enhanced by accomplishing goals, acquiring competence, and gaining power. Teen Outreach students gained power by choosing their volunteer jobs and setting their own volunteer schedules. They proved to themselves and their supervisors that they could keep their commitments and take pride in their work.

Findings of this study agree with Conrath’s (1986) application of locus-of-control theory. Teen Outreach gave students the opportunity to be externalizers, who have confidence in themselves and feel control over their own lives. Enhancement of self-esteem was accomplished by gaining confidence in their own competence. Students learned to set attainable goals regarding attendance and volunteer work. They fulfilled their commitments to volunteer jobs, so they experienced success, thereby elevating self-esteem.

Clemes and Bean (1990) theorized that models are one of the conditions for developing high self-esteem. Modeling, according to Clemes and Bean, is related to one’s ability to refer to examples that serve to help her establish meaningful values, goals, ideals, and personal standards. In Teen Outreach, adults working with teens—speakers, volunteer
supervisors, Junior League members—provided good role models and positive adult-teen relationships. The speakers were fine adult role models in that they communicated expertise as well as genuine concern. Agency supervisors modeled professionalism, offered guidance, and set reasonable expectations to be met in the workplace. Junior League members, who volunteered to make presentations, to provide transportation, and to serve as "coaches' to the students, related well with teens and modeled positive values. The facilitator also gave individual attention and modeled favorable adult-teen relationships.

Clemes and Bean (1990) theorized that adults could create experiences for young people that would provide the necessary conditions for the development of positive self-esteem, particularly connectiveness and uniqueness. Students experienced connectiveness through shared activities and group volunteer projects. They obtained a sense of their own uniqueness by discovering their talents and exploring special interests in volunteering.

The four basic ingredients of an esteeming environment (Mecca et al., 1989) were present in Teen Outreach. Students experienced belonging to a special group; their volunteer work contributions were significant, their efforts were recognized with praise, prizes, and awards; and they acquired competence when they mastered new job skills.

Accessing Resources. Unanimously students reported that guest speakers were an important part of Teen Outreach. Each recalled presenters and presentations of particular interest to her. Many of them revealed seeking help for personal problems as the result of information delivered by speakers. Half of them started to attend support groups, such as Ala-non and Alateen, or a group for students who were sexually abused.
Teen Outreach enabled teens to network in the community by making them aware of available services.

Clemes and Bean (1990) proposed that children are empowered by having the resources to influence the circumstances of their lives. In Teen Outreach students learned about the community services available to them, and transportation arrangements were made in several cases to enable students to obtain help.

**Supporting Each Other.** Students reported that Teen Outreach was a safe place where they felt comfortable and at home. Acceptance and trust were foundational to the framework of Teen Outreach. As students bonded through shared activities, togetherness formed friendships. In this non-threatening situation students did not have to fear judgment or rejection, so they could risk being themselves. The Teen Outreach environment was also protective in that it shielded them from harm. Teen Outreach provided a haven where for a few hours they were protected against being hurt. For some, the time spent in Teen Outreach prevented them from getting in trouble. Students had the assurance that Teen Outreach was there for them.

In terms of Maslow’s hierarchy of needs, the Teen Outreach students were, for the most part, existing at the primary levels, attempting to meet basic physiological and safety needs. Due to adverse home situations, as in poverty or domestic violence, many of them were struggling to obtain proper food, clothing, shelter, and rest. Since food was provided at Teen Outreach, teens were nourished physically as well as emotionally. As trust developed in a caring atmosphere they began to feel secure, to form friendships, and to sense that they belonged in the group.
Coopersmith's research (1967) indicated that a supportive environment involved interdependence in which each person depends upon others for support, friendship, and satisfaction of needs. The development of interpersonal skills (Glenn, 1989) was made possible by socializing in a supportive environment. Clemes and Bean (1990) stated that connectiveness results when one gains satisfaction from significant relationships.

Young (1990) considered a supportive environment to be a key component of the effectiveness criteria for alternative programs. He found that cooperation, mutual respect, and trust were encouraged in a family atmosphere. He stated that smallness contributed to informality and facilitated togetherness. Smallness allowed for closer relationships between teacher and student, as well as among students. Within a large mainstream high school with a student body of 1,600, Teen Outreach was a small group of 10 to 16 members, and because of its smallness there was little opportunity for students to "fall between the cracks." Teen Outreach's smallness, supportive environment, and concern for the whole student contributed to the development of a sense of community, which was fostered by having our own space, wearing Teen Outreach T-shirts, and doing special activities together. The mission of Teen Outreach was stated clearly in its two main objectives: to increase the graduation rate and to decrease the pregnancy rate.

Wehlage et al. (1989) found that effective alternative programs required performance within a supportive environment. Prior to joining Teen Outreach, students were interviewed and informed of the course requirements, and they also signed a contract in which they agreed to attend and participate 54 hours in nine weeks to earn one credit.
All students were expected to abide by the group rules or accept the consequences determined by the group.

