WHAT TEEN MOTHERS KNOW

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In the United States, low-income or minority populations tend toward earlier births than the more advantaged. In disadvantaged populations, one factor that may exert pressure toward early births is "weathering," or pervasive health uncertainty. Are subjective perceptions of health related to fertility timing? Drawing on a small sample of intensive interviews with teenage mothers-to-be, I suggest that low-income African American teenagers may expect uncertain health and short lifespans. Where family economies and caretaking systems are based on kin networks, such perceptions may influence the decision to become a young mother. Heuristic typologies of ways socially situated knowledge may contribute to the reproduction of fertility timing practices contrast the experiences of poor African American interviewees, working class white interviewees, and middle-class teens who typically postpone childbearing.

KEY WORDS: **African Americans; Culture; First birth timing; Mortality; Reproduction; Risk taking; Socioeconomic status; Teenage pregnancy.**

What can we learn from teen mothers? I have argued that population differences in fertility timing suggest strategic considerations (Geronimus 1987).[1] As a general rule, in the United States, members of minority racial/ethnic groups tend to begin childbearing at earlier ages than members of the majority white population, and within population groups, poorer women tend to begin childbearing at younger ages than

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the more affluent (NCHS 1995). Within identifiable population groups, views on appropriate fertility timing may be influenced by socially situated knowledge, by expectations about the cadence of life course demands or about norms of care across and within generations, and by structural and economic contingencies. These contingencies configure differently across population groups; within groups they may coalesce into distinct patterns of fertility timing.

The general socioeconomic or cultural factors that may influence variation in fertility timing distributions include grandparental expectations and patterns of involvement (primarily whether extended kin or grandparents are active versus symbolic caretakers) (Burton 1990; Geronimus 1987; Stack 1974); women's anticipated earnings profiles and labor market trajectories (Conrad 1993; Geronimus 1987; Jones 1985; McCrate 1992); and the social and economic role of fathers (Geronimus 1987; Stack 1974; Sullivan 1989). Another key factor in specific disadvantaged populations may be pervasive health uncertainty or "weathering" (Geronimus 1994). Expectations of premature illness or mortality may have complex effects on fertility timing, exerting pressure toward early fertility timing distributions. This is because of the relationship of adult health to interests in having healthy babies, the desire of parents to survive and see their children grow up, and ideal grandparental ages in populations where grandparents actively help rear children and children actively care for aged grandparents. (See Burton 1990 for an example of how norms of multigenerational caregiving lead to compressed generations in one local African American setting.) In communities where family economies and caretaking systems are kin-based, concerns about the health profile of kin are poignant.

With few exceptions, the empirical approach I have taken to studying "weathering" and its hypothesized role in shaping fertility timing distributions has been population-based and statistical. My colleagues and I have documented early health deterioration among African Americans along a number of dimensions (Geronimus 1994). For example, we estimated that, by age 45, roughly 50% of African American women suffer from chronic hypertension, facing four times the odds of being hypertensive relative to white women of the same age. Indeed, white women, on average, do not approach comparable levels of hypertension prevalence until old age (Burt et al. 1995). We have observed that patterns of infant health risk by maternal age vary across identifiable U.S. populations. For example, among whites, on average, teen mothers experience the highest rates of low-birth-weight babies and infant deaths, while among African Americans, fifteen- to nineteen-year-old mothers experience lower rates of these adverse outcomes than mothers in their twenties (Geronimus 1994). Our empirical findings also suggest that, among

African Americans, especially those residing in low-income areas, early health deterioration contributes to the increased risk of poor birth outcome with advancing maternal age beyond the teens (Geronimus 1996). Moreover, within populations, patterns of fertility timing correspond to maternal age patterns of infant health risk (with women more likely to have first births at the ages associated with the lowest infant health risk in their group) (Geronimus 1994).

These patterns suggest that women may time childbirth strategically, according to what they observe are the lowest-risk ages—not necessarily only in terms of measurable infant health outcomes, but perhaps also in a broader sense of peak maternal health and access to social support for which infant health may be a marker. But how does this happen? Are subjective perceptions or expectations of health or social support related to observed fertility timing patterns? Here, albeit in the context of the outlines drawn by the earlier statistical studies, I begin to address this question by drawing insights from a small set of intensive exploratory interviews with a select group of teenage-mothers-to-be.

I interviewed twenty-one minority (primarily African American) or white first-time mothers-to-be, each eighteen years of age or younger, in her second or third trimester of pregnancy, unmarried at conception, and recruited from one of two economically depressed locations, one in the rural south and the other in the urban north.[2] As a group, the African American interviewees tended to reside in areas in the bottom 15% of the mean family income distribution in their state. The white interviewees were somewhat better-off, tending to reside in areas in the bottom half. African Americans in poverty and relatively low-income whites are more likely than members of more affluent groups to become teen mothers, although the rate for impoverished blacks is much higher than that for working class or lower middle class whites (Abrahamse et al. 1988). Here I draw on these interviews as a departure point for considering what some of the factors may be that motivate young women in populations characterized by early fertility timing distributions to reproduce these patterns. What leads them to become young mothers?

It is common to construe childbirth occurring outside majority norms for timing or family structure as accidental or mistaken. Even my argument that early fertility timing can be adaptive in some populations has, at times, been interpreted as functionalist—that is, as conditioned completely by social structure and in the absence of personal agency. Through different lenses, all of these perspectives—those explaining teenage childbearing as purely accidental or misguided and the functionalist perspective—portray young mothers as passive. Instead, I wish to discuss early childbearing among low-income African Americans in the late twentieth century—a time period when major social resources

and cultural capital have been expended to stigmatize, punish, and prevent teenage childbearing—as a measure of active coping. Poor and minority youth constantly face social inequality that limits economic options and avenues for meaningful activity. Conditions of persistent poverty or discrimination might also undermine young women's faith in their continued health or longevity and those of the people they care for and depend on. In such circumstances, early childbearing can be seen as an attempt to solve problems posed by the complexities of the situation African American poor, teens, and their kin face. Such an analysis focuses on the binds and burdens that social systems create for actors, thus providing a "context for understanding actors' motives and the kinds of projects they construct for dealing with their situation" (Ortner 1984:152). By looking at differences patterned according to racial and class lines in some of the interviewees' reports, I hope to offer a glimpse of one set of possible ways that social and cultural systems are at once "powerfully constraining and yet . . . can be made and unmade through human action and interaction" (Ortner 1984:159).

