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"Help me!" and "Leave me alone!"  
The Pregnancy Experiences of Telegraph "Street Kids"

by

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B.A. (Case Western Reserve University) 2003  
M.A. (Case Western Reserve University) 2003

A thesis submitted in partial satisfaction of the  
requirements for the degree of  

Master of Science  

in  

Health and Medical Sciences  

in the  

GRADUATE DIVISION  

of the  

UNIVERSITY OF CALIFORNIA, BERKELEY

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Spring 2006
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Spring 2006
Dedication

This thesis is dedicated to Grace, Freedom and Samantha. Their family's story was the motivation for this study.
Acknowledgements

I would like to thank all of the participants in this study and the Telegraph street youth community for their support of this project. I greatly appreciate the support of the Suitcase Clinic Youth volunteers, Suitcase faculty advisor Alan Steinbach, and the service providers who work with Berkeley homeless youth. A special thanks to my committee members, Coco Auerswald, Philippe Bourgois, Jane Mauldon and Emily Ozer, and my thesis advisor, Karen Sokal-Gutierrez, for their support and feedback. This thesis would not have been possible without my JMP classmates, particularly Suzanne Lee and Paul Shen, and the JMP faculty and staff. The signature page (the 2nd version) would not have been possible without Carolyn Eggert and Ally’s tour of the Sunset. Finally, a very special thanks to my partner, Jason “Mighty Mighty J-Bone/Monkey” Siegel for his patience and support in desperate times.
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CHAPTER I

At age 5, G's parents divorced. At age 15, she was sexually abused by her stepfather. At age 17, she was removed from her family by authorities and placed into foster care. At age 5, F was given drugs by his stepfather and sexually abused. At age 17, he ran away from home. By age 18, they were both living on the streets in Berkeley. And at age 22, she became pregnant and they were faced with a life altering decision.

- G and F, a Berkeley homeless couple

G and F represent a typical couple within the Berkeley homeless youth population faced with making a decision about an unintentional pregnancy. The objective of this literature review is to frame the discussion of pregnancy decision-making among couples such as G and F within the known literature. Unfortunately, there is very little direct understanding of the pregnancy decision-making process specific to the homeless youth population within the academic literature. A literature review meant to frame the pregnancy decision-making process of this population requires an understanding three main areas of research: the life trajectory of homeless youth; the development of youth experiencing extremely stressful situations during periods of critical cognitive development; and the pregnancy decision-making process of non-homeless populations. This broad scope is necessary as the availability of research on homeless youth consists of many relatively small studies on specific groups of homeless youth living in various cities across the United States. Research on the development of decision-making among the homeless youth population must be extrapolated from usually retrospective studies of abused and neglected youth and the impact of extreme childhood stress on the decision-making process. Any research specific to pregnancy decision-making must be extracted from the various large, retrospective surveys and small, prospective, qualitative studies of this process among predominantly housed individuals.
We will begin by exploring homeless youth’s childhood experiences and relationships with families in order to answer the question, “How do homeless youth become homeless?” There are some generally understood patterns of becoming homeless among homeless youth. However, conclusions from these studies may not necessarily be applicable to all homeless youth in every community. Then we will move to answer the question, “What is the experience of an adolescent who lives on the streets?” Here we will review socialization into youth culture and the extremely stressful lifestyle homeless youth face in meeting their needs. We will also review how this population’s gender relations and sexual practices create a situation in which pregnancies are common. Because each study of homeless youth is community-specific, in this review we will focus on patterns that are reported widely in the homeless youth literature. After reviewing the series of events that often lead up to a pregnancy, we will then discuss how the extreme nature of life experiences may affect a homeless youth’s cognitive development and the skills necessary to make important life decisions. Finally, because there is little information available regarding homeless youth and pregnancy decision-making, we will briefly examine some of the important factors cited by non-homeless individuals during pregnancy decision-making including family, relationship with partners and social services. This literature review is an attempt to draw connections between important areas of research that have not been previously studied.

Homeless Youth Studies

Homelessness is a notoriously difficult subject to research because of a number of factors including sampling issues, logistical difficulty of following participants and social stigma of homelessness (Phelan and Link, 1999). This is particularly true for
homeless youth who are often undercounted and largely ignored in studies designed to capture homeless individuals because they purposefully avoid the kinds of services such as adult shelters and soup kitchens where these studies are conducted (Finkelstein, 2005; Ensign, 1998). The current understanding of homeless youth draws on four types of approaches – large studies of broad adolescent populations in which data is parsed based on those individuals who identify with a history of homelessness (Ringwalt et al, 1998), youth from shelters or transitional housing (Steele et al, 2003; Whitbeck and Hoyt, 1999), clinical settings (Barry et al, 2002) and street locations where homeless youth congregate (Auerswald and Eyre, 2002; Finkelstein, 2005; Whitbeck and Hoyt, 1999). Each of these sampling methods captures only a small segment of the homeless youth population. Because most study designs are based recruiting homeless youth attending services or those congregate in identifiable groups in outdoor locations, those youth who do not utilize services or “look homeless” are very difficult to enroll into studies.

In their review on homeless youth literature, Robertson and Toro (1998) cogently point out that because of limited research on this population, the majority of the information known about certain characteristics of the population is often based on a single study. This is particularly true for studies on the qualitative experience of pregnancy among homeless young women (Saewyc, 2003). While there is a large gap in understanding many characteristics of this population, there are some trends, such as troubled childhoods, heavy drug and alcohol use and a distrust of authority, which appear consistently throughout the literature. In this review, I have attempted to summarize these broad trends as well as highlight individual studies that may contribute to an understanding of pregnancy decision-making among homeless youth.
Who are homeless youth? - Defining the population

The most commonly cited definition of homelessness is the one used by the United States Housing and Urban Development Department (HUD) based on the McKinney-Vento Homeless Assistance Act of 1987 and its subsequent revisions. This definition states that homeless individuals are adults and children living in places not meant for human habitation, including abandoned buildings and vehicles, and those in emergency or transitional shelters. Homelessness can be defined more broadly as anyone living in “substandard, temporary housing” — in motel rooms, “couch surfing” from relative to friends or doubling/tripling occupancy (Ensign, 1998). Homeless youth are considered a subset of the general homeless population. While many authors agree that homeless youth are fundamentally different from the adult population and they perceive themselves as such (Ensign and Gittelsohn, 1998), there is no standard definition of “homeless youth.”

Age is most often used to differentiate homeless youth from the more general homeless population. For ethical and legal reasons, homeless youth under 18 and 18+ are often studied separately (Ensign, 2003). Some studies limit homeless youth to those under the age of 18, while others include older individuals, often up to age 25 (Finkelstein 2005, Ensign, 1998, Ensign and Gittelsohn, 1998, Rew and Horner, 2003 and Greene and Ringwalt, 1998). However, the division of homeless youth based on age is often artificial and not representative of the social organization of the streets (Ensign, 2003). Many of these young people have been on the streets since they were under the age of 18 (Ringwalt et al, 1998) and continue to live on the streets well into legal adulthood, maintaining affiliation with other, often younger, homeless youth. Because a young age is not always central to inclusion within the culture of homeless
youth, many service providers loosely define "homeless youth" as individuals who are generally in their mid-twenties or younger (Barry et al., 2002).

A broad definition of homeless youth captures individuals, regardless of age, who are in a state of social and mental development consistent with childhood, adolescence and/or young adulthood and are accepted within the community of homeless youth. More narrow definitions of homeless youth are generally age-based and allow us to be specific about the criteria needed to be considered a homeless youth. The risk of using narrow definition is the exclusion of individuals who are a part of the social network of homeless youth. In this paper, we will define "homeless youth" as individuals from their early teens to their mid-20's living in places not normally used for human habitation. This definition is purposefully ambiguous to allow for the inclusion of all materials that relate to young people who have no permanent place of current residence.

Demographics of Homeless Youth

There are 500,000 - 1.5 million homeless youth in the United States (Ringwalt et al, 1998), more if one includes individuals older than 18. Homeless youth currently make up approximately 3% of the urban homeless population (Finkelhor, 1990). While many popular images of homeless individuals include older individuals protecting shopping carts of possessions or families with young children during hard times, adolescents 12-17 years old are at greater risk for homelessness than adults (Robertson and Toro, 1998). Despite an extensive body of literature on the adult homeless population, only recently have homeless youth attracted researchers’ attention. They remain a poorly understood subgroup of the homeless population.
The gender and ethnic make-up of the homeless youth population is highly dependent on the geographical location and sampling pool of the study (Robertson and Toro, 1998). Based on a nationwide study of 6496 youth aged 12-17 years, boys are more likely to have experienced a period of homelessness than girls (Ringwalt et al, 1998). Homeless youth are ethnically diverse: 54% are White, 26% African-American, 13% Hispanic, 4% Native American and 3% Asian (HUDD, 1999). However, the ethnicity of homeless youth is highly varied based on the geographic location (Robertson and Toro, 1998). There are also different "types" of homeless youth in various geographic locations. "Street youth" are individuals who do not primarily live in shelters and tend to stay in large, urban areas on the East and West Coasts including Seattle, San Francisco, Los Angeles and New York. Homeless youth may be considered "locals" if they are from the surrounding area (Ensign and Bell, 2004) or if they have moved from another area but have remained in this community for some time, usually one year (Robertson and Toro, 1998). White homeless youth are more likely to be "transient" - traveling farther from home, hitchhiking and live nomadically than non-white youth (Brennem Huizinga and Elliot, 1978 cited in Finkelstein, 2005). European-American traveling youth often connect with the punk rock and anarchist subculture and may leave home to join groups of other "punk kids" (Finkelstein, 2005). African-American and other non-white youth are more likely to stay close to home.