Confidentiality was crucial so that students could share personal matters with the assurance that what they said would not leave the room. To my knowledge, that trust was not violated. [Students were informed that the facilitator was bound by law to report possible cases of child abuse and/or suicidal tendencies.] The students stated that they felt free to talk about real life concerns without being afraid of punishment or ridicule. Students were aware that they were not alone with their problems, that help was available, and that change was possible. As compared to more traditional classroom situations, students favored an informal setting and were aware that the circle arrangement created a sense of unity. They preferred relating to the teacher as a peer, rather than an authority figure.

**Volunteering to Help in the Community.** The findings of this study agree with the findings of Allan and Philliber (1990) in that the quality of volunteer work was significantly related to program success. My research supports the researchers' suggestion that in replication of the program, efforts should be made to make volunteer experiences meaningful.

The findings of my study also confirmed the conclusions of research by Allan, Philliber, and Hoggson (1990) which found that Teen Outreach sites were most successful which intensively implemented the volunteer component. Participants' reports at the Centertown site support findings by Allan et al. (1990), that Teen Outreach students all over the country reported that volunteer work was meaningful to them. There was also a
relationship between volunteer service and fewer behavior problems at the Centertown site (Philliber & Allan, 1988). Over and over students reported that by helping others they felt better about themselves--thereby reinforcing the helper-therapy principle and theory of empowerment cited by Allan, Philliber, and Hoggson (1990).

Through volunteering students found they could make meaningful contributions to their community. In individual volunteer job placements, feelings of achievement came from learning to do new tasks, for example, filing or running copies in an office. A sense of accomplishment resulted from mastering vocational skills, such as behaving appropriately and responsibly in a business setting. Students reported that volunteer work offered opportunities that generated feelings of competence and success.

Applying Glenn's (1989) significant characteristics of low-risk youth, volunteering gave students opportunities to strengthen their perceptions of personal capabilities and personal significance as they became involved in meaningful service to their community.

Applying Education. Students wanted to be informed about serious issues and to be treated as adults. It was crucial that information presented was actually useful in real life. They prided themselves in having a higher knowledge than their peers on these topics. For example, Teen Outreach began AIDS/HIV education in 1984, before it was offered in classes in Centertown School District.

Positive self-esteem was also improved by instruction and application of decision-making and goal-setting skills, important aspects of the Teen Outreach curriculum. Self-confidence, self-reliance, and self-respect resulted from making responsible decisions and reaching goals. The Teen Outreach curriculum concentrates on life skills training,
including values identification, problem-solving, and life-planning, providing learning experiences effective in developing intrapersonal, systemic, and judgmental skills believed by Glenn (1989) to be significant characteristics of capable, low-risk people.

Students liked being able to determine the structure of the group by suggesting topics, speakers, and projects that they wanted. They desired to be actively involved in program planning, as opposed to assuming a passive role as in a traditional class. Because they had say, they were involved, committed, and had ownership.

Glenn (1989) and Clemes and Bean (1990) concurred that power comes about when an individual has the capability to influence the circumstances of his or her life in significant ways. Teen Outreach students expressed that they liked having control in the group—setting rules, deciding on topics, speakers, and activities. They had power in determining the direction and structure of the program. They were able to exercise personal power in the Teen Outreach situation, thereby possibly leading to a sense of empowerment.

In general, these prevention program processes influenced immediate, short-term, and long-term program impact. Immediate impact [while they were enrolled in the program] was staying in school and no teenage pregnancy. Short-term impact was demonstrated in high school graduation, reduced teenage pregnancy, and some improved health-related behaviors. Long-term program impact was evaluated in educational achievement and overall wellness.

School Health Promotion Components and Outcomes. Kolbe listed eight components of school health promotion: school health services, school health education,
school health environment, integrated school and community health promotion efforts, school physical education, school food service, school counseling, and schoolsite health promotion program for faculty and staff. The Teen Outreach Program encompasses these three components: school health education, integrated school and community health promotion efforts; and school counseling.

**School Health Education.** In Centertown Public Schools, health education is integrated into the K-12 curriculum. Curriculum materials and videos were borrowed from the educational service district's (ESD) health education coordinator. At Multi High School, students were required to take one health education class, which contains a sexuality component. Sexuality, taught by the Centertown Public Schools' sexuality educator, focused on anatomy, pregnancy, contraception, and STD prevention. The sexuality educator was invited to Teen Outreach to speak on issues of concern to the students. Prior to her coming to the group, students wrote down their questions about sexuality and put them in a question box. When the sexuality educator came to the group, she answered the questions one by one. She was also a Teen Outreach Board member.