Through this discussion, I try to illustrate how the dynamics of a woman's socioeconomic position may affect her decision about when to bear her first child and to emphasize that, even among African American teenage mothers living in poverty (perhaps primarily among them), age at first childbirth represents, if not a conscious plan or an unconstrained choice, a decision made and embraced. To do so, I focus on the ways in which the interviewees' reports suggest that the socioeconomic facts of their lives are fused with salient, personal or cultural values to influence fertility timing behavior (Geertz 1973; LeVine and Scrimshaw 1983). While other important considerations have been discussed elsewhere (e.g., Geronimus 1987), here I emphasize contingencies related to inequalities in health.

While some would argue that without a conscious plan to conceive, a teenager has not decided to become a mother, the terrain is probably more gray than that argument suggests. At the simplest level, the cascade of behaviors that result in early motherhood provide several junctures where becoming an early mother can be encouraged or avoided and where active decision-making may take place. In some sense these are obvious. The chances of becoming a young mother are affected by whether or not one is sexually active; if sexually active, whether one consciously tries to conceive or, if one does not plan a pregnancy, the measures one does or does not take to avoid conception; and finally, one's willingness to terminate a pregnancy. The likelihood that a teenager will take risks that can lead to a conception or will carry an "unplanned" pregnancy to term varies among population groups. This variation may reflect different personal, familial, or cultural predisposi-

tions toward early childbearing. That is, the teenager does not progress along the outlined continuum of repeated decisions and trade-offs in a vacuum. Her behaviors and decisions occur in the context of the models, values, expectations, responses, and anticipated responses of the elders and peers who are important to her.

This framework does not rule out the idea that an individual's participation in a collective's reproductive strategy may invite tension, contradictions, or personal costs. Often reproductive decision-making reflects trade-offs made based on the best available information about important considerations, rather than choices made among alternatives that are unambiguously attractive or unattractive. But this framework does imply that the nature or degree of risk that teens take when engaging in specific behaviors may be qualitatively distinct. Two different teenage girls who engage in "unprotected intercourse" are not taking the same risk, for example, if one has reason to expect that her mother will accept and support the pregnancy that may result while the other knows her mother will find a pregnancy intolerable and refuse to provide any practical or moral support should she consider carrying the pregnancy to term. A teen's decisions and the (anticipated) reactions of important members of her social network may, in turn, reflect their socially situated knowledge of broader contingencies such as those on which this paper focuses. That is, they may be mechanisms through which socially situated knowledge is translated into fertility timing patterns.

Although I draw on reports of teen mothers-to-be, the current formulation remains largely theoretical and simplified—more of a thought experiment than a research report. I consider three groups: African American low-income interviewees; white, somewhat economically better-off interviewees; and middle-class teens who postpone childbearing. I combine evidence that these three groups hold different perspectives on the age deadline for a woman to complete childbearing with evidence from an earlier paper that their pregnancies (or, for the middle-class group, nonpregnancies) are embedded in different family caretaking systems. These different caretaking systems require of them greater or fewer caretaking responsibilities in childhood and affect their expectations about whether their pregnancies will be tolerated within the system and about who will be responsible for the care of their children, and under what circumstances (Geronimus 1992).

Please note that I did not interview the middle-class teens. I approximate their perceptions of the age deadline for women to complete childbearing by drawing on survey evidence from a random sample of the Chicago metropolitan area, which appears similar in composition to the U.S. population and is therefore socioeconomically better-off, on average, than either the African American or the white interviewees

(Settersten 1992; Settersten and Hagestad 1996). In addition, for the purposes of this thought experiment, I draw the inference that the middle-class teens generally accept the dominant U.S. ideal that childbearing should be postponed beyond the teen years, and can be postponed considerably longer, from the fact that they typically do not become teen mothers. I further assume that they believe childbearing best occurs in a nuclear family, preferably marital, context from the fact that most middle-class women have marital births (NCHS 1995). Because I am making assumptions about this group, and because I conducted only a small number of intensive interviews with members of the other groups, the formulations I present are intended to be heuristic.

PERCEIVED CHILDBEARING DEADLINES

I asked the teen mothers-to-be when they thought a woman should stop childbearing. Consistent with the actual fertility timing patterns of their demographic group, the African American interviewees (who, in this sample, primarily came from extremely socioeconomically disadvantaged backgrounds) gave answers ranging from twenty-five to the late thirties, with most answering that about thirty was the age by which a woman should complete childbearing. They tended to suggest upper bound ages that members of other sociodemographic groups might view as appropriate ages to *begin* childbearing, and certainly that fall comfortably within the distribution of childbearing ages, rather than at the tail. In a world where advances in reproductive technology are pushing the biological limits of childbearing through the early forties without much social eyelash batting, and sometimes into the fifties and sixties with moderately more social eyebrow raising, it may seem unusual to view 25 or 30 or even 35 as the upper limit for childbearing. Indeed, survey responses by the random sample of residents of the Chicago metropolitan area show that only 5% perceived the deadline to be less than 35 years old (with only 1% answering less than 30 years old), while almost 60% pegged the deadline at age 40 or above (Settersten 1992).

The reasons given by these interviewees to support their view imply a different understanding of how old one is at 40 or 50 than more mainstream notions of these ages as part of the prime of life or, at worst, middle. *"[A woman should stop having children by age] 32, because if you get too old, it will be hard on you. Sometimes you can't take it,"* said one young mother-to-be with compassion for her mother's generation. *"Well, the way I look at it, I think [a woman should stop at] 30. If you just got married and you really want a baby, 35 is okay but I wouldn't recommend it. When the kid's 10 and still needs a lot of attention, really hasn't grown up, then she's already*

45. And then, here she is 50, and the kid is like an adult, but she could be dying. So, I think 35 is too old," argued another. Note here that the "kid" who "is like an adult" is fifteen years old, not like an adult by mainstream standards. But her fifty-year-old mother is seen as facing a nontrivial risk of dying, also unlike the mainstream view. This perspective on age was repeated in others' responses: *"Some people wait until they are 35. I don't think they should, 'cause you only got a few more years, you know,"* opined an interviewee, further suggesting that even if the mother who has continued childbearing beyond age thirty doesn't die, she will certainly become "old" during her children's childhood: *"Your kids will see you old and stuff when they get older."* A similar point suggesting not only early aging, but also peer-maintained social norms against having middle-aged parents, was raised by another interviewee. She said, *"[A woman should stop by age thirty] otherwise they be old. Like old, old parents. Other kids will say 'She's your mother? She so old!'"*

Related understandings of the parameters of "old age" and its implications for caretaking are seen in others' answers. One interviewee projected concern for the care of the child in the face of expected patterns of adult illness:*"[A woman should stop having children by her late thirties] because she can raise the child until it get 'bout my age [16], you know, and if she get sick or something the child'll be almost grown at least. Be able to be on its own if something happened to the parent. [Otherwise] by the time you get fifty you'll have a ten-year-old and if something happen to you, somebody would have to take care of the child."* Another evidenced an understanding of the need to have children early enough to ensure that they are ready and able to take care of their mother when her health falters: *"[A woman should stop by about] 33. By that time [if you had your children younger] your children could be growing up. They can start taking care of you."* This answer echoes others, that to postpone childbearing to later ages would be to miss the opportunity of having in-house support when it's needed. And it suggests that such support may be needed as early as the mid-thirties.