Homeless youth may be "runaways," youth who leave home voluntarily, "throw-aways," youth who leave home involuntarily, or "system kids," those removed from their families by authorities due to unsafe conditions, overt abuse or neglect, death or incarceration of the parent and have subsequently run away from care or "aged out" of care at 18 but have no permanent residence (Ensign, 1998). Once
without permanent shelter, homeless youth are often categorized as "street" and "shelter" based and are studied as discrete populations with different characteristics (Ensign and Santelli, 1997). However, this may be an artificial classification resulting from sampling methods that tend to target youth in one location or another. As opportunities arise, many homeless youth survive by quickly adapting to their present situation. As several exploratory interview and focus group based studies in different US cities have shown, homeless youth move fluidly between different locations, including returning back home, living with friends and relatives and returning to the streets (Rew and Horner, 2003; Saewyc, 2003). Youth may stay on streets when it is desirable based on weather, company of others, or health. They use shelters when they are available, convenient or more desirable than being outdoors.

While homeless youth may move between shelters and the streets, studies have shown that there are some important differences between the shelter and street based populations. Based on a nationwide survey of 631 youth staying in shelter and 528 street sampled youth aged 12-21 year old, street-based youth tend to be homeless for longer, are farther away from home, have less access to care and are more likely to have experienced more serious health problems including more incidence of forced sex and violence than shelter-based youth (Greene and Ringwalt, 1998). Street-based youth spend an average of 4 years on the streets (Ensign and Bell, 2004) - 4.3 years on the street for men and 3.7 years for women (Finkelstein, 2005). Shelter-based youth have been homeless for an average of 4 months (Ensign and Bell, 2004), tend to be younger and stay closer to home than street youth (Green and Ringwalt, 1998). The length of time of homelessness may reflect different reasons for becoming homeless – street youth have often chosen to remain on the streets.
while shelter youth may be unwilling to adopt this lifestyle or have not yet fully
adopted the lifestyle of a “street kid.” Tyler et al. (2004) hypothesizes that shelter
youth tend to be younger because homeless adolescents who have spend less time on
the street have fewer survival skills and are at higher risk of victimization. Shelter
youth are also more likely to be women while street youth are more likely to be men.
One critical similarity between shelter-based and street youth is that both groups do
not identify with the older “adult population” (Ensign and Gittelsohn, 1998) and often
refuse to use adult homeless services (Rew, 1998 and Ensign, 1999).

A popular myth about homeless youth, particularly those that congregate in
certain areas of urban centers – “the loop” in Des Moines, “the wall” in Saint Louis, the
“ave” in Seattle, East Village in New York, the Haight-Ashbury area in San Francisco or
“Teley” or Telegraph Avenue in Berkeley, is that street youth are actually wealthy
suburban youth pretending to be homeless to be “cool.” While there may be some
youth who do partake in this practice, across the country, youth on the streets will not
be going home for the night. Based on the observations of researchers investigating
homeless youth from the Midwest to New Youth City, most “street kids,” “runaways,”
“gutter punks,” and “system kids,” are not “faking it” – they do not have a place to go
for the night (Finkelstein, 2005 and Whitbeck and Hoyt, 1999, p. 3).

Childhood and Family Experiences of Homeless Youth

Many homeless youth left home at a very young age. Across the country,
average age most male and female homeless youth report leaving home is 13.5 years
and almost all have run away at least by age 16 (Whitbeck and Hoyt, 1999;
Finkelstein, 2005). At a time when many children are beginning to explore their
independence from their parents, many homeless youth are completely removed from their parent's or any other adult's care. Many of these youth have compelling reasons to leave. If there is one overwhelming consistency in the homeless youth literature, it is that many homeless youth have experienced severe trauma and chaos during their childhoods (Rew, 1999; Ennett et al, 1999). The effect of this trauma may have lifelong consequences, as we shall see in the section on cognitive development and decision-making. Childhood experiences and parental role models have also been cited in numerous studies as important considerations for pregnancy decision-making (Hanna, 2000; Lena and Hammarstrom, 2004).

**Childhood Abuse**

Neglect, physical, mental/emotional and sexual abuse characterize the family life of homeless youth (Barry et al. 2002). Defined as the insufficient attention to a child’s physical, emotional or development well being, neglect is reported by a majority of homeless youth (Robertson and Toro, 1996). According to the US Department of Health and Human Services (1997), 46% of runaway and homeless youth had been physically abused. In a study of 120 matched caretaker and runaway youth interviews in four Midwestern states, Whitbeck, Hoyt and Ackley (1997) report that 71.5% of boys were physically abused and 80% of youth report being slapped or physically assaulted by an adult caretaker. In a survey of 840 shelter youth aged 12-21 years old from 25 shelters across the country, 81.7% reported emotional abuse from their primary caretakers (Ringwalt, Greene and Robertson, 1998). In a cross-sectional, retrospective study of 775 youth aged 12-19 from New York, San Francisco and Denver, Molnar et al. (1998) found that 70% of female participants and 24% of male participants reported sexual abuse (Molnar et al, 1998). Other large, cross-sectional
studies have found rates consistently 30-40% and rates for men are usually lower than women, consistently around 20% but as high as 38% (Whitbeck and Hoyt, 1999; Tyler and Cause, 2002). In a study of 372 homeless youth (13-21 years old) in Seattle, youth identified their abusers as predominantly men aged 20-30 years and reported that the abuse lasted 2-3 years (Tyler and Cause, 2002). Perhaps most strikingly, 92% had disclosed the abuse to a parent or other adult and 21% reported that the adult was not at all concerned by the abuse. In many instances, these young people have been the victims of sexual abuse at the hands of people charged with their protection.

In *Nowhere to Grow*, a retrospective study of 602 street and shelter based homeless youth aged 12-22 years old in four Midwestern cities, Whitbeck and Hoyt describe the multiple levels of disorganization and difficult life transitions that characterize the “life matrix” of homeless youth (1999). Over 50% had at least one parent with a drug or alcohol problem, 35% had at least one parent who had a problem with “hard drugs” and 42% of their primary caretakers (parent or stepparent) had been arrested for a serious law violation. As young children, 2/3 of the men and ¾ of the women had experienced major changes in family structure such as divorce, remarriage of parent and geographical changes. Nearly 2/3 of homeless adolescents have been institutionally removed from families into foster care or other placements. The majority of homeless youth across the country has been involved with the criminal justice system and most have had multiple detentions (Robertson and Toro, 1998). These stressors contributed to the establishment of violence and constant change as the norm in the lives of the adolescents. In observing the life trajectory of many homeless youth, a pattern emerges: the greater the number of changes during childhood, the more erosion of family ties, the earlier children begin to run away.
Family Conflict

Across the country, most homeless youth cite conflict with their family as their primary reason for leaving home (Ennett et al, 1999; Robertson and Toro, 1998). In a five year longitudinal study of homeless and housed poor families in the US, Shinn and Weitzman (1996) found that homeless youth often report that their parents either “threw them out” or “did not care” when the child announced that he or she would be leaving. Whitbeck, Hoyt and Ackley (1997) investigated 120 matched adolescents and their parents’ perspectives on their parenting, family violence and adolescent behavior. While parents were likely to downplay their violent behavior and emphasize the behavior of the adolescent, parents corroborated the levels of less severe violence but tended to report fewer incidences of more severe violence such as threatening youth with a weapon or severe assault. While they accepted responsibility for the violence, these parents also attributed some of the family issues to the adolescent’s behavior - 60% of the parents would accept the adolescent back under certain behavioral changes on the part of the adolescent. However, in some families the damage seems to be irreparable – 18% of parents reported that they would not welcome the adolescent home under any circumstances. The ability to return home may be indicative of the resources available of homeless youth in a time of need such as pregnancy.