**Integrated School and Community Health Promotion Efforts.** Teen Outreach was integrated with community health promotion efforts by working cooperatively with organizations such as Planned Parenthood, the local hospital, Educational Service District, and the Junior League. Students' volunteer jobs were arranged through Volunteers in Action. Representatives of the following organizations were Teen Outreach board members: sexuality educators from Centertown Public Schools and Planned Parenthood, a community health educator from the local American Red Cross, the volunteer coordinator
from Volunteers in Action, the director of social services from the local hospital, the school principal, school counselors, and a Junior League representative. Monthly board meetings were led by the director of curriculum and instruction for Centertown Public Schools. Board members were guest speakers at least once a year so that they could see first-hand what the group was about. Representatives from community health organizations were invited to Teen Outreach board meetings to keep the board up-to-date about Teen Outreach involvement in their organizations. We also coordinated with national health promotion efforts, such as the American Lung Association's Great American Smoke Out and National Drug Abuse Prevention Week.

**School Counseling.** I coordinated Teen Outreach with school counselors in several capacities. Counselors referred students to me, and I referred some students to the counselors. If a particularly difficult or sensitive issue came up, I consulted with the counselors about how to best deal with it. Counselors were invited to make presentations to the Teen Outreach group, which also helped them feel good about referring students to the program. Sometimes counselors and administrators disclosed information about a student to me to assist me in helping the student.

School counselors had heavy caseloads--three counselors for 1600 students. With most of their time spent in academic counseling, there was little time left for helping students with emotional problems. Nevertheless, Kathy, Renee, and Sandy each named a particular counselor who helped her.
Conclusions

The lives of these young women reflect trends over the past three decades in the U. S. As a group, and as individuals, they have experienced first-hand what has happened in the context of the larger culture. Like the majority of youth today, their diet has been inadequate, mostly related to eating processed foods and fast foods, and their exercise has been insufficient. They have witnessed the dissolution of the traditional nuclear family. Their lives have been directly impacted by the rising divorce rate, incidents of violence, numbers of births to unmarried women, and increases in single-parent households. They have grown up in a youth culture in which sexual activity, alcohol and drug use, are the norm. As adolescents, all but one used tobacco, alcohol, and drugs. Everyone but two were sexually active and did not consistently use protection against pregnancy and STDs, despite sexuality education in school, nationwide television campaigns encouraging safer sex, as well as the efforts of the Teen Outreach Program. In the areas of sexual behavior and chemical abuse, the program seemed to make little difference. Even though they had the knowledge and the resources, still peer pressure and individual choice determined their behavior.


This study occurred around issues related to education, pregnancy, employment, and relationships. By examining participants' self-report data, patterns of program impact emerged.

Education. One of the Teen Outreach Program's two main goals was to increase the numbers of students graduating from high school. All students stayed in school when
they were enrolled in the program. All except one have earned a high school diploma or GED. All have attended at least one term at the community college, and one has a college degree. Although they have made progress in reaching their educational goals, still they are not adequately prepared to compete in the workplace. Except for the one who graduated from college, all have held low-level service jobs.

**Pregnancy.** The second Teen Outreach Program goal was to reduce the numbers of adolescents' pregnancies. Not one participant became pregnant while attending Teen Outreach. One was pregnant prior to enrollment in the program, and she became pregnant three times after she left the program. Two participants became pregnant at 19 and gave birth when they were 20. Following TO involvement, 13 pregnancies occurred among four participants, resulting in seven live births, three abortions, and one tubular pregnancy. Teen Outreach had immediate impact on pregnancy when they were involved in the program, but it did not seem to make a difference in short-and long-term impact.

**Employment.** Teen Outreach gave participants work skills and business experience. A variety of individual volunteer placements were tailored to meet individuals' needs. We attempted to match each job with the student’s talents and/or career interests. In this manner they were able to explore various kinds of work.

Learning about the job interview process was valuable in preparing students for the world of work. A recruiter from the local business college, also a Junior League member as well as Teen Outreach board member, came to instruct students in appropriate interview appearance and behavior. She also taught the students how to prepare a resume.
and fill out job application forms. Volunteering gave each one work experiences and references that she could add to her resume.

Jane said that she gained communication skills by giving presentations to Junior League, the school board, faculty meetings and other organizations in the community. Because she had volunteered at a nursing home, she was hired there as an activity assistant. Several of the participants said that volunteering gave them the confidence to go out and apply for a job. Many said that her self-esteem was improved by volunteering.

Relationships. Participants reported that the Teen Outreach Program impacted their relationships in two main ways by informing them about (1) dysfunctional families and (2) healthy relationships. For the first time Mary learned about dysfunction and codependency from speakers who came to the group. Both young women were raised by an alcoholic mother, and they did not realize that other families had problems similar to theirs. They learned how to access resources to get help for themselves, but to date neither has sought professional counseling to deal with these problems. Once Amy called a toll-free crisis line number, provided in Teen Outreach, but she hung up when her parents came home. Listening to how others with similar problems handled them helped the group members to feel that they were not alone. It gave them hope that others have survived.

Half of the participants similarly stated that in Teen Outreach they learned the difference between a healthy and an unhealthy relationship. Mary said that she was first attracted to David, the man who would become her husband, because “he seemed so normal.” Beth was able to break off a violent relationship because she was referred to the
appropriate resources. Renee recognized the warning signs of an abuser, and was able to leave that relationship before the violence escalated.