A particularly poignant and pointed response came from an interviewee whose answer revealed the conflict between the middle-class notion that one should postpone childbearing until one has achieved greater maturity, knowledge, or wisdom than exhibited by youth and the notion, voiced so often in these interviews, that to postpone childbearing is to risk compromising one's ability to care for children due to rapid aging, incapacitation, or mental stress. *"[A woman should stop] 'bout 30. They're too old. They have bad nerves and everything. She wouldn't be as fast as she was. She would* ***know*** *a lot, but she wouldn't have the nerve to do it anymore."*

In contrast, the white lower middle class interviewees were more likely to give the late thirties as the cutoff age for childbearing or to say

that the cutoff age depends on the individual or situation. While several rationalized their answers by appealing to health considerations, these considerations tended to focus on pregnancy risks to mother or child. *"[A woman should have her children] by 35, because after that I heard that you run into a lot more physical difficulties when you're pregnant when you're older,"* said one. *"[A woman should have her children] by the late thirties. [After that] you'd feel scared that it might come out with like some kind of birth defect,"* offered another. A third said that a woman should stop childbearing by *". . . about 30, 'cause it's dangerous. Having a kid (after that) could harm you or hurt you."*

As a group, these white teens sounded considerably more abstract and vague in their answers than the poorer African American interviewees. Unlike the view that one is old in her forties and may well be dead by fifty, the views of pregnancy risks expressed by the white lower middle class interviewees were ones they had heard about, rather than experienced directly; and they are health risks that are widely viewed, among the middle class, as increasing with age in the late thirties, in some cases dramatically. Still, they preferred a younger age cutoff than the majority of the more affluent Chicago survey respondents, who perceived the age deadline for childbearing at or above forty (Settersten 1992). (See Figure 1 for a summary of the variation between groups on perceived deadlines for childbearing.)

The white interviewees were as likely to emphasize psychological distance between mother and child as a problem for older mothers as they were to talk about health risks as the primary reason they believed women should stop bearing children by age forty. They tended to become more engaged with and animated in their answers when talking about psychological distance. *"I'd say [a woman should have her children by] about late thirties. Older than that would be a mid-life baby or something. They might be too old psychologically for the child. Not know how to handle their child anymore,"* answered one. *"[Women should have their children] before they're forty. The body changes. The person changes. When you're that much far apart, the age difference, I think, it's hard to associate with your child. The times have changed so much that you're not on the same agreement,"* argued another. *"[Women should stop having children] in their thirties. Most kids feel weird if their parents are old when they go to school. You know, they're like sixteen and their parents are in their fifties. You know they feel weird,"* said a third, confidently. And one white interviewee answered that it would depend on the individual. *"[When a woman should stop having children] I guess would depend on the woman,"* she said.

The whites noted that older parents would not *know* how to handle their children and would not be on the same emotional or psychological *wavelength*, but they did not express particular concern about physical

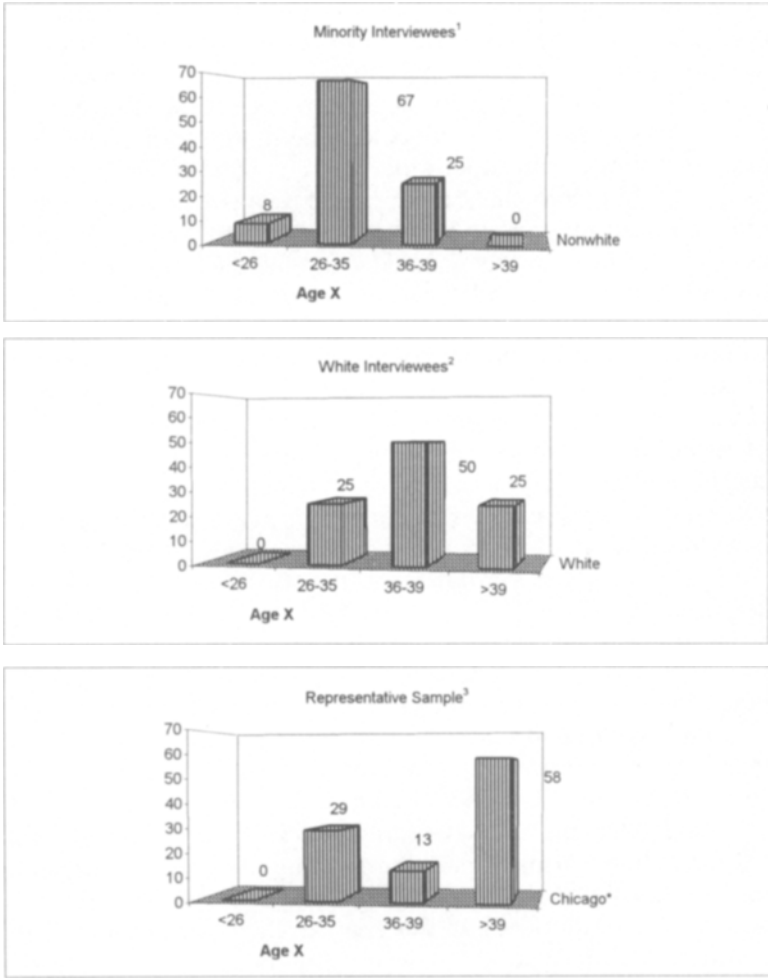

Figure 1. Percent of respondents reporting age X as the deadline for completing childbearing

1. Based on reports of the twelve minority interviewees who answered the relevant question.
2. Based on reports of the eight white interviewees.
3. Representative of the Chicago metropolitan area (data from Settersten 1992:Tab. 3-17).

limitations. Unlike the African American interviewees, the white interviewees suggested that they thought more about the health risks specific to pregnancy than about those associated with life in general. This contrast itself may imply that the social world of the white interviewees was

less likely to be permeated with health uncertainty than that of the African American. The white interviewees were more able to concern themselves with questions of psychological distance or aging—what one referred to as the "weirdness" felt by teenagers who have older parents. In this sense, they were able to be more "adolescent" in their thinking than the African Americans, identifying with the children rather than projecting into the experience of women at older ages. The African American mothers-to-be suggested that to wait might mean to orphan your child or leave yourself overwhelmed with the stress of coping with childrearing and "bad nerves" or without care in your "old age." One nineteen-year-old low-income African American mother whom I interviewed in another context had made object lessons of her older sisters: *"My 34-year-old sister is dying of cancer. Good thing her youngest child is 17 and she seen her grow up. My 28- and 30-year-old sisters got the high blood and sugar. The 30-year-old got shot in a store. She has a hole in her lung and her arm paralyzed. Good thing she had Consuela long ago. My 28-year-old sister wants a baby so bad. She had three miscarriages and two babies dead at birth. Doctors don't think she can have a baby no more. All my sisters weigh 250. I bet you wouldn't believe they looked just like me at my age. I'm sure I'll look like them when I'm old."* The lesson she drew from her sisters' experiences was that early childbearing can have benefits, while to postpone, even to the mid-twenties, comes with increased risks, running the gamut from involuntary permanent childlessness to lack of physical ability to keep up with your children to dying before they are grown.