Conflicts with caretakers that result in youth homelessness are not always violent. “Generational” or “cultural” gaps between parents and their children can also contribute to incompatible living situations that lead to youth leaving the home. Ensign (1998) describes youth raised by grandparents who leave home when expectations of duties and responsibilities have not been met by either the grandparent and/or the
child. A similar phenomenon occurs among first generation immigrants. As youth attend local schools, they tend to assimilate faster than their parents, resulting in conflict over appropriate roles of children and parents (Xiong et al, 2005). Ensign (1998) reports that 1/3 of all Southeast Asian refugee families living in Seattle have had at least one child run away. Most of these runaways are rarely reported to authorities because of language and distrust of authorities. During secondary analysis of survey data compiled from 425 homeless adolescents aged 16-20, a startling 73% of homeless, homosexual youth and 25.6% of homeless, bisexual youth report that conflict over their sexual orientation was a major contributor to leaving home (Rew et al, 2005). This is important regarding pregnancy decision-making among homeless youth as sexual orientation is not necessarily protective against pregnancy. In fact, Saewyc (1999) found that among 3816 housed students in Seattle, homosexual and bisexual women had similar rates of heterosexual sex as self-identified heterosexual women and significantly higher rates of sexual abuse, ineffective contraceptive use and pregnancy.

**Economic and Housing Instability**

The second most common reason cited by youth for leaving home is economic or housing instability (Ennett et al, 1999). A family's economic problems may result from a lack of affordable housing, limited employment opportunities, insufficient wages, lack of medical insurance, or inadequate welfare benefits. Some studies have shown that homeless youth from impoverished families are not more likely to become homeless but family poverty may be related to more chronic or repeated events of homelessness (Robertson and Toro, 1998). This cycle of economic instability can lead to "generational cycling" of homelessness. Parents who experienced homelessness as a
young person are likely to have a child who experiences homelessness (Ensign, 1998), which may be particularly relevant to the segment of the homeless youth deciding to parent.

Numerous nationwide studies of the adult homeless population have correlated a history of foster care, institutional setting or group home to becoming homeless at an earlier age and remaining homeless for a longer period of time (Mangine et al., 1990, Herman et al 1997, and Heffron et al, 1997). The National Association of Social Workers (1992) reports that more than one in five youth who arrived at shelters come directly from foster care, and that more than one in four had been in foster care in the previous year. Many homeless youth also run away from foster care because of harm from caretakers, perception of being able to care for one’s self, missing family, inadequate attention to mental health needs and/or lack of access to normative youth experiences such as sports or friends (Courtney et al, 2005). The experience of foster care and other institutional care may play a role in homeless youth’s decision-making for his or her own child.

*Leaving Home as Rite of Passage*

There is yet another factor contributing to youth homelessness that seems to be unique to the developed world. Leaving home as a rite of passage into adulthood and experiencing the “open” and “free” Kerouac lifestyle of the road can be a powerful motivator. This lifestyle is particularly attractive to youth who do not do well in school, have not found satisfying employment or are not interested in maintaining a standard working class existence (Finkelstein, 2005). Many of these individuals come from higher socio-economic strata (SES), tend to travel farther from home than the majority of homeless youth (Ensign, 1998) and are more often European-American (Finkelstein,
2005). Many of these "street kids" travel across the country several times a year hitchhiking or hopping trains (Finkelstein 2005, Rew 2002, Ensign and Bell, 2004). While these youth choose to travel and live a "more free" lifestyle, most have had troubled relationships with their families, ranging from disparate values from their parents to severe abuse and neglect. Some cite dissatisfaction with an oppressive social and capitalistic organization of their hometowns. By leaving harsh homes and seemingly repressive life paths, these youth are agents of their own actions – they have chosen to leave a more traditional lifestyle and participate in the counterculture as an act of resistance. In making a critical decision to leave, homeless youth prioritize a powerful set of non-traditional values of communal or nomadic lifestyle. This set of values may be influential in guiding decisions about how a pregnancy and/or a child fit or do not fit into this lifestyle.

**Educational Status**

Because they left home so early, most homeless youth have interrupted their formal education. Robertson and Toro's (1998) review of several nationwide studies revealed that 35% of homeless youth have been held back at least one grade. In Whitbeck and Hoyt's study of 241 men and 361 women, 42% of men and 32% of women had dropped out of school and the vast majority had been suspended from school for behavioral problems at least one (1999). One third of the men and 22% of the women had been diagnosed with a learning disability. Poor performance in school may indicative of a variety of issues including an unstable home situation and/or cognitive development problems. It may also indicate a lower level of literacy and other skills often necessary to follow through with the decision to leave homelessness by applying for welfare or employment.
For many of these youth, the path to homelessness has been paved with experiences of trauma and suffering that have shaped these young people’s development. Before they left home, these youth had less than ideal childhoods with high levels of conflict with parents, abuse and violence. Many did not have positive school experiences and struggled with both disciplinary and academic requirements at school. Rew (2002) argues that the experience of sexual abuse often places an adolescent on a trajectory of poorer social connectedness and high levels of loneliness that leads to homelessness. Herman et al. (1997) hypothesize that childhood trauma can lead to increased vulnerability to homelessness because poorer family support and a higher predisposition to mental illness such as depression or substance abuse. As a result, the youth may be less able to earn adequate income and maintain stable housing. These factors are important in understanding the reasons why homeless youth become homeless. Experiences of disrupted childhoods may also be indicative of the resources and family support available to youth as they make important life decisions once on the streets.

Into the heart of street culture - Learning to Survive on the Streets

No matter how they were separated from their families, the adjustment to life of the streets has been called the “greater equalizer.” Once on the streets, homeless youth experience the same need for basics such as food, shelter and safety (Mclean, Embry and Cauce, 1999). In order to learn to meet these needs, these adolescents often become embedded in social networks composed mainly of other homeless youth. This process does not occur overnight – leaving one social network and entering another takes time and learning a new set of social norms and practices.
Auerswald and Eyre’s (2002) model (Figure 1) is helpful in appreciating the process of integration into homeless youth culture. This model is based on participant-observation with San Francisco street youth and 20 exploratory interviews with youth 24 years old and younger. In the “first on the street” stage, the individual is characterized by the loneliness and disorientation of being an outsider. These individuals have not yet acquired the knowledge and skills needed to secure basic needs and protect oneself. “Street mentors” often take on the newcomer and introduce the individual to other street folk. These relationships are viewed as beneficial for both the street mentor and the initiatee. The new member is socialized into the street culture and “learns the ropes” (Finkelstein, 2005) and becomes “street smart” (Auerswald and Eyre, 2002). In exchange for this information, the mentor may gain status, a share in the newcomer’s money and assets – beer, cigarettes, drugs, sex - or even labor in the informal street economy of drug networking, panhandling (or spare changing - “spanging”), stealing or “dumpster diving” for goods (Auerswald and Eyre, 2002). These mentors are also important in introducing the newcomer to services, presumably including pregnancy-related services, considered helpful and welcoming to this community.
Figure 1 – Homeless Youth Life Cycle Model

Fig. 1. The life cycle model of youth homelessness.

Street Based Peer Networks

There are two major studies that have informed the understanding of the social networks of homeless youth: Whitbeck and Hoyt's study of Midwestern homeless youth has been described above, and Finkelstein's ethnographic study of 50 New York City street youth under 21 years old. As individuals are accepted into the street network, they begin to make very intense but very short-lived relationships with both friends and sexual partners (Finkelstein, 2005 and Whitbeck and Hoyt, 1999). This individual replaces "conventional intergenerational sources of support" with peers who often have similar family backgrounds (Whitbeck and Hoyt, 1999, p. 70). Homeless youth often form peer group-based fictive kin, (Finkelstein, 2005: 44) in which they have "street brothers" and "street sisters." Some street kids view themselves as part of the same crowd, "tribe" or "one big happy family" – a traveling, nomadic and
interconnected group of people who help and protect each other from harm (Finkelstein, 2005). This pattern of establishing fictive kin when blood kin is unavailable or unable to meet the needs is common among other marginalized groups, including poor, urban African-Americans and the gay and lesbian community (Patterson, 2004 and Oswald, 2002). Fictive kin often fills the void left by lack of family or other social support by providing protection and means for securing money, food and drugs. However, this fictive family may be less able to provide support in times of crisis when more resources are needed, such as pregnancy, illness or other periods of distress.

While they can provide protection and a sense of belonging, members of this "protective family" can also become exploitative and violent. While these networks may be the "first satisfying family life that many kids have ever experienced" (Finkelstein, 2005: 49), the risk for victimization may not be so different from when the individual was living at home. Homeless youth are at high risk of theft, physical and sexual assault, harassment from other homeless youth, people who offer rides to hitchhikers, older homeless people, drug dealers, pimps, and "johns" (Finkelstein, 2005; Kipke et al, 1997b). Alcohol and drugs overuse can lead to fights with friends and partners. Competition for resources can result in battles over spanning territory and theft from other street kids and older homeless individuals. Both men and women, particularly those involved in the sex trade, are at risk for sexual victimization. Among 372 homeless youth interviewed in Seattle about the victimization experiences, women were twice as likely to be assaulted than men (23% versus 11%), most often by a man who is known to them, while men are more likely to be assaulted by male strangers (Tyler, Whitbeck and Hoyt, 1999). It is important to remember that street youth, including women, can also be victimizers (Finkelstein, 2005). Intimate partner violence
is pervasive (Whitbeck and Hoyt, 1999). In the end, violence is again an accepted part of existence.