**Health Outcomes.** All the participants have experienced serious illness and/or injury requiring medical treatment. Half have serious psychological problems. Half have made suicide attempts. All have inadequate diets, except for the one with a minor in nutrition. Today, none has sufficient exercise.

**Key Finding.** The key finding of this study was that caring impacted participants' lives in meaningful ways. Participants expressed that they felt cared for and they learned to care for others, their community, and themselves. This cycle of caring is still an ongoing, dynamic, life-long process that continues to impact their daily lives and daily activities. Increased care for self, care for others, and care for their community created higher levels of self-esteem, which in turn led to higher self-esteem positively impacting individuals' actions, such as school attendance, academic achievement, and some health-related behaviors.

**Recommendations**

**Prevention Program Content Areas.** Of the health education 10 content areas, the Teen Outreach curriculum included seven content areas. I recommend adding three others—environmental health, nutrition, and physical fitness. Given that all had inadequate nutrition as adolescents, education regarding adequate nutrition, especially during pregnancy, should be included in the curriculum. Given that the majority of these
individuals had insufficient exercise when they were in high school, and not one exercises sufficiently today, adding a physical fitness component would be beneficial.

The "education part" was the component participants mentioned least. For the education component to have greater impact, I would propose that the curriculum be revised to make these important issues more relevant, engaging, and current. Strategies to engender resiliency traits should be integrated into the Teen Outreach curriculum. The Teen Outreach content and activities should be incorporated into the comprehensive school health education curriculum, K through 12.

**Teacher Preparation.** Teen Outreach programs should be staffed by professional, prepared, and licensed school health educators. School health personnel who are academically trained and licensed by their respective states are prepared to deal with the content and process of the Teen Outreach Program. Such individuals should hold CHES [Certified Health Education Specialist] certification.

Teachers must be able to identify risk factors as well as encourage protective factors in individuals. Those who teach high-risk youth should be adequately prepared to work with individuals with complex, multifaceted problems. Caring for self, others, and the community must be an essential component of prevention programs. All teachers should serve as positive role models for their students. Teachers must be aware of the power of their position to influence students' lives. Continuing education and professional certification should provide opportunities to fine tune techniques of caring.
Program Development. Understanding gained from this research may be valuable in developing and evaluating future prevention programs. The merits of volunteerism for all students should be acknowledged.

An awareness of social inequities must be cultivated comprehensively in the schools at developmentally appropriate levels. Information about sexism should be incorporated into the school curriculum. All children should be taught to recognize sexism, and they need to understand how sexism operates to harm everyone. Girls should be instructed in how to deal with sexism in empowering ways in their lives. Teachers, counselors, administrators, and staff should be educated about sexism and gender bias, and they should actively combat sexism in the school setting. A healthy school climate should be created in which sexism is not tolerated, each individual is valued, and all have equal opportunities to succeed. The value of community service must be further evaluated.

Funding. Funding should be made available to offer prevention programs to students at risk, as well as to all students. Werner and Smith (1992) recommended, "... some of the most critical predictors of adult outcomes are present in the first ten years of life. Our findings alert us to the need for setting priorities, to choices we must make in our investment of time and resources" (p. 208). As the incidence of abuse increases, prevention programs with life skills training should be offered to all students as part of the school curriculum. Funds should be made available for teachers to make home visits to bridge the gap between school and home, to form a partnership with teachers and parents.

Future Research. Further qualitative research is needed to assess the status of high-risk individuals for extended periods of time over the life span to determine specific
behavioral outcomes and program impact. Such studies may be timely and costly, but funding should be provided to researchers specializing in this type of inquiry, but in order for that to happen, societal attitudes regarding the value of qualitative research, the value of high-risk students, and the value of women should be changed. Qualitative research such as this study should be published in scholarly journals—particularly in the fields of education, health education, and public health—and made accessible to the public at large.
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## Preparing Youths For Adulthood

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<th>Work</th>
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Appendix B: A Priori Assertions
A Priori Assertions

My knowledge and experience as a teacher and a health educator predisposed me or would lead me to expect certain outcomes.
1. The participants from adverse home situations will tend to repeat the self and other destructive behaviors modeled in their dysfunctional families.
2. The only ones to succeed in not duplicating those negative patterns will be those who distance themselves both emotionally and physically, physically moving away or emotionally removing themselves from unhealthy situations.
3. Those who are teen parents will be heavy users of community resources.
4. Teens whose mothers were teen parents are more likely to be teen parents themselves.
5. I would assume that 10 years later, when they are in their late 20s, that all of these participants would have had sexual experiences by now.
6. If the parents smoked, then there is a greater likelihood that the children would also be smokers.
7. If one or both parents are alcoholics then there is greater likelihood that the child may have problems with alcohol.
8. I would predict that those whose parents divorced would tend to divorce themselves and those growing up in tumultuous households would be more likely to have home lives that would duplicate those conditions.
9. Those who experienced violence in their homes or were abused are more likely to abuse their own children and repeat those violent patterns.
10. I forecasted that the middle class young women, because by birth they have more advantages than working class women, would be the first to succeed in education and work, i.e., they would achieve higher levels of education and attain middle class white-collar jobs.
11. Those of the working poor or lower class will probably not rise above their social class and those who are middle class will remain middle class.
12. The ones whose parents have graduated from high school and college would be more likely to reach higher levels of education themselves.
13. Also those undergoing psychiatric care or counseling in order to deal with childhood traumas would tend to be better adjusted and more functional adults.
14. I think that they will probably be more self aware, perhaps more self asserting, better able to set limits and boundaries than when they were teenagers, and able to move on with their lives.
15. I felt that ones seeking treatment they would probably be more reality based than those who continue to deny the realities of their lives.
16. Of greatest importance, though, is that those who have gone through therapy would be less likely to hand down the pathology to the next generation.
17. I am also assuming that the ones that make a deliberate conscious effort to do the opposite of their negative parent models would be more inclined to have more fulfilling lives and healthy children.
Appendix C: Informed Consent Document
Informed Consent Document