Other African American interviewees also appear to have drawn lessons from their daily experiences that may have influenced their fertility timing. As I have reported (Geronimus 1992), these young women viewed early childbearing as part of a permanent experience of family as a multigenerational extended kin network (Burton 1990; Stack 1974, 1996; Stack and Burton 1993). In this context, they had first-hand experience with child care and with concern for the needs of aging family members. Sometimes these concerns were fused. For example, one interviewee described some of the circumstances in which she had taken care of babies and young children in the past. *"I love kids. . . . Where I live at now, my grandmother got custody of three other little kids. . . . I let her go out to church because the kids be worryin' her, and she's so old, and she gets sick of that house, and she don't know nothin' else to do but yell and fuss. So, I keep the kids while she goes out."*

This description reveals her desire to protect her grandmother and the young children, as well as her awareness of the mental stress that taxes older poor women who care for young children. Her experience (including not only what she has done, but also what she sees around her in her perceptions of her grandmother's daily life) may be providing incentives

toward early childbearing, to avoid the strain of caretaking at an older age and, perhaps, to provide caretakers for herself as she ages.

In this sense, fertility timing decisions can be seen as steps in what Ortner (1984) describes as a larger developmental project. Becoming a mother usually implies a long-term commitment of some sort to participate in the actual development of another human being. It may be hard to imagine a teenager taking account of whether she has the physical ability to participate for the length of the project or considering whether the specific timing of the project affects its value as an investment in her social security. Yet, under economic circumstances where social capital is experienced as the most, perhaps only, reliable capital, and where this capital is physically limited and may have an early expiration date, these considerations may not be so peculiar. The rationales offered for the importance of completing childbearing at relatively early adult ages suggest that future health considerations and possible dependency needs may, indeed, exert pressures toward early fertility timing.

The interviews contain other more direct evidence that experience with early death or disability informed the pregnancy resolution decisions of these interviewees. Not only were they concerned about their own health or longevity and that of their female kin, but some also showed evidence of being painfully aware of the compromised life prospects of their boyfriends. The most dramatic case is revealed in the way one interviewee described her boyfriend's influence on her decision to carry the pregnancy to term. *"When I told him (I could be pregnant), he had gotten shot and he was in the hospital. He got shot while sittin' in the movie theater. They didn't know if he was going to live or not, so I went to the hospital. . . . I told him that I was pregnant, that he couldn't die. . . . He said, 'I can't die because I'm having a baby. Don't do anything to my baby. . . .' Before he had known that I could be (pregnant), but I guess I just needed him to know that I was. That he had to live for somethin'.*

[That influenced my decision to carry the pregnancy] because I felt as if somethin' happened to him, that he did leave somethin' behind. Even though I just wanted him to live so bad, I had to realize that he could die."

The unreliability and relatively low level of male employment or wages has been discussed as one reason poor African American women may be more likely to have nonmarital births and to invest more in the development and maintenance of kin networks than in marriage (Wilson 1987). Early childbearing itself has been discussed as one form of investment in kin network development (Stack 1974; Geronimus 1987, 1992). Theoretically, one can also imagine that concerns about men's survival would provide an impetus toward earlier childbearing and investing in kin network-based childcare systems above nuclear family units. That is, the impact of high levels of premature male mortality may

be another important way that population mortality contributes to reproductive decisions.

MORTALITY TRAJECTORIES IN POOR AFRICAN-AMERICAN POPULATIONS

Are the interviewees' voiced perceptions of the likelihood of early death or poor health exaggerated? I have already noted that descriptive analyses of national data for African American and white women of reproductive age suggest excess and relatively rapidly increasing rates of hypertension among African Americans (Geronimus 1994). Similar disparities are apparent for other health indicators. For example, almost half of African American women in their thirties are obese, while white women do not reach a comparable level until their fifties (Kuczmarski et al. 1994). In middle age, diabetes prevalence is 30% greater for African Americans compared with white women (Hadden and Harris 1987). Racial differences by age in unhealthy levels of circulating blood lead are also great and increase over the reproductive ages (Geronimus and Hillemeier 1992). In addition, variations in women's or men's mortality profiles between U.S. populations are clear, with profiles being quite severe for those living in some persistently low-income African American communities (Geronimus et al. 1996).

I do not have data for the specific geographic areas in which these interviewees resided, but the following findings for Harlem and a poor, predominantly African American part of Alabama in the black belt region (named for its sticky black clay soil) suggest that it is reasonable for young African American women residing in low-income areas to have doubts about their own survival through middle age, as well as the survival of the potential fathers of their children. Table 1 shows, for U.S. whites and for African American residents of Harlem or black belt Alabama in 1990, the probability that a woman or man who lives to be fifteen years old will survive to age 45, 55, or 65. While African Americans in the black belt Alabama population fare better than Harlem residents on this health indicator, they fare worse than the white average. The disparity between the white average and the survival experience of Harlem residents is striking. While 95% of white women survive to their fifty-fifth birthday, only 78% of Harlem women survive. More than one-third of Harlem women die by age 65. For men, the statistics are more grim. Only 71% survive to age 45 (compared with 94% of U.S. whites). Only a little more than half of Harlem men can expect to survive to age 55, and almost two-thirds of Harlem men who reach their fifteenth

Table 1. Probability of Surviving to Age X Conditional on Survival to Age 15 in Selected Populations, 1990

Age X	*U.S. Whites*	*Black Belt Alabama*	*Harlem*
		Women	
45	.98	.95	.87
55	.95	.89	.78
65	.87	.77	.65
		Men	
45	.94	.91	.71
55	.89	.79	.55
65	.77	.63	.37
Percent of First Births to Teenage Mothers	20	50	40

Note: Mortality calculations by Geronimus et al. (1996) using data from the U.S. Census (adjusted for coverage error) and from death certificates; percent teen births are tabulated from birth certificates and rounded to nearest 10%; Harlem refers to African American residents of the Central Harlem Health Center District in New York City; black belt Alabama refers to African American residents of predominantly black, rural counties with persistently low mean family incomes in western Alabama.

birthday will not live to see their sixty-fifth. These distressing findings are consistent with the view expressed by several African American interviewees that community members have reason to be concerned about their survival beyond age 50.