In negotiating the stresses of homeless and home life, youth move within multiple social networks to meet their current needs. In many instances, street youth communicate with their families while on the streets, particularly if family life was not severely abusive and if they provide current financial support (Millburn et al, 2005). While previous research has claimed that adolescents often completely sever ties with previous family and friends and form homogenous ties with other street youth (Whitbeck and Hoyt, 1999; Finkelstein, 2005), new research has also shown that homeless youth often identify their peers from before they left home, their current street friends, and their parents and/or family members as part of their social networks (Johnson, Whitbeck and Hoyt, 2005). Maintenance of a wide variety of social networks may be an adaptation to the violence present in all areas of these adolescent’s lives. As one situation becomes intolerable, they may rely more heavily on another group of their social network. This may be particularly important when an individual desires to leave the street life, as may be the case in the decision to parent.

Daily Stresses of Homeless Life

Much like their life at home, life on the streets for these youth is characterized by extremely stressful daily existence. In an ethnographic study of street youth in Toronto, malnutrition, a known pregnancy risk factor, was common due to food scarcity and the use of beer and other alcohol, a known teratogen, as replacement for calories (Dachner and Tarasuk, 2002). While some youth stay in shelters, particularly during cold or rainy weather, shelters are generally avoided as they are seen as dangerous, dirty and jail-like places (Finkelstein, 2005; Dachner and Tarasuk 2002;
Robertson and Toro, 1998). Preferring to sleep in public places such as doorways, abandoned buildings, encampments in the woods, under bridges and rooftops, homeless youth are often visible to other individuals, putting them at risk for physical assault and theft. Obtaining cash is often a daily struggle that includes soliciting from parents, spanging, theft and/or illegal trade in drugs or sex (Whitbeck and Hoyt, 1999; Auerswald and Eyre, 2002; Finkelstein, 2005). While many are interested in working and 46% have worked odd jobs such as washing dishes or windows, picking crops, helping street vendors or cooking (Whitbeck and Hoyt, 1999; Finkelstein, 2005), they often are unable to gain legitimate employment because of discrimination, appearance, or lack of identification. The longer an individual remains on the street, the less likely they are to gain employment (Finkelstein, 2005). As a result of limited options, approximately 28% of street youth and 10% of shelter youth nationally surveyed have engaged in “survival sex” – exchanging intercourse or other sexual acts to meet subsistence needs. Prostitution is a common last resort for supporting a drug habit (Greene, Ennett and Ringwalt, 1999).

*Drug and Alcohol Use Among Homeless Youth*

Virtually every study involving homeless youth mentions the high levels of drug and alcohol use. Alcohol and marijuana use often begins in very early adolescence, usually around 12 or 13 years old (Finkelstein, 2005; Whitbeck and Hoyt, 1999), particularly among those with a history of sexual abuse (Rew L et al (2001b); Whitbeck and Hoyt, 1999). Among 186 homeless youth aged 16-25 in Denver, in the past nine months, 74% had used marijuana, 69% alcohol, 30% hallucinogens, 25% ecstasy, 18% methamphetamines, 19% cocaine, 13% ketamines and 12% had used heroin. Of these 11% had traded sex for drugs, food or money and 13% reported sharing
needles. (van Leeuwen, 2004). Many youth acknowledge that substance abuse is harmful and have often made attempts to quit using (Finkelstein, 2005). Frequent and heavy drug and alcohol use may be particularly relevant for pregnant women and their partners considering their future.

Health Effects of Street Life

Because life on the streets is chronically stressful, the longer youth live on the streets the more their health declines (Ensign, 1998). Homeless youth are seventeen times more likely to be diagnosed with a mental illness (Whitbeck et al, 2004). High levels of suicide, depression, Post-Traumatic Stress Disorder (PTSD) and psychiatric hospitalization have been reported in numerous cross-sectional surveys of homeless youth in Seattle, Baltimore and San Francisco (Rew 1996, Ensign and Gittelsohn, 1998, Molnar et al, 1998). Many youth report that they focus on the present and try not thinking about the future or future uncertainty (Rew, 2002). Focusing on the present may be an adaptive mechanism for staving off the mental anguish of past horrors or future threats. While this strategy may work in the short-term, it may also be depriving these young people from “developing a perspective of a very long future” (Rew, 2002) – they expect to die young, thus they live for the present. In dealing with these past demons and threatening futures, 25 homeless youth interviewed using the Defense Mechanism Rating Scale, demonstrated a relationship between the maturity and the types of psychological defense mechanisms and cumulative victimization experiences (Mournier and Andujo, 2003). An understanding of these defensive strategies may be important in recognizing when these strategies may hinder a person’s ability to interpret a situation, make a decision or act based on that decision.
Sexual Histories of Homeless Youth

Similar to drug use patterns, homeless youth are likely to begin having sex earlier than their housed peers (Feldman and Middleman, 2003). Kral et al (1997) reports that 49% of 775 homeless youth population surveyed in New York and San Francisco had sex before the age of 13. For those who were sexually molested, the earliest sexual experience may have been as young as five years old. In a survey of 190 runaways in Los Angeles, those sexually abused before 13 years of age are even more likely to become involved in sex work than peers abused at an older age (Rotheram-Borus et al, 1996). Once on the streets, sexual violence often continues. Homeless youth surveyed in Baltimore emergency shelters are almost 4 times more likely to have been forced to have sex than housed youth (Ensign and Gittelsohn, 1998). Young, homeless men, particularly those who are gay and bisexual, are 6 times more likely to be victimized by a stranger (Tyler et al., 2004). They are also less likely to consistently use condoms (Greene and Ringwalt, 1998).

As a result of infrequent condom use, homeless youth are at high risks for a sexually transmitted disease (STD) (Rotheram-Borus et al, 1996). Noell et al. (2001) investigated 532 homeless youth in Portland interviewed at baseline, at three months and six months. They found that young women are significantly more likely to contract an STD within a six-month period (16.7%) than her male counterpart (9.8%) (Noell et al, 2001). Furthermore, homeless youth have 2-10 times the HIV rates of housed adolescents (Ensign, 1998). These rates tend to be higher among those who are IV drug users (Ennett et al, 1999).
Pregnancy among Homeless Youth

Within this life context of early self-reliance, violence and sexual predation, homeless youth are also negotiating sexual expression and the risks associated with sex. Young homeless women are more likely than their housed peers to become unintentionally pregnant (Wilson, 2003) and high rates of problems in pregnancy including substance abuse and partner violence are common (Bassuk et al, 1998a; Bassuk et al. 1998b). In a national study on youth between 14-17 years old, young homeless women on the streets had a lifetime pregnancy rate of 48% versus 33% of young women in shelters and 10% of young women in living indoors (Greene and Ringwalt, 1998). Whitbeck and Hoyt’s study, which included 361 shelter and street-based women aged 12-22 years old in the Midwest, found that 25% of women had been pregnant at some point (1999). Of these women, 69% had become pregnant at age 15 or younger. While there is very little information available on homeless young men and potential fatherhood, Whitbeck and Hoyt (1999) also found that of the 241 men interviewed 16% of the men had fathered a child.

Multiple pregnancies are common for homeless young women and men. In Whitbeck and Hoyt’s study (1999), 22% of the women had two pregnancies and 11% had had three or more pregnancies. Of the men, 26% had fathered two pregnancies and 13% had fathered three or more pregnancies. In Greene and Ringwalt’s nationwide study, approximately 9% of the street youth and 1% of the shelter youth reported three or more pregnancies (1999). Because of the high rates of pregnancy, this population has rich experience in pregnancy decision-making.

There seem to be some differences in the characteristics of young homeless women that become pregnant and those who do not. In a five-year prospective cohort
study of 225 homeless women aged 14-25 in Montreal, Haley et al. (2004) found that 41.8% became pregnant during this time. Compared to the women who did not become pregnant, those who became pregnant were more likely to have experienced intra-family incest, sexual abuse at an earlier age and more severe sexual abuse. They are also more likely to have kicked out of their homes, become homeless earlier, start use drugs and alcohol earlier.

Childhood neglect and sexual abuse may alter self-image and attitudes towards sexuality. As a result, youth may tie self-worth to acknowledgement by others, usually sexual partners, which can lead to potentially coercive sexual activity with a high number of sexual partners, more willingness to engage in unprotected sex for fear of rejection and an increased likelihood of initiating sex at a younger age (Greene and Ringwalt, 1998). Homeless youth who have been abused can seek out sexual experiences for feelings of comfort, acceptance and intimacy as well as a feeling of power over their sexuality. As a result, they may find themselves in sexually exploitative relationships with little power to negotiate contraception (Saewyc et al, 2004).