The research project to be conducted by Tamara Lee Shaub of Oregon State University's Department of Public Health as a doctoral candidate has been explained to me. I understand that my participation in this research is completely voluntary. Further, I understand that if I agree to participate, I will:

1. discuss in narrative form my ideas, thoughts, and feelings regarding my participation in the Teen Outreach Program;

2. permit Tamara to use information from these sessions as long as my name is never associated with the materials; and

3. provide some personal information regarding pregnancy and education.

I further understand that:

1. my selection as a subject in this study has been solely on the basis of my participation in Teen Outreach.

2. all information is confidential and confidentiality will be insured by the use of assigned numbers;

3. I am free to withdraw my consent, along with all information shared to that point, and to discontinue my participation in the project at any time; and

4. any questions I have about the project will be answered.

On the basis of the above statements, I agree to participate in this project.

Participant's Signature

Investigator's Signature

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Date
Appendix D: Personal Data Form
Personal Data Form

Name__________________________

Date__________________________

Birthdate______________________

Date of high school graduation__________________________

Year(s) participating in Teen Outreach______________________

Address__________________________

__________________________

Phone #__________________________

Friend/
Relative__________________________

Address__________________________

__________________________

Phone #__________________________
Appendix E: Interview Cover Sheet
Interview Cover Sheet

The purpose of this study is to record the participant's life history and to see how the Teen Outreach Program has impacted participants' lives.

The oral history interview is conducted using open-ended questions. The first general introductory questions are:

Thinking back to the time when you were a teenager, how would you describe yourself?

Let's begin when you first turned 13 - - What were you like then?

Now let's talk about how you felt about yourself during your later teen years.

To obtain certain aspects of the participant's experiences, a series of categorized orienting questions are used.

Interview Questions:

Education
At the time that you were in TOP, how would you describe your academic standing? What were your grades like?
How did you feel about your reading skills? Writing skills? Speaking skills? Math skills?
Did you graduate from high school?
Were you the first in your family to graduate from high school?
Since high school, what has happened with your education?
What are your educational goals?

Work
Describe your job skills when you were in high school.
What kinds of work skills did you learn when you were in TOP?
Now what kinds of work skills do you have?
Where are you working now?
Where have you worked?
What other jobs have you had?
How have you supported yourself?
Have you had public assistance?
Where have you lived?
What are your employment/career goals?
**Relationships/social responsibility/awareness**
Have you maintained friendships with students from Teen Outreach? High school?
Describe the kinds of people who are your best friends.
How have your friends helped [or hindered] you?
What have your support systems been?
In what ways has your relationship changed with your mother? Father? Siblings? Step Siblings?
How has being a woman affected your life?
What's been happening with your relationships? Lover(s)? Boyfriend(s)? Husband(s) Partner(s)?
What's going on with your family?
How do you feel about yourself as a parent?
Describe your experience as a parent.
What is your relationship like with your child/children?
How do you discipline your child/children?

**Race, gender, class issues**
Tell me what you like best/least about being a woman.
What are the advantages/disadvantages of being a person of your in your community?
How would you define your social class? (working class, middle class, upper class)
What do you see as the advantages/disadvantages of being a member of your class?

**Health risk behaviors**
When you were a teenager, did you get sufficient exercise?
Did you get adequate sleep and rest?
What was your nutrition like?
Did you use tobacco?
How much tobacco would you say you used?
Did you use alcohol?
How much alcohol would you say you used?
Did you ever try other drugs?
Were you sexually active as a teenager?
What precautions did you take to prevent STDs?
What did you do to prevent pregnancy?
How long have you been smoking?
Have you used alcohol?
Can you describe how much you have used?
Do you consider yourself to be a drug user?
Do you or have you used other drugs?
If so, how would you describe the extent of your drug use?
What were your eating habits when you were in school?
How would you describe your eating habits and nutrition now?
Do you get what you consider to be sufficient exercise?
What activities do you do to exercise?
Now do you get sufficient sleep?
What community resources have you used?
How has access to birth control affected your life?
Have you been pregnant?
How many times have you been pregnant?
What have been the outcomes of your pregnancy/pregnancies?
How has having a baby affected your health? Your life?