For heuristic purposes, another way to read Table 1 is to look across the three populations on the diagonal. Doing so, one sees that, among women, the probability of survival to age 65 for U.S. whites (.87) is comparable to the probability of survival to age 55 for African Americans in black belt Alabama (.89) and to the probability of survival to age 45 in Harlem (.87). From such figures, one might infer that common sense notions of age 65 in the majority population might provide some purchase on how ages 55 or 45 are viewed in the poor African American populations. Among men, this thought experiment requires a little modification. While survival probabilities for U.S. whites to age 65 (.77) and black belt Alabama African Americans to age 55 (.79) are comparable, the probability of surviving to age 45 in Harlem (.71) is *lower* than the probability of surviving to age 65 for U.S. whites.

The final row of Table 1 shows the percent of first births to teenage mothers in each population. Of first births in 1990, 40% and 50% were to teen mothers in Harlem and black belt Alabama, respectively. These

represent far greater proportions than the 20% of U.S. white first births that occurred to women less than 20 years of age.

TYPOLOGIES OF FERTILITY TIMING: LINKS TO FAMILY CARETAKING SYSTEMS AND ECONOMIES

In an earlier study of these interviews, I perceived a relationship between the extent of a young woman's previous childcare experience and early fertility (Geronimus 1992). The primary finding was that, in contrast to popular stereotypes about the inexperience of teenagers who become mothers, the majority of the interviewees had extensive infant and childcare experience prior to their pregnancies. However, some differences in the nature of those experiences were suggested between those interviewees who were African American and poor and those who were white and slightly better off. I wrote:

> . . . For the white interviewees, previous childcare experiences tended to be expanded versions of conventional babysitting . . . the interviewees served as "child care assistants." This assistance might take place under the supervision of their own mothers, or within actual work (day care) settings. Instances of greater responsibilities were limited to extreme situations where they "stepped in" as mother surrogates for individual babies, when the biological mother was incapacitated (e.g., in the hospital or an alcoholic). In contrast . . . every nonwhite interviewee (with extensive childcare experience) reported having helped raise other children. They reported having spent very large proportions of their daily lives . . . around the clock, caring for children. These responsibilities went well beyond simple babysitting. . . . Often these activities began at a young age. Their narratives also (suggest) . . . that they were socially expected to play major roles in care giving . . . (and that) they are enthusiastic about and take pride in their caregiving responsibilities (1992:324).

I noted further that the African American poor interviewees expected to have the most help in raising their children. They, themselves, had been raised in extended families and expected, in turn, that their families would incorporate their infants. Kin would assume major caretaking functions, up to and including custody. None had plans to legally marry her baby's father or to move into an independent household with her baby. In contrast, the white, better-off interviewees clearly identified themselves as expecting to be the primary (sometimes exclusive) caretakers of their infants. They reported that they could count on family members to watch their babies for specific purposes, such as attending school. Some planned to extend their nuclear families of origin tempo-

rarily through their babies' births by remaining in their parental household for a time period, sometimes along with new husbands; others had already launched or expected to launch independent nuclear family households (on their own or with husbands).

Growing up in a multigenerational, extended family does not occur arbitrarily or at random. Structural factors (perhaps including concerns about early death or dependency) as well as cultural traditions predispose some populations toward undergirding family economies and caretaking systems with such networks. Stack (1974) illustrated how extended family structures can provide critical social insurance against the high risk of severe income shortfall in poor African American communities. In addition, comprehensive paid day care is often unavailable to or unaffordable for poor families (Kamerman and Kahn 1995; Stack 1996). Yet, childcare is needed for working mothers of young children. When mothers need to work at wage labor, then, relying on available (unpaid) kin to watch children is a common strategy (Parish et al. 1991; Stack 1974). Thus, another factor that may predispose members of such communities toward early births is the attempt to calibrate childbearing with available care systems and with optimal work opportunities. Early childbearing may enable new mothers to care for their children during the time when their work opportunities are the smallest or offer the least penalty for labor market absence (Conrad 1993; Geronimus 1987). Bearing children as teens may also permit them to become more permanently attached to the labor market at an older age. Then, their children will require less constant attention than infants or very young children, and they may be able to "help out" and manage increasing amounts of household tasks and responsibilities as the years progress. Among these responsibilities, older children and adolescents may be recruited for the kin work of meeting the demand for childcare for working mothers (Stack and Burton 1993). This responsibility sounds onerous for an adolescent, and surely, at least sometimes, it must be. Yet, alternative uses of time may be circumscribed or experienced as more onerous or less rewarding. Educational experiences may be of poor quality, dehumanizing, with questionable value, and even dangerous (Kozol 1992); opportunities for achievement are more generally restricted; jobs are scarce or dead-end (Blank 1995).

In fact, most of the interviewees were in a position to make direct comparisons. While a few of them described how the activities of motherhood would fill a void in their lives, more often the lives of the African American interviewees prior to becoming pregnant were already busy with school, jobs, and major home responsibilities. Not only had they had substantial infant or childcare experience, but despite being so young, most had held at least part-time (in some cases, full-time) jobs.

They often moved between jobs, when work became too boring or offensive. These four vignettes are illustrative:

> "I was about twelve [when I worked at my first job] and I lied [about my age]. I have had plenty of jobs. I would be at one for a while, and then I just got tired of doing the same thing, so when the next one called me, I'd just go on. Most jobs I worked eight hours (a day); I worked 3–11 one time, then I worked 7–3 at one point. I had 7–3 at one job and it was hard for me to go to school. So I said I'll go to night school and I could still go to work, daytime. Then I went to night school for three nights, and the night job called and said I could work 3 to 11. So I quit the day job and went to the night, 3–11, and I went to school in the day time."

> "[I worked since I was fourteen at an international fast food chain. After a year and a half] I left because the new manager thought that she was gonna have us do unreasonable jobs. I've never scrubbed trash cans in my life! I've sprayed them down with a hose, you know, to keep them clean, but I wasn't about to jump in a trash can and scrub it down."

> "Since I was about five I did errands. You know, doin' errands for people and they give you a quarter. And, then, in sixth grade . . . [I started house] cleaning. That lasted . . . almost four years. . . . [More recently, I had to] stand and cashier. It's very humiliating. A lot of customers come through and . . . they're very rude . . . and they treated you just like a dumb cashier. 'Cause anybody can really be a cashier but . . . it made you mad because they treated you like a nitwit. So, I was glad to get rid of them."