Some homeless women do not believe they can become pregnant because they are amenorrheic due to malnutrition or drug use (Ensign and Panke, 2001). Barriers to obtaining a regular supply of birth control, condoms and other contraceptives are common (Wenzel et al, 2001; Ensign and Panke, 2001). In a national study, participation in survival sex among young, homeless women has been highly correlated with rates of pregnancy (Greene, Ennett and Ringwalt, 1999). Despite numerous studies that discuss the pregnancy risk factors for women, there are no similar studies on young, homeless men.
There is no available literature specifically focused on intentional pregnancy in this population. However, it is likely that some young women actively trying to become pregnant. Others may not be avoiding pregnancy. They may in fact want a child in order to extricate themselves out of a potentially "developmentally toxic environment" (Saewyc, 2003). For young men who were abused and have developed sexually confused identities, a pregnancy may be one way to firmly establish their heterosexuality (Saewyc et al, 2004).

Gendered Homelessness

Passaro (1996) has argued that "homeless" is not merely the absence of shelter, but rather a culturally specific and judgmental term that reflects the power structure of American society. Passaro conducted a two-year ethnographic study with over 1000 homeless people in New York City. She argues that unsheltered people are not called "houseless" because it is not merely shelter that they lack – they lack a "home." A house is a physical construction of walls and roof but a home is a powerful concept of inclusion and exclusion. Through a process of selective inclusion and exclusion, our society uses the concept of home to establish the nuclear family as the normative unit of social organization. Under this definition, homeless individuals are not marginalized merely because they lack shelter. More importantly, these individuals are in violation of fundamental social norms – they are disassociated with the most fundamental unit of social organization, the nuclear family. By no longer partaking in the nuclear family, homeless individuals threaten the power dynamics of gender and class that define appropriate roles of men, women, children and capital-generating activities. At the essence of Passaro's argument is the idea that parenthood and
homelessness are culturally incompatible because homeless mothers and fathers cannot teach children to reproduce the gender hierarchy and class structure. Without a home, homeless men and women are “unfit” to parent.

In deliberating a pregnancy decision, young homeless women and men come into direct conflict with powerful gender roles that shape their opportunities and responsibilities as future parents. Homeless women make up only 15-30% of urban, homeless populations (Marpsat, 2000; Sommer, 2001). To understand this disparity is to understand the ways in which gender power dynamics have shaped the lives of women and men in entering into and getting out of homelessness. Women, particularly those within childbearing years, are protected from homelessness by their subordinate status to men – to remove a woman from the home is to remove her from socially defined role as mother and homemaker (Passaro, 1996 and Marpsat, 2000). Women are much more likely to be understood as “deserving poor” – they deserve sympathy because within a traditional gender hierarchy they are treated as the weaker, more vulnerable and more dependent sex. Women are able to draw upon support from friends, family and the welfare system because they believe themselves to be too vulnerable to survive on the streets. Because they expected to be dependent, women are both more willing to ask for help and more likely to receive help than men. Women are also more likely to receive help from social welfare programs, other governmental programs and private charities that are specifically designed to meet the needs of homeless women or those at risk for becoming homeless (Marpsat, 2000).

Women are treated differently from men and mothers are treated differently from fathers. Mothers are prioritized by social services such as Temporary Aid to Needy Families (TANF) and other government programs. They are provided with shelter,
money and food resources as long as they are willing to fulfill the role of caretaker to children. Young, childless women are protected from homelessness because they still have the potential to become mothers (Passaro, 1996). As women on the streets age, they take on the “bag lady” persona – a desexualized being that is no longer given the same sympathy as her younger counterpart (Marpsat, 2000). Because access to services is tied to motherhood, women with no children may be more likely to stay on the streets for longer than women with children. At the bottom of the protected status hierarchy are homeless men. They are the least protected from homelessness and are often abandoned by social services once homeless. Men who have become homeless have essentially failed at their gender role as a provider (Passaro, 1996).

These gender roles are not only imposed on individuals, they are internalized and reproduced by men and women within their everyday relationships. Bourgois, Prince and Moss (2004) introduce the idea of “everyday violence,” coercive political, social and economic macro-level forces that shape day-to-day interactions between men and young women who are injection drug users within the San Francisco homeless community. This qualitative study included both long-term participant observation and field interviews with members of overlapping social networks of drug-injecting, homeless, young women in the Haight area of San Francisco. In this study, women quickly become and stay involved with male companions who protect them from sexual predation by other men. In return for protection, women used their sexuality to gain access to money, drugs and other goods. Within these couples, violence was the currency by which love, affection and caring was expressed. Violence may be the result of physical, mental or sexual abuse or more insidiously, the exposure to Hepatitis C because couples often share needles for convenience and as a symbol of
trust within the relationship. This gendered violence may extend to pregnancy –
women gain protection while simultaneously placing themselves at risk for unintended
pregnancy within the context of a violent partnership.

With respect to pregnancy decision-making, access to services may play a
factor in how a homeless individual is able to negotiate their desire to have, or not
have, a child. In gaining access to services, women and men are essentially forced to
mold to traditional gender roles – men as the providers and women as the caretakers.
Men are preferentially offered job training and women are more often offered housing
and welfare, particularly if they are accompanied with children (Susser, 1999, Passaro,
1996). In choosing parenthood, homeless women are supported as long as they agree
to construct their identities as mothers. While homeless men are able to gain access
work-related services, as fathers, these men are often completely ignored and
relegated to “dead beat dad” status.

Ironically, homeless couples are often unable to fulfill these ideal gender roles if
they engage social services. Welfare programs often preferentially support single
women with children and after certain time periods, requiring them to work. For single
parent households, requirements for employment without adequate job training and
childcare benefits can place women in a position in which they cannot realistically meet
work requirements and care for their families. However, couples or two parent
households working low-end jobs may also not be able to meet their financial needs
and find themselves homeless. Emergency shelters are segregated by sex and do not
provide couples housing. Men are often unable to make enough money to support
coupled life (Passaro, 1996). Because of the different services available to men,
women and couples, access to these social services may play a role in pregnancy
decision-making, and perhaps more importantly, the implementation of this decision.

Race and Homelessness

There is also an important parallel hierarchy within homelessness. As men are
overrepresented in homelessness, minorities are also overrepresented. While they are
only 25% of the US population, racial and ethnic minorities make up 60% of the
homeless population. African Americans make up 40% of the homeless population but
represent 11% of the US general population (Sommer, 2001). Based on nationwide
HUD data, the majority of homeless youth are European-American, which may reflect
different experiences of becoming homeless and subsequently trying to leave
homelessness. An understanding of the ways in which race has shaped access to social
services may inform some of the ways in which homeless youth experience available
services.

In conceptualizing risk for homelessness and the ability to leave homelessness,
Passaro (1996) argues that African American men are most likely to become homeless
and the least likely to be able to leave. Some of the factors that lead to an
overrepresentation of African Americans in the homeless population include limited
access to employment with a livable wage, few supportive services once homeless and
the historical separation of an African American manhood from fatherhood. African-
American women also represented a higher percentage of homeless women heads of
household with children (Toohey, Shinn and Weitzman, 2004). Because African-
American men and women are often unable to obtain jobs that will support a family,
they are more likely to rely on social services, including public housing, that effectively
discriminate against a nuclear family because married couples are eligible for fewer
There is a much more extensive body of literature on the role of race in homelessness in America. Within the context of this literature review, we will only touch on this subject to say that race may be an important factor in entering and leaving homelessness which may be experienced differently by homeless youth compared to the adult homeless population.

**Adolescent Cognitive Development**

**Homeless Youth and Developmental Issues**

Homeless youth are exposed to an extreme amount of stress from increased vulnerability due their living situation, daily subsistence and threats to personal safety. When they leave home and begin their life on the streets, these adolescents transition into adulthood with traumatic pasts and presents and uncertain futures. In this literature review, we are concerned with how a homeless youth is able to consider the ramifications of a pregnancy and parenthood. In order to fully appreciate this process, we need to understand the cognitive effects that the pattern of abuse, stress and precocious independence may have on these young people’s ability to make decisions.