**Personal growth**
In the past 5 years, what are you most proud of?
What are some of the obstacles you've faced?
When did you discover that you were special?
How have you survived?
What are some coping strategies you've used?
How would you describe your self-discipline?
Do you remember how you felt about yourself when you were in TOP?
Describe how you feel about yourself today.
Do you have any regrets?
Where do you see yourself 5 years from now?
What hopes and dreams do you have for your child/children?

**Teen Outreach Program**
Why do you think you were referred to the program?
Can you recall something you learned in Teen Outreach that has helped you?
Can you remember something in Teen Outreach that hindered you?
What do you think should be the characteristics of a Teen Outreach facilitator?
What suggestions do you have for improving the Teen Outreach Program?
In what ways has the Teen Outreach Program impacted your life?
Appendix F: Data Boxes
<table>
<thead>
<tr>
<th>Name</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renee</td>
<td>&quot;It boosted my self-esteem.&quot;</td>
</tr>
<tr>
<td>Amy</td>
<td>&quot;Making you feel OK about yourself.&quot;</td>
</tr>
<tr>
<td>Jane</td>
<td>&quot;Gave me a sense of self-worth. How you treated us. You treated us like we were worth something. You gave a lot of yourself to a lot of us. It gave me a piece of myself. It helped me explore who I was. I learned I wasn’t who my father said I was. I wasn’t who my teachers said I was. Teen Outreach laid a foundation of good. I’m a different person because of Teen Outreach. I’m a lot more confident in who I am and how I look than when I was a freshman.&quot;</td>
</tr>
<tr>
<td>Beth</td>
<td>&quot;It helped my self-image and self-esteem and gave me positive reinforcement. Instead of focusing on the negative, like some of my friends, it gave me a more positive whole outlook.&quot;</td>
</tr>
<tr>
<td>Kathy</td>
<td>&quot;Helping the less fortunate raised my self-esteem. It made me feel really good about myself.&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;. . . to work with the public building up your self-esteem.&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;Teen Outreach makes you a stronger, more confident person.&quot;</td>
</tr>
<tr>
<td>Sandy</td>
<td>&quot;I could be more natural, I could just be me.&quot;</td>
</tr>
</tbody>
</table>
| Mary   | Question: "When did you discover you were special?"
Mary: "When I volunteered tutoring a deaf girl, Jenny. Twice a week I’d go to her school and help her. I know sign language." |
| Renee  | "Regular praise, I mean daily praise for attendance or for whatever. Knowing that somebody thought that you were a good person or that liked you as a person. It was very important and you are pretty unconditional anyway. I get emotional. . . ." |
### ACCESSING RESOURCES

<table>
<thead>
<tr>
<th>Name</th>
<th>Quote</th>
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<tbody>
<tr>
<td>Renee</td>
<td>&quot;It impacted me by giving me valuable information and resources.&quot; &quot;All the information, I had so many resources from the time in Teen Outreach. I even to this day will go back and try and remember what did that person say about such and such, and oh, I remember that in Teen Outreach.&quot; &quot;I remember even to this day when Beth Winston came and talked about the Battered Women's Shelter. . . I remember her, she was probably one of my favorites.&quot;</td>
</tr>
<tr>
<td>Amy</td>
<td>&quot;Speakers letting us know resources.&quot; &quot;In Teen Outreach we had speakers and we talked a lot about alcoholism and dysfunctional families. I never talked about it. I even called one of those hotlines one time. My parents came home and I had to hang up real quick and act normal.&quot;</td>
</tr>
<tr>
<td>Beth</td>
<td>&quot;Speakers exposed us to a variety of issues.&quot;</td>
</tr>
<tr>
<td>Kathy</td>
<td>&quot;I learned about programs to tap into resources, like Adolescent Pregnancy and Parenting Program [APPP]. Teen Outreach opened a lot of doors for me. It put me in touch with my community.&quot;</td>
</tr>
<tr>
<td>Mary</td>
<td>&quot;I learned how to network and access resources, different people to help me when I needed it. I didn’t learn about these resources in my other classes. . . I called three places. I was trying to find a place to live so I could get away from my mother. I called First Love, CRC [Crisis Residential Center], and a crisis line. I learned about AA, Alateen, Alanon, and I went to some of their meetings.&quot; &quot;Suicide resource, not myself, but I’ve talked other people out of it-- Example of how Teen Outreach changed me. I would hook them up to people who could help them instead of trying to handle it myself.&quot;</td>
</tr>
<tr>
<td>Name</td>
<td>Quote</td>
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<td>-------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tbody>
</table>
| Mary  | "Teen Outreach was the major turning point in my life. I had a personal relationship with you and other students in the group."  
"I learned compassion. In Teen Outreach I sat and looked at these other kids that were in there with me . . . specially when I was helping out with the younger kids, I probably learned more from watching them from anything else. Just listening to their lives, it really showed me how common those kinds of problems are." |
| Sandy | "I learned that people can be there to help you when you are down. The Teen Outreach group was my second family since I had no family life."  
"I could just be me."                                                                                                                                 |
| Amy   | "I learned it's OK to be different and I learned to talk to different kinds of people."  
"Letting you know other people have problems and they've survived too."                                                                                                                                 |
| Kathy | "Support from you, support from students in the group, a strong group."                                                                                                                                 |
| Renee | "Sense of belonging, make sure you say that, that's important."  
"... just having support and someone available that you knew would stand behind you or support you or give you ideas or be your friend."                                                                 |
| Diane | "Being in the group made me more compassionate towards other people. Most of the people were troubled and had problems. I learned there was another side of people."  
"The thing that helped me the most was just the kind of people that were in the class, that you wouldn't normally talk to or hang around with. Because there were all different types in the class, I think helped stretch your thinking a little bit about people. You learned that they have feelings too and problems and just because they are not the way you are, necessarily doesn't mean they are not important." |
### VOLUNTEERING TO HELP IN THE COMMUNITY