> "[My first job was at a fast food restaurant] when I was fourteen. I told them I was sixteen. . . . I left [the restaurant] because I couldn't stand the cockroaches. Cleaning the shake machine was just too much for me. So, I left because of the bugs, I just couldn't stand the sight of it anymore."

These young women are industrious, combining work and other activities from an early age. Their accounts of their behavior are inconsistent with some popular views that teenage childbearing occurs among urban teenagers who are idle and without ambition. That these teens do not appear to see a point in sticking indefinitely with any one particular job in the face of humiliation is consistent with economic analyses. Such analyses suggest that the labor market opportunities of African American low-income women have become increasingly stagnant. Such women can expect relatively flat earnings profiles and advancement opportunities (Blank 1995). And Blank (1995) notes that job placement officers working with poor women indicate that their clients perceive few advancement opportunities, a perception also described in intensive interviews with poor mothers deciding whether to continue low-wage employment (Edin and Lein, in press). The interviewees might have little reason to remain attached, without break, to menial, often humili-

ating, low-wage jobs if the acquired seniority or work experience will not translate into better jobs.[3]

In contrast, childcare activities may provide inherent challenges and joy. Even the unpleasant or trying aspects can be accepted as parts of a larger dignified project. And the challenges and joys of childrearing may be emphasized in a community committed to extended kin network systems. (This is not the case in middle-class, nuclear family–oriented communities, where the difficulties of and negatives associated with childbearing are selectively highlighted for middle-class teenagers or in teenage pregnancy prevention campaigns.) For poor teenagers, childcare may be considered meaningful work in and of itself (Geronimus 1992). This is suggested by the enthusiasm with which many of the African American poor interviewees described their previous childcare experiences. They did not see childrearing as the exclusive province of the biological mother, or as an inappropriate activity for children. These views are consistent with observations made by ethnographers in several low-income African American settings (Stack and Burton 1993).

Together, these social realities and values pave the way for children and teenagers to have important childcare responsibilities, and even for the social expectation that they do. In fact, in populations faced with restricted educational and labor market opportunities as well as highly uncertain health or longevity, parenting strategies that emphasize multiple caretakers may be economically sensible and desirable on broader grounds. For example, the development of a strong primary attachment to one's mother (or mother surrogate) may be a prescription for psychological distress in populations in which children and mothers can expect to be separated, either because of the unrelenting nature of women's work responsibilities (Jones 1985), or as a result of migration (Stack 1996), or possibly because of premature disability or death (Geronimus 1994; Geronimus et al. 1996; and see Table 1).

Poor African American teenagers, then, make decisions about fertility timing against a backdrop that differs from the one that middle-class teenagers face. In many ways this backdrop is rife with constraints—few alternatives for meaningful work in the larger social system and highly gendered family or cultural pressures to engage in informal domestic labor. But in coping with these constraints they may have garnered extensive childcare experience, expectations of kin support, and relative maturity with respect to decision-making and economic independence from their parents. And within these constraints, through their decisions to become mothers at a young age they may also embrace the chance to perform meaningful work—work that is intrinsically engaging, future-oriented, and likely to provide some security.

Turning to the middle class, teenagers typically expect access to high-quality and advanced educations, opportunities for financial security and rewarding careers, and long lifetimes. Under these circumstances, a parenting strategy that includes a primary caregiver, who enables her child to concentrate on extra-domestic responsibilities, and with whom the child develops a strong attachment, is a supportable approach that is likely to be rewarded. This approach may be expressed or supported by the view that childcare is not the province of children or adolescents but is, instead, the project of the mother or her (adult) surrogate. Such an approach is viable when families are able to operate on one income or, if both parents work outside the home, when day care is available and can be purchased. It works when adolescents are not needed to contribute to family economies or caretaking systems and when they are engaged in other interesting activities that are seen as higher priority. These activities may be instrumental in exploiting the opportunities for achievement that are more readily available to members of the middle class than to the socioeconomically disadvantaged. Finally, this approach works when members of a group are able to sustain what Hagestad (in press) refers to as an "unspoken premise of everyday plans, ambitions and evaluations in our society," that is, when a group can assume a predictable future with death far off in its "logical position . . . at the close of a long life" (Blythe 1979, cited by Hagestad in press).

The white lower middle class interviewees offer an interesting middle ground. Through their reports and actions they revealed a general preference for nuclear families, but also the willingness of those families to become extended temporarily, under certain circumstances. Temporary extension can be seen as a coping mechanism for addressing finite but real burdens faced by individual families. While the ease with which families became temporarily extended suggests families expect to experience these specific burdens from time to time, their retreat back to nuclear family forms between extension episodes suggests an ideological commitment to the nuclear family form. It also suggests that such burdens may be less chronic or unrelenting than those expected among African American poor families. In this context, the unplanned pregnancy of an adolescent may be seen as a problem that needs to be coped with but that is a tolerable problem. The African American interviewees were less likely than the whites to report that family members viewed their pregnancies as problems. Some African American interviewees reported that their elders pressured them to carry their pregnancies to term, and almost all expected their babies to be incorporated unceremoniously and permanently into family networks. Although the parents of the white interviewees viewed adolescent pregnancies as problematic, they were willing to cope with them through temporary

household extension or even to view the problem as "solved" if the pregnancy were legitimated. (Presumably, these outcomes would be unacceptable in middle-class families, where the only acceptable "solution" would be to avoid teenage motherhood altogether.)

Although nonmarital conceptions among white working-class teenagers were seen as a family burden, it is important to recall that some of the interviewees revealed situations *preceding* their pregnancies in which temporary appeal to a more multigenerational approach to childcare was invoked within their otherwise traditional nuclear families. Prior to their own pregnancies, some of the interviewees had been called upon to compensate for the temporary loss of their mothers' contribution to the family caretaking system, often due to health-related problems such as maternal hospitalization or alcoholism. The willingness to employ the temporary extension strategy in both directions (calling on daughters to step in for mothers and mothers to step in for daughters) bespeaks a strong value placed on caretaking activities as one of the important roles that women play (in addition to the economic necessity of this role). That these episodes were most often described as isolated instances, bounded in time, again suggests that the white interviewees had not internalized the sense of pervasive health uncertainty suggested by the reports of the African American interviewees. Still, witnessing their own mothers' temporary disabilities may have left them feeling vulnerable to premature illness. Having experienced the temporary loss of their mothers may have been a factor in their willingness to take risks or make pregnancy resolution decisions that resulted in early motherhood. And working class or lower middle class daughters are more likely to experience such losses than more affluent girls (Adler et al. 1994; Benson and Marano 1994; House et al. 1990).