**Adolescent Cognitive Development**

While most psychologists and medical professionals agree that adolescence is an important period of development and transition from childhood to adulthood, there is no standard age for this period. According to the American College of Physicians, adolescents are aged 12-24, however, the World Health Organization defines adolescents as 10-24 years old. This stage of development is characterized by physical and sexual maturation, development of abstract thinking, questioning, self-consciousness, experimentation, and sometimes defiance of authority and rebellion.
(Barry et al, 2002, Ensign, 1998). Thus far, we have used the ambiguous term “youth” to describe the young homeless population. This reflects the sociological definition of youth – an individual who is transitioning from “from adolescence to adulthood, from dependence to independence, and from being recipients of society’s services to becoming contributors to national economic, political, and cultural life” (United Nations Development Program, 2000). However, this definition uses employment and autonomy from parents as signifiers of adulthood. This may be problematic for the homeless youth population as some young people may be labeled as “adults” who have been forced into early employment by necessity while other individuals have “aged out” of the category of youth may not have fully transitioned from adolescence into adulthood psychologically or emotionally (Mufume, 2000).

In order to understand the ways in which homeless youth’s development of decision-making may be different from that of their peers, we will first review normal adolescent cognitive development. In general, the development of the brain in childhood and adolescence is poorly understood (Casey et al, 2000). There is recognition of tremendous developments in the brain during early childhood. This has led to the general misunderstanding that the most important periods of brain growth occur during infancy and early childhood and that adolescence is merely a time of maturing and refining the structure and anatomy of the brain (Herrman, 2005). A growing body of literature points to adolescence as a sensitive and critical period of cognitive development that may result in normative or maladaptive patterns of development (Steinberg, 2005).

While there is some controversy regarding when the brain is finally mature, most researchers agree that development of the brain occurs at least until the early
20's and up to the age of 25 (Beckman, 2004). Large-scale brain changes during early and late adolescent and even into adulthood include substantial proliferation of gray matter, pruning of neuronal synapsing and myelination of neurons (Steinberg, 2005; Herrman 2005). The brain does not develop uniformly. The pre-frontal cortex, responsible for executive brain functions, develops well into early adulthood (Casey et al, 2000; Hermann, 2005; and Steinberg, 2005). As the prefrontal cortex matures, working memory, spatial and rule learning, and emotional processing, especially of unpleasant stimuli, develop tremendously. During adolescence, the hippocampus, involved in learning and memory, the amygdala, a coordination center for emotional response and the body's reaction to stress, and the mesocorticolicimbic system, a pathway that is clearly linked with substance addiction and the ability to modulate stress, all develop tremendously (Spear, 2003). These brain centers are important in information processing, prioritization of information and ability to modulate stress, which are important skills during important decision-making.

Research suggests that environmental conditions during childhood and adolescence have a profound impact on brain anatomy and cognitive development (Steinberg, 2005; Teicher et al, 2003; Spears, 2000; and Bremner and Vermetten, 2001). Most researchers have described developmental pathways characterized by high levels of trauma, abuse or neglect as "suboptimal" (Steinberg, 2005). While some stress is healthy for the brain challenging it to grow, stress at extreme levels is "toxic agent that interfered with the normal progression of brain development" (Teicher et al, 2003). Because many homeless youth have experienced family dysfunction, tumultuous childhoods and the stress of daily existence on the streets, they may be particularly susceptible to altered brain development.
Stress and Brain Development

Two of the brain structures most sensitive to stress are the hippocampus, which is involved in learning and memory, and the prefrontal cortex, a center for executive functioning and decision-making. Children who have experienced abusive home situation often have elevated levels of stress hormones, which can lead to a decrease in the size of the hippocampus (Carlson and Earls, 1997; Gunnar, 2000; De Bellis, 1999). An important role of the hippocampus in learning is encoding and retrieval of episodic information, which may explain how alterations in hippocampal development can lead to amnesia of traumatic events (Teicher et al, 2003). Altered hippocampal development has been linked to the fear response (Hamm and Wei, 2005) and learned helplessness particularly in female victims of sexual abuse (Bremner and Vermetten, 2001). Reduced hippocampal volume has been linked to major psychiatric disorders including major depressive disorder (MDD), generalized anxiety and PTSD (Brenner et al., 1995; Brenner et al, 2000). Since the prefrontal lobe is the last to fully myelinate, it is very susceptible to stress-mediated alterations. Early stress may actually increase the development of the prefrontal cortex, resulting in a precocious but stunted development (Teicher et al, 2003). People with lesions in the pre-frontal cortex have significant difficulty with making informed decisions – they have difficulty assembling facts and data about a particular subject and making a conclusion based on the information (Burt, 1993). This becomes particularly relevant during important and stressful life event decisions such as pregnancy.

There is substantial evidence to suggest that children who experience extreme stress have altered cognitive abilities compared to their peers. Children who were sexually or physically abused have higher rates of disassociation and amnesia and are
often unable to recall large portions of their childhood, particularly during the times of the most traumatic events (Noble et al, 2005). This suggests that intense and chronic traumatic experiences may lead to a disruption in processing and storing information (Chu et al, 1999). Those who witness violence have lower IQ testing, lower school performances, symptoms of anxiety and depression, lower self esteem and have a greater propensity for sexual acting-out than their non-abused peers (Hurt et al., 2004, Noll, 2005). In particular, early sexual trauma may lead to an impaired feeling of self (Roesler, 1994) that is so fundamentally distorted that the individual may be unable to recognize their own needs and emotional states as different from that of others. Without this internal sense of self, an individual may not be able to comfort or insulate themselves adequately, appearing to overreact during painful or stressful times (Briere and Eliot, 1994).

Research Applicability to Homeless Youth

Homeless youth often cite escape and emotional numbing as the reason they began to use drugs, particularly alcohol and marijuana, at an early age. Early use of drugs and alcohol can significantly affect brain development. Adolescent-onset alcohol use may also contribute to a decrease in hippocampal volume, leading to impairments in learning and memory (Bremner and Vermetten, 2001). Marijuana use initiated between ages 12-15 is associated with decreased attention spans as a result of alterations in the endogenous cannabinoid system (Ehrenreich et al, 1999). Early onset of alcohol use is strongly associated with later alcohol dependence as well as other drugs (Spear, 2002).

Homeless youth have usually experienced traumatic childhoods. Even for those youth who have not experienced early childhood stress, life on the streets is without
exception a highly stressful environment. Although there is no research specifically focusing on the cognitive development of homeless youth, there seems to be some evidence that these issues are even more prevalent in the homeless youth population. In the general population, dissociative behaviors are found in 6% of the population (Mulder et al, 1998). Tyler et al (2004) found that 60% of 328 homeless youth in Seattle surveyed report dissociative behaviors. Molnar et al. (1998) found that 59% have a conduct disorder, 75% are depressed, 41% have considered and 27% have attempted suicide. Homeless youth’s brains may have adapted to extremely stressful environments with earlier prefrontal cortex development, smaller hippocampi, and increased emotional sensitivity. These adaptations may be beneficial in life of threatening situations, allowing an individual to take on earlier executive function enabling survival without parental help, granting an inability to remember very painful events and facilitating heightened emotions of aggression and fear. The disadvantages of these adaptations are that the individual is unable to process environmental information and cues that are non-threatening, develops an inability to store and process complex information and has difficulty in regulating fear and defenses in non-threatening situations. Homeless youth may be exquisitely adapted to the highly stressful situations in which they must protect themselves, but because of these adaptations, they may have problems with decision-making. Because of mental health issues stemming from abuse, they may not be able to socially connect with other individuals, leading to isolation and an inability to ask for and receive help.

Resiliency and Homeless Youth

"Strange as it sounds...I believe it is often a sign of health for children to run away. For kids to muster the strength to walk away from situations that have been filled with abuse and mistreatment is better than to just stay and suffer, and often shows
unexpected strength and hope.\textsuperscript{a} Sister McGeady of the Covenant House (cited in Mycek, 1999)

Recently, researchers have begun to expand their understanding of alternative pathways of brain development as potentially beneficial and adaptive to highly stressful situations. Barry et al (2002) and Mycek (1999) both cogently point out that youth who leave home are often actively leaving pathological situations. The streets may in fact be safer than their own homes. From this perspective, the act of becoming homeless can be interpreted as an empowering sign of resiliency and strength.

Resilience refers to the "process of overcoming the negative effects of risk exposure, coping successfully with traumatic experiences and avoiding negative trajectories associated with risks" (Fergus and Zimmerman, 2005). Most adolescents in high-risk situations become highly functioning adults – they successfully implement the resiliency process. Cognitive development plays an important role in this process (Masten, 2004). The transition from early to late adolescence, the period when most homeless youth leave home, seems to be a critical period when either risks or protective factors emerge.

Resilience is not a trait but rather a state of being based on current availability of assets and resources. Both internal and external factors are important for an individual's ability to overcome pressures that may result in negative outcomes. Assets are the positive, internal factors such as high self-esteem, coping skills and competence. Resources are external positive factors including parental support, community organizations and adult mentoring (Fergus and Zimmerman, 2005). Both assets and resources are the tools that an individual can use to protect one's self from stressors that might increase vulnerability to negative outcomes such as discrimination,
substance abuse, early pregnancy, STDs, mental illness and violent behavior. These stressors may be biological (e.g., prenatal exposure to substances with potential for developmental delays), psychological (e.g., maternal depression or other psychopathology), economic (e.g., malnutrition and inadequate health care), and social (e.g., high unemployment and crime) (Aronowitz, 2005). Finally, assets and resources are highly contextual. In one scenario, a male companion for a homeless woman may protect from victimization by other men but may also place the woman at a higher risk for unintentional pregnancy.