<table>
<thead>
<tr>
<th>Name</th>
<th>Quote</th>
</tr>
</thead>
</table>
| Kathy  | "Before Teen Outreach I didn't have any job skills--just babysitting. After Teen Outreach I learned job skills like social work. I liked working with the kids, to daycares, nursing homes, Operation Santa Claus, worked with people. That gave me the confidence to go and get a job . . ."

"In a nutshell Teen Outreach gave me a sense of community. I felt more connected to people around me and not so egocentric. I learned about other’s needs and helping others. Teen Outreach was good practice for real life. Volunteering carried over later. When I lived by an elderly couple I offered to do daily-like things, like waxing the car, doing errands. I get pleasure out of helping people. People gave to me, so I’m giving back. Now I volunteer for Jonathan’s school. I’m a den mother for his Cub Scout troop. During the recent flood disaster I volunteered to help flood victims by delivering supplies to them. I volunteered at the co-op daycare at the community college. I’m a member of Amnesty International."

"We did so many different volunteer projects. It was like an introduction to a number of different jobs."

| Beth   | "I volunteered at the hospital for the kidney dialysis unit and part of my job was to help do clerical work. I made labels and I filed and things like that. I like it. I liked the atmosphere and I liked being there and it was peaceful."

| Sandy  | "Working with the dogs, it was almost like working with homeless children. You want to help them as much as you can and so that taught me to care about other people and other things. "I think it showed me a different life, going to the nursing homes and different places."

| Renee  | "I also had a volunteer job at the convention center. I learned how to use the coffee machine and how to make copies on the copy machine and how to answer the phone appropriately, but most importantly I think I learned how to be in the business environment. Those skills are extremely important and you don't learn them in school."
| Jane   | "Volunteering led me to other opportunities and gave me experiences, like volunteering at the nursing home helping with activities. Because I volunteered I got the job I have now. Teen Outreach emotionally prepared me for the job I have now. I'm an activity assistant at the convalescent home's special care unit--people with Alzheimer's and dementia."
           "I've been involved in AIDS education ever since Teen Outreach. I did AIDS peer education for the Red Cross. Now I volunteer with Care Bearers. We provide help for people with AIDS. I have a patient that I check in on to see if he needs anything. We do things like picking up groceries. I also do office work. I volunteered for World AIDS Day Dec. 1. They had a vigil at the cathedral. I put up the display."

<p>| Mary   | &quot;I volunteer at my church. I'm in charge of communications--doing the newsletter and bulletin board.&quot;  |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathy</td>
<td>&quot;The education part--we learned baby care, it helped me for taking care of Matthew.&quot;</td>
</tr>
</tbody>
</table>
| Beth | "I’m able to analyze situations. I learned there’s more than one way of looking at things. I can see things from another standpoint." {decision-making and problem-solving}  
   "I learned the difference between a healthy and a unhealthy relationship. My husband and I, I think that we have a healthy relationship." |
| Mary | "I learned the terms and signs of drug and alcohol abuse and codependency."  
   "Teen Outreach was the major turning point in my life. I tried to reach my goal of graduating from high school."  
   "I learned what made me a healthy person and not a sick person."  
   "I progressively lost abusing alcohol and drugs. It didn’t happen all at once." |
Beth