Relying on daughters to fill in for mothers may reinforce the daughters' identities as caretakers, elevating and promoting their role within the family, at least temporarily. As with the African American interviewees, this role presumably exposed white interviewees first-hand to the rewards associated with caring for children. The benefits associated with childcare in their families, the sense of mastery or efficacy they may have achieved through their earlier family responsibilities, and the knowledge that their own mothers would tolerate a pregnancy and offer practical support to allow them to pursue other specific goals (for example, vocational education), all may have influenced their decisions to become mothers. In addition, many of the white interviewees reported work experience in day care centers. These experiences suggest that they may have needed or been expected to work to contribute to their families' economic well-being, and that of the limited options they would have had for employment, they chose ones that involved caretak-

ing. Their work experience may also have contributed to their confidence in becoming young mothers.

STRUCTURE, AGENCY, AND MIXED MESSAGES

In discussions of social structure and personal agency, the domestic sphere has been thought of as a major locus of the conservatism of the system. As Ortner (1984:150) notes, "It is precisely in those areas of life—especially in the so-called domestic domain—where action proceeds with little reflection, that much of the conservatism of the system tends to be located." Certainly one way to interpret the current argument is in this light: Poor and working-class teenage girls reproducing historically persistent patterns of early fertility are enmeshed in gendered domestic labor, sometimes (among African American interviewees) reporting substantial pressure from mothers, grandmothers, or boyfriends to carry to term pregnancies that they, themselves, sometimes reported being ambivalent about. But this perspective is incomplete. At the simplest level, it does not jibe with how the interviewees talked about their pregnancies. Almost all of the interviewees, both white and African American, saw themselves as having given a lot of thought to and having made a range of decisions about their pregnancies. Some reported that they had actively planned their pregnancies. More often, once pregnant, they gave a lot of thought to whether to carry the pregnancy to term and to the conditions in which they would raise their babies. In addition, several of the interviewees had been pregnant before and chose to terminate those pregnancies because *then*, they said, they had been "too young." How did they decide that they were too young at fifteen, but not at seventeen? If teenage childbearing were an accidental experience rather than a decision they made, why weren't the teens swept into it the first time? This is not to say that their decisions to carry to term the current pregnancy were made in the absence of either internal conflict or conflict with (or at least input of) significant others. But while both their family systems and larger cultural or social systems may have powerfully structured their decisions, the interviewees did not see themselves as having simply followed a script. They did not act without reflection, consideration, and sometimes conflict. With only one clear exception (a very young interviewee who became pregnant when she was raped), the interviewees appeared actively engaged—cognitively and emotionally—in the project of impending motherhood.

There are inadequacies of the model positing that teens' fertility decisions are not reflective specific to each group of interviewees. Its inadequacy in terms of the white interviewees stems from the fact that they had received a strong cultural message about the importance of setting up nuclear family households, a task that would be more straightforward if they waited to have children until they had completed their (often vocational) educations and were already married. Violations of this standard were tolerated and backed up with practical support; still, they were violations. The teens' decisions to become mothers can be seen as "undoing" the social expectations of their cultural system as easily as they can be seen as fulfilling them.

There is also a shortcoming to viewing the African American interviewees' fertility timing as almost exclusively conditioned by their cultural system. While they appear to have received a range of messages from kin suggesting tolerance, support, or even pressure toward early childbearing, they must have also been aware that the larger society views teenage childbearing with disdain. Indeed, teenage motherhood, especially among poor African Americans, has been described as the hub from which virtually all other social problems stem (Luker 1991; Nathanson 1991). And there can be little question that these teens and their elders were aware of this. Not only has there been a multimedia blitz to this effect, but teen pregnancy prevention campaigns are common in schools, implicitly in the beliefs of school personnel and messages conveyed by posters on the walls and sometimes as explicit curricula or parts of school-based clinics. Teen parents must notice these. For example, in a newspaper article about teen parents in central Philadelphia (Vrazo 1990), the reporter describes the reactions of two teen mothers, Miller and Ramos:

> The two young women are angry that many people think teen mothers are doomed to lead lives without money, jobs or hope, and that their children face a similar fate. They resent the anti-teen pregnancy message, as embodied in a Children's Defense Fund poster hung not far from their classroom door. It shows a sad-eyed teen holding her baby under the words: The one on the left (the baby) will finish high school before the one on the right. "A lot of times I fell like ripping those posters right off the wall," Ramos complains vehemently, "This ain't true!"

And, interestingly, the social scientific view is coming around to being closer to Ramos's view than to the one implied in the poster. The magnitude and, in some cases, even the direction of the conventionally accepted consequences of teenage childbearing have been called into question by serious scientific scrutiny. The poorest members of society

and, among them, those with the least chance for success according to more socially acceptable routes to upward mobility, are dramatically overrepresented in the population of teen mothers. The emerging scientific consensus is that many of the presumed consequences of teenage childbearing have been exaggerated by the failure of earlier study designs to account adequately for such selection into teen motherhood (Bachrach and Carver 1993). Empirical findings suggest this may be the case for a wide range of outcomes, including high school drop out (Geronimus and Korenman 1992; Olsen and Farkas 1989; Upchurch and McCarthy 1990), low birth weight (Geronimus 1996; Geronimus and Korenman 1993; Rosenzweig and Wolpin 1995), offspring's performance on standard tests of achievement and development (Geronimus et al. 1994; Moore and Snyder 1991), and future wages or welfare receipt (Conrad 1993; Geronimus and Korenman 1992; Hotz et al. 1995; McCrate 1992).

Another factor that implies that these teens' decisions may not have been completely straightforward is that, although some of the African American interviewees' elders supported or even pressured the teens to have children, others, who were probably aware of the way teen childbearing is viewed in the larger society, did not react as positively. A caring elder's reaction to the news of a teen pregnancy is complicated, not only because she may sense a conflict between her own experience and what official conventional wisdom in the larger society tells her about the likely consequences, but also because her own experience tells her that the life prospects of her daughters will vary. Some will not be negatively affected by young motherhood, while others are more likely to fare better if they do postpone (Burton 1990; Ladner 1971). An elder may have to fine-tune her messages to fit the circumstances of different girls of the same age or the same girl at different ages. Elders may also offer conflicting messages because maintaining and developing kin networks as community safety nets may require that different types of kin work be performed by different teens (Stack and Burton 1993). How is an elder to feel confident that she understands individual girls and that she can effectively address different messages to them? Different elders may come to different conclusions.

Perhaps the pregnancy resolution decisions of the African American interviewees testify to the conservative and constraining pulls of their family and cultural systems. But that may be an oversimplification. In the late twentieth century, African American teens from low income areas such as these interviewees—who have occasion to think about when to have children, or who are faced with whether or not to take specific risks that could result in pregnancy, or who find themselves

pregnant—have to make decisions by weighing messages that are not only conflicting but that may be strong and extreme in their differences.