There is a considerable amount of research on the resiliency process of homeless adolescents. Some argue that being homeless is evidence that these adolescents are not resilient because they have not been able to adapt to stressors and are now living on the streets. Others have argued that in fact for many homeless youth, the decision to leave home is in itself evidence of a youth's resiliency (Barry et al, 2002; Mycek, 1999) – they leave home in a courageous attempt to avoid further abuse. Regardless of the path to homelessness, these youth have become even more vulnerable to victimization, exploitation and the negative outcomes discussed above. As a means of self-preservation, all homeless people must develop strategies for protecting themselves. In their cross-sectional in-depth interviews of eleven shelter-based individuals, McCormack and MacIntosh (2001) found that homeless individuals use internal factors such as lifestyle changes, attitude and personal values as well as external factors including use of services to avoid negative effects on physical and mental health.

Studies on homeless youth have revealed that once on the streets, youth incorporate a wide variety of strategies. In a secondary analysis of three cross-
sectional, qualitative studies of homeless youth in central Texas, Rew (2003) examined individual interview and focus group interviews for personal strengths that serve as motivators for health promoting behaviors. Homeless youth know their environment, develop street-wise skills, and utilize youth-specific services and other services where they feel comfortable. They maintain a network of peers that protect against loneliness and hopelessness (Rew et al, 2001a). They also have pets (dogs, cats, mice, and other animals) for protection as well as to combat some of the loneliness and isolation of homelessness (Rew, 2000). Internally, homeless youth also use self-improvement including sense of freedom, responsibility for others, feeling good/satisfied with efforts to promote health and setting goals for the future as ways to feel persevere through difficult situations. Homeless youth actively try to better themselves by learning new skills, engaging local resources such as libraries and practicing assertive communication skills in negotiating with peers (Rew 2003). Resilience can be interpreted as evidence that a homeless youth actively make decisions and take action to end threatening situations.

All of these external and internal factors of resilience are crucial to understanding the decision-making of a young, homeless pregnant woman. As young women attempt to navigate through their pregnancy, they will rely on the personal assets and resources available to them. The ability to recognize and support the personal strengths and resources available to a young, homeless pregnant woman may be key to facilitating her decision-making process.
Pregnancy Decision-making

We know that homeless youth are exposed to high levels of stress, abuse and violence. We know that homeless youth leave home at a young age during a period of critical periods of development for decision-making and that they have the capacity for resilience and courageous decision-making. We also know that homeless women and men have a high probability for becoming pregnancy and facing an important life decision while homeless. There is very little research on the subjective experiences of pregnancy and decision-making among the homeless youth. This section is reviews the literature available on the process of decision-making and how it relates to pregnancy. The literature on pregnancy decision-making is based primarily on housed populations.

Understanding decision-making

Decision-making is not a single act. It is a process that draws on deeply held beliefs and attitude and molds them into action. For most individuals, everyday decision-making is usually subconscious. In contrast, the decision-making of life-altering events is an active process that prompts evaluation of ingrained beliefs and attitudes in considering future actions. All types of decision-making require a complex set of cognitive processes that include information search, processing, problem solving, judgment, learning and memory (Mann et al, 1989). These skills are acquired as a part of the cognitive development process that begins in early childhood and continues through adolescence and even into young adulthood (Beckman, 2004). As we have seen, the cognitive development of many homeless adolescents may have been less than ideal.

While age and increased cognitive capacity are certainly correlated with the increased ability to make autonomous decisions, the development of decision-making
is more complicated. Traditionally, cognitive development has been organized as a linear progression from less sophisticated thinking in childhood to more sophisticated in adolescence and adulthood (Jacobs and Klaczynski, 2002). Most models of decision-making development are also structured progressively: the child is an immature decision-maker who needs help and guidance from parents to navigate through options and consequences while the ideal adult decision-maker is a “supreme economist” and “superb statistician” who is able to balance risk and benefits of a situation.

Mann et al. (1989) describes a competent decision-maker as one has obtained nine important characteristics: willingness to make a choice thus indicating internal locus of control, comprehension including meta-cognition (understanding one’s own decisions), creative problem solving; compromise; consequentiality; correctness of choice (ability to make the “right” decision), assessment of credibility of information sources; consistency (showing a pattern of decision-making); commitment to the decision. By age 15, most adolescents are able to demonstrate competence as decision-makers, particularly in areas in which they are knowledgeable. However, adolescents are less competent decision-makers than adults in their abilities to seek advice, evaluate a situation, balance multiple goals at one time and process information quickly (Byrnes, 2002).

Jacobs and Klaczynski (2002) have argued that the development of decision-making is actually the process of developing two different information-processing systems, the experiential and the analytic. In any given situation, we are presented with more information that can be processed consciously. In order to deal with the most amount of information, we develop heuristics or short-cuts. In experiential
processing, we use inductive reasoning to develop context-specific memory and short-cuts for processing the information. This processing is sub-conscious, requiring little cognitive effort and can lead to mistakes. For example, a homeless youth may learn that authority figures are a threat. When this individual interacts with a social provider, he or she likely assumes that authority figure is there to censor or control his or her actions, not protect or help. These heuristics are seen in children as young as five and can be very useful in judging the probability of events.

What happens when the social service provider is trying to help? The answer is that simultaneously, children and adolescents also develop the analytic processing system, which allows for the suppression of these short-cuts. While experiential processing occurs in contextualized situations, analytic processing is fundamentally decontextualized. It allows the decision-maker to view the situation as unique from all others and evaluate choices and consequences of these choices as unrelated from other scenarios. In the previous example, the adolescent views the social worker as a new entity with no previous history. While these are crude examples, they are meant to illustrate that youth who have not developed an analytical processing system may be unable to approach a new situation without falling back on the heuristics learned as a child.

Homeless youth may also not have the luxury of using an analytical processing system. We know that children and adolescents who have been abused are more to have negative self-image, less trust of others and more feelings of betrayal (Fischer et al, 1997). While no study has specifically linked the development of decision-making with maladaptive behaviors, it seems that abused children may rely more heavily on experiential processing than analytical processing – they cannot afford the risk of
decontextualizing a situation. This may be adaptive in the short-term goal of immediate protection but maladaptive in the long-term need of building and maintaining meaningful, trusting and long-lasting relationships.

*Stress and Decision-making*

The impact of stress on decision-making is particularly important to consider within the context of young, homeless pregnant women and men. Stress produces a narrowing of attention and scanning of options. It tends to decrease the chances of discovering the best option in a complex situation. This may be particularly true for adolescents who have little social support. With little guidance, they may not have the awareness of negative consequences of poor decisions that are important in the acquisition of risk-balance management. Psychoactive substance use is also associated with similar affects on decision-making as stress (Byrnes, 2002).

Studies have been quite consistent in revealing that most adolescents engaging in risky behavior understand that they are engaging in an activity that is dangerous and do so despite knowing the dangers (Steinberg, 2005). One proposed explanation for this phenomenon is that younger people are able to understand and perform the same logical risk-benefit analysis that adults perform but that this process is somehow altered by presence of their peers (Gardner and Steinberg, 2005). Teens are more likely to engage in risky behaviors such as smoking and driving under the influence while accompanied by their peers than adults (Spears, 2000). Homeless adolescents function in an environment in which they are primarily surrounded by their peers and do not have more “adult” role models for support (Finkelstein, 2005). Thus the increased likelihood for risky behavior may be partly a function of their social circumstances.
Adolescents are more likely to take risks because peer influence (Steinberg, 2005), to use heuristics in judgment (i.e. "I've done it before and it didn't hurt me") and to lack the life experience of mistakes (Byrnes, 2002). There is also evidence that, in fact, younger adolescence are better assessors of risk than young adults (Millstein and Halpern-Felsher, 2002). In this study, young adolescents (5th, 7th and 9th graders) and young adults between 20-30 years old were asked to assess the risk of various actions. Interestingly, adolescents were far more likely to overestimate risk than young adults (e.g., getting sick after excessive alcohol use). This is likely due to the continued development of heuristics. As young homeless men and women do not use contraceptives, perhaps they develop feelings of invulnerability as a result of fewer than expected negative consequences leading to more unplanned pregnancies.