"I was involved in a relationship that was an extended relationship but when it started out it wasn’t abusive but not far into the relationship he started to be very abusive, verbally and not wanting me to be with my friends or go to classes and be very possessive and always wanting me to be with him and it escalated enough until it was physical. He would also get more violent but it didn’t require alcohol. He was to the point where it didn’t require alcohol but that just escalated it. I was 15, we were both 15, it was a really difficult situation and it finally escalated to the point that he was abusive to me at school and somebody saw it and that is when it began to end and he was expelled from school so there wasn’t the opportunity to see him at school anymore and also my mother forbade me to see him and it was very difficult to break off the relationship but with a lot of pressure and help from others the relationship was dissolved and I remember also that Tamara, you helped me by taking me to visit a woman whose name was also Beth, at an abuse shelter. I am not sure exactly now what her position was but that worked with abused women in abusive relationships and it was really helpful and insightful and since then I have gone on to have healthy relationships. It made me more aware of warning signals of violent men but it wasn’t really something that I ever thought about before because my parents had a healthy relationship and I hadn’t been around any type of abuse before so it was never something that I would have looked for in a man before. But afterwards especially as an adult woman even talking with friends or things like that it is something that I really keep in the back of my mind. I learned the difference between a healthy and an unhealthy relationship. As far as Richard was concerned I haven’t seen him for about 5 years, but we dissolved our relationship at that point and it was a big turning point in my life also where after that I started to make a lot of positive changes in my life."

OTHER COMMENTS

| Kathy   | "Teen Outreach was good practice for real life."  
|         | "I wouldn’t be the person I am today without Teen Outreach."  
| Jane    | "Teen Outreach also got me out of the house. We had some place to go besides home."  
|         | "I’m a different person because of Teen Outreach."  

Appendix G: Participants' Employment
<table>
<thead>
<tr>
<th>In High School</th>
<th>After High School</th>
<th>Today</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Amy McDonald's, Skippers, Dairy Queen, Navy</td>
<td>child care in home</td>
<td></td>
</tr>
<tr>
<td>2. Beth babysitting, waitress</td>
<td>WIC certifier, bank teller</td>
<td>insurance adjustor, State Farm Ins.</td>
</tr>
<tr>
<td>3. Diane hostess</td>
<td>receptionist, church</td>
<td>receptionist, radio station</td>
</tr>
<tr>
<td>4. Jane Albertson's, Penny's, B.Dalton Bookseller, Software, Etc, Convalescent Home, activity assistant</td>
<td>house manager, drug and alcohol treatment center</td>
<td></td>
</tr>
<tr>
<td>5. Kathy babysitting, McDonald's, daycare, community center</td>
<td>wineries tour guide, pizza parlor, bartender, Barnes &amp; Noble</td>
<td>film developer, photo lab; Reike instructor; Blue Green Algae, distributor</td>
</tr>
<tr>
<td>6. Mary pizza parlor, Albertson's, Avon</td>
<td>Penney's-sales; Red Lion-waitress, bartender, beverage manager; Montgomery Ward-drapery sales; film company-sold TV &amp; radio advertising; radio &amp; TV station, sold advertising</td>
<td>community educator, Citizen's Action Coalition (lobby to reduce TV &amp; radio advertising; radio &amp; costs for disabled)</td>
</tr>
<tr>
<td>7. Renee babysitting, busgirl</td>
<td>Burger King-cashier, bank teller, button designer, phone book distributer; waitress various restaurants</td>
<td>waitress, bar &amp; grill</td>
</tr>
<tr>
<td>8. Sandy cashier</td>
<td>Burger King-cashier, minimarts-cashier, fruitpicker, fruit warehouse; construction company-carpenter, winery</td>
<td>[in-training to be legal secretary]</td>
</tr>
</tbody>
</table>

Table G. Participant's Employment
Appendix H: Participants' Social Class
<table>
<thead>
<tr>
<th>SOCIAL CLASS</th>
<th>PAST</th>
<th>PRESENT</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Amy</td>
<td>WC</td>
<td>WC</td>
<td>Lives with family; babysits for relatives</td>
</tr>
<tr>
<td>2. Beth</td>
<td>WC</td>
<td>WC</td>
<td>College degree; professional position-insurance adjustor</td>
</tr>
<tr>
<td>3. Diane</td>
<td>MC</td>
<td>MC</td>
<td>Married middle class; husband-management position</td>
</tr>
<tr>
<td>4. Jane</td>
<td>WC</td>
<td>WC</td>
<td>Lives alone; activity assistant in nursing home</td>
</tr>
<tr>
<td>5. Kathy</td>
<td>MC/W</td>
<td>WC</td>
<td>Previously on welfare; single parent; manager of photo lab</td>
</tr>
<tr>
<td>6. Mary</td>
<td>WC</td>
<td>MC</td>
<td>Married into middle class; husband-management in corporation; works part-time for lobbying organization</td>
</tr>
<tr>
<td>7. Renee</td>
<td>UMC</td>
<td>W/WC</td>
<td>Used welfare assistance; married twice to working class men; now lives with working class boyfriend; works as waitress</td>
</tr>
<tr>
<td>8. Sandy</td>
<td>WC</td>
<td>WC</td>
<td>Married working class husband; now in training to be legal secretary</td>
</tr>
</tbody>
</table>

Past = Class of family; class by birth
Present = Class now

<table>
<thead>
<tr>
<th>WC</th>
<th>MC</th>
<th>UMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>W/WC</td>
<td>WC</td>
<td>W</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>UMC = upper middle class</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MC = middle class</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WC = working class</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W = welfare</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table H. Participants' Social Class