It may be more accurate to think of members of our middle-class group as unreflectively moving toward delayed parenthood than to think of the African American teen mothers as having passively been pulled into their fertility timing decisions. As Giddens observes:

> it is not implausible to suppose that, in some circumstances, and from some aspects, those in subordinate positions in society might have a greater penetration of the conditions of social reproduction than those who otherwise dominate them. . . . Those who in a largely unquestioning way accept certain dominant perspectives may be more imprisoned within them than others are, even though these perspectives help the former to sustain their position of dominance (1979:72).

Certainly, many young middle-class women or couples appear to wait to socially engineer the "perfect" timing for motherhood. Given their more rigid adherence to the nuclear family ideal, it is easy to understand why they would want to feel completely prepared before taking on the full responsibility for child rearing and economic support. But this perfect timing is implicitly understood to be when all the stars are aligned: personal maturity, professional tenure, marriage, economic security, and, often, home ownership. Unfortunately, sometimes these stars do not come together or only do so as biological fecundity is waning (and there is some reason to believe that macroeconomic forces make it increasingly difficult to realize all of the middle-class prerequisites for childbearing—see, for example, DaVanzo and Goldscheider 1990 or Newman 1994). The apparent promise of technological reproductive assistance may permit young middle-class individuals to feel confident in disregarding rather than facing the contradiction between their childbearing ideals and the limitations imposed by biological and social structural reality. The middle-class tendency to postpone childbearing must be viewed as a reproductive strategy that is at least in part responsive to available opportunities. Yet, it may also be viewed as partly a passive acceptance of dominant ideals for combining dual-career development and childbearing in a nuclear family context (a tall order). Thus, while risk-taking behavior among some socioeconomically disadvantaged teenagers may be part of a larger collective and motivated life-cycle strategy, highly conscious planning among more affluent and highly educated couples in their twenties or thirties may, at times, be seen as an unreflective action that serves to maintain dominant perspectives without critical review. More generally, the extent to which individual conscious planning drives reproductive behavior may be a poor marker for

the extent to which that behavior is strategic or reflects unconstrained choice.

CONCLUSION

To summarize, I am suggesting that teens from different sociocultural groups are more or less likely to take risks that result in pregnancies and, when pregnant, decide whether or not to carry their pregnancies to term in large part based on the values and realities of their social structural positions. But those from populations where teen childbearing is common who themselves become teen mothers do not do so without reflection. Today, in the latter part of the twentieth century, they are exposed to strong messages that teenage childbearing is unacceptable and destructive behavior deserving of stigmatization and punishment. Their own lived experience and that of their elders sometimes contradicts this societal belief. For many, those experiential messages are the more salient.

For the majority of Americans who take for granted the unspoken premise of a predictable long life, the possibility of postponing reproduction indefinitely into the future—while not without its own set of associated hazards and implications for the heroics expected of some middle-class women—can be seen as sensible. But for those who face not simply a shorter, but a far more uncertain lifespan, one that is intensified in its uncertainty by the fact that those on whom they must depend and who depend on them also face such uncertainties, the calculus of being future-oriented becomes more complicated, less linear, more probabilistic. Theories about early fertility that ascribe to teen mothers an inability to plan for the future may be mistaken. By deciding to become teen mothers, young women in some persistently impoverished populations may be planning for the kind of future they have every reason to expect. Long life and the freedom to postpone central or cherished goals are not universal. This point is not to be confused with the notions of fatalism and of a tendency toward immediate gratification, which are sometimes posited in discussions of cultures of poverty. Nor should it be taken to suggest that, as a society, we abandon vigilant efforts to promote reproductive freedom for all women. However, as a matter of social policy, focusing on teen pregnancy prevention as the solution to persistent poverty may be the modern-day equivalent to suggesting that those without bread can eat cake. Instead or in addition, policy approaches that would offer poor women and men real reasons to expect to live predictable, long lives deserve a prominent position on the policy agenda. Until then, building social and cultural capital through

childbearing may be a perceptive and caring investment for young women facing truly uncertain and highly circumscribed futures. And such a project may be life affirming amidst death all around; it offers the engagement and structure of work that asserts, rather than denies, human dignity.

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NOTES

1. As many readers of this journal are aware, a parallel discussion in the literature raises the possibility that family composition or stress in childhood may affect pubertal timing, the onset of sexual activity, and the timing of childbearing (e.g., Belsky et al. 1991; Draper and Harpending 1982; Surbey 1990). Even more closely related to the current argument is Chisholm's (1993) suggestion that a community's mortality experience may be a distal contributor to the proximate determinants of its reproductive strategy—operating through family stress and composition to affect children's psychological and biological development. These frameworks and findings suggest a developmental suite of traits that are directionally consistent with my argument. And they extend to deeper levels the notion that reproductive strategies can operate or be implemented short of conscious planning. However, a full discussion of the relationship between the relevant life history theory or research and the argument developed here—any overlap, complementarity, or disagreement—is beyond the scope of this paper.

2. Metropolitan referrals were made through one of the largest hospital-based adolescent maternity clinics in the area. Rural referrals were made through county health departments. In the metropolitan area, all qualified maternity patients with clinic appointments during the initial recruitment phase of the study were asked if they would like to participate. Because the initial interviewees were disproportionately minority, and possible variation by class or

racial identification was of interest, whites were, in effect, "oversampled" by extending the recruitment period for whites until several were included among the participants.

The investigator traveled to the rural site to conduct the rural interviews. At the rural clinics, qualified patients who had scheduled appointments during the investigator's visit were invited to participate. In one case, a referring nurse deviated from the selection procedure by referring an exceptionally depressed patient, who had been withdrawn since the incident from which her pregnancy resulted (an alleged rape), hoping that the interview might be therapeutic for her.

Of those asked, one urban patient explicitly refused to participate, and two others initially agreed to be interviewed but changed their minds. All three of these women were white. None of the rural patients refused to participate (although one was not interviewed because she required a diagnostic procedure that conflicted with the interview). One African American rural interviewee did not give a specific age in response to the question about what age a woman should stop childbearing and, thus, is not included in Figure 1. See Geronimus (1992) for a more complete description of the interviews and interviewees.

3. That is, the experience of poor African American teens in low-wage jobs should not be confused with that of middle-class teenagers who may hold temporary summer or after-school jobs in places like fast food restaurants. The better-off teens may well go on to better jobs, owing to their connections and educational opportunities that prepare them for higher-level occupations or careers. Nor should the low-wage work of today's poor teens be confused with that of earlier cohorts of poor teens, who more often were able to use low-wage jobs as a first step in the door of the work-world with a realistic hope of moving up from there. Apparently, comparable expectations are no longer realistic for many poor women (Blank 1995).

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