Recent research has shown that adults are neither always the most competent decision-makers nor are children completely incapable of making logical decisions. In an elegant experiment, subjects choose cards from four different decks: two decks have high gains but are paired with occasional and high losses or moderate and frequent loses – these decks result in a net loss over time; the other two decks have lower gains but are paired with either frequent, small loss or sporadic modest losses – these decks result in a net gain over time (Crone and van der Molen, 2004). The youngest children (6-9 year olds) chose equally from the both “net loss” and “net gain” decks with improvement over age of child (10-12 year olds and 13-15 year olds) with the oldest (18-25 year olds) pulled from the “good” deck 75% of the time and shifted earlier than the other age groups. In another experiment of adults, healthy adults also shifted earlier to the “good” decks of cards but those with lesions in the prefrontal cortex, individuals with substance abuse problems and those with daily high risk-taking
activities persisted in choosing from the “bad” decks (Stout et al, 2005; Cauffman E and L Steinberg, 1995).

Although there have been no studies conducted on homeless youth and their decision-making strategies, we do know that 71% would qualify for a diagnosis of drug abuse disorder (Kipke et al, 1997a). Extrapolating the results of the card study, homeless youth may also pull more often from the high yield/high risk deck of cards than their counterparts because they are a population who engages in high risk behavior and often have substance abuse problems. This suggests homeless youth may have differential development of the prefrontal cortex, an important area of the brain in decision-making. Additionally, we know that high stress can lead to alterations in the prefrontal cortex, indicating that homeless youth may be at higher risk for altered decision-making and risk management. Homeless youth are making decisions for themselves at earlier ages, experiencing development of decision-making in a social environment made up of primarily peers and undergoing extreme stress that may alter their ability to process information. When confronted with decisions regarding sex, pregnancy and life altering changes, homeless youth may not have the same decision-making skills as many their housed counterparts.

Pregnancy Decision-making

Reproductive decision-making is an incredibly complex process that is simultaneously and fundamentally biological, psychological and social (Miller, 1994). Miller (1994) and Moos et al (1997) agree that reproductive decision-making is a mixture of conscious, unconscious and learned processes. Both authors argue that most individuals enter a sexual relationship with the knowledge that unprotected sex or protected sex in which the contraception fails can lead to pregnancy. This level of
knowledge is generally true for most adolescents (Davis, 1994). In actively using contraception, most heterosexual individuals are consciously choosing to protect against themselves against pregnancy (and or sexually transmitted diseases). However, the opposite is not true — in not using contraception, an individual may not actively be seeking to become pregnant.

**Contraception and Pregnancy Decision-making**

Miller (1994) and Moos et al (1997) both suggest gradations of reproductive intent — some do not use contraception in an active, conscious act to become pregnant; others do not use contraception, are not actively seeking to become pregnant but are not against having a child; still others do not use contraception believing that they are unable to become pregnant. Others risk pregnancy (or an STD) for some benefit including spontaneity of intercourse, perceived pleasure of unprotected sex or barriers to the use of contraception. Adolescents are often particularly ambivalent about their reproduction — they may or may not want to delay child-bearing which can have significant effects on their contraceptive use and the consistency of that use (Bruckner, Martine and Bearman, 2004). Adolescents who become pregnant most often cite that they would not mind having a child, or explicitly want a child, as the most common reason why they did not use contraception during intercourse. These reasons are followed by contraceptive failure, perception of inability to get pregnant and “not getting around to it.” Moos et al, (1997) suggests that the effectiveness of public health message in educating that contraception prevents pregnancy may contribute to individual’s beliefs that they are infertile. By incorporating this message and past experience of not using contraception but not becoming
pregnant\(^1\), individuals interpret this to mean that they are unable to become pregnant. This may be particularly true for adolescents who are still learning about reproduction and contraception (Bruckner, Martine and Bearman, 2004) and women who are substance abusers (Murphy and Rosenbaum, 1999, p. 51-53). Homeless women are less likely to have access to contraceptives and are more vulnerable to coercive sexual relationships, sexual violence, and survival sex than the housed populations on which models of reproductive decision-making are based (Bloom et al, 2004).

*Pregnancy Options and Considerations*

Once a pregnancy has been confirmed, an individual must begin to consider his or her present situation and assess their resources and ability to invest emotionally and physically into becoming a parent. This is often a time when people consider their life holistically – “where have I been and where am I going?” This decision allows for retrospective consideration of their own childhood and the strengths and weaknesses of parenting that they experienced. Both the mother and the father will often consider the quality of the relationship with their partner and the various support individuals in their community (i.e., family, neighbors, etc.). He or she may also consider the magnitude of financial and social responsibility that is inherent in caring for and raising a child. While the outcome of the decision-making will vary widely, the process of making the decision almost universally provides an opportunity for an individual to evaluate their priorities, life ambitions and role of children and partners in their life (Shvo et al., 2003; Seibold, 2004; Lena and Hammerstrom, 2004).

In general, a couple has four broadly defined choices when a pregnancy is

\(^{1}\) After three months of sexual intercourse with no contraception, only 50% of couples will become pregnant.
confirmed:

1. Terminate the pregnancy
2. Continue the pregnancy to term and maintain primary custody of care
3. Continue the pregnancy to term and allow child to be fostered in a formal institution (foster care) or informal setting (grandparents or other relatives) without relinquishing parental rights
4. Continue the pregnancy to term and relinquish parental rights to one or more individuals

These four choices are particularly relevant for women whose pregnancies are "unintended." While homeless pregnant women do have high rates of unintentional pregnancy, they are certainly not an anomaly. In the United States, 49% of all pregnancies are unintended, meaning unplanned and/or unwanted (Henshaw, 1998). There is a very clear inverse relationship between age and intention of pregnancy – amongst 18-19 year old, 75% of pregnancies were unintentional, in 20-24 years old 58.5% were unintended and in 25-29 years olds approximately 40% of pregnancies were unintentional. Unintentional pregnancies are associated with more negative outcomes if they are carried to term (Husley et al, 2000; Sable et al, 1997).

Pregnancy Intention and Decision-making

Much of the literature concerning reproductive care and homeless women focuses on the high rates of unintentional pregnancy (Gelberg et al., 2002; Reid et al., 2005). Because unintentionality has significant impacts on pregnancy resolution decision-making (Fischer et al, 1999, Moos et al, 1997), it is important to unpack the meaning of this word. Researchers conducting qualitative interviews with women have consistently argued that the terms unintended, unplanned and unwanted are
irappropriately used interchangeably (Fischer et al, 1999, Moos et al, 1997). For many women, these terms are not useful in decision-making because planning is a process that occurs only after pregnancy status has been confirmed. (Moos et al, 1997).

Particularly among adolescent women, the term “unwanted” is more related to decision-making than if the pregnancy was “unplanned.” More “unwanted” pregnancies end in abortion versus those that are “wanted” but “unintended” (Fischer et al 1999). Unlike mistimed or unintended pregnancies, unwanted pregnancies are correlated with poor outcomes such as low birth weight (Sable et al, 1997) and the late onset of prenatal care among low-income adolescents (Husley et al, 2000). The determinants of pregnancy wantedness are often relationships with other people including support from family and friends, attitudes towards children and abortions and general feelings about readiness are correlated with feelings of wantedness more than intention or planning to get pregnant (Fischer et al, 1999). Pregnancy wantedness is directly related to partner support (Kroelinger and Oths, 2000), marital status and partner’s childbearing desires are directly correlated with pregnancy wantedness (Miller, 1994). Moos et al (1997) corroborate this finding and additionally found that having a home was correlated with wanted pregnancies. There are no studies focusing on homeless women and pregnancy intention. However, we should be careful in assuming that an unintentional pregnancy among homeless women is necessarily unwanted.

Abortion

Of unintentional pregnancies, approximately 50% will end in abortion. In the United States, women who choose to terminate their pregnancy are most often unmarried and young (Henshaw, 1998). In the most comprehensive study of American
women choosing abortions, Henshaw found that over 70% of women cited a dramatic change in life and inability to afford a child. Other women cited potential problems with the fetus (13%) or their health (12%) as major factors for choosing abortion. Additional reasons included having enough children, partner's wish to not have children and pressure from male partner as reasons for having an abortion (Finer et al, 2005; Broen et al, 2005). Sivho (2003) found that women who have higher educational background are more likely to have an abortion, while those with lower educational goals are more likely to have a child to gain social identity.

Adoption

Of the 50% of pregnancies that are carried to term in the Untied States, less than 1% of these will be formally voluntarily relinquished for adoption (Chandra et al, 1999). Formal relinquishment is a legal process in which parental rights are transferred from the biological parents to one or more individuals. The number of women choosing to adopt out their children has declined substantially in the past three decades due to legalization of abortion in 1973 (Bitler and Madeline, 2000), increased social acceptance of single motherhood and social support programs (Miller and Coyl, 2000) and decreased stigmatization of illegitimate children (Nathanson, 1991). Chandra et al. (1999) have also argued that there has also been an increase in informal relinquishment of children to relatives and neighbors for care, particularly in the African American community.

Namerow et al (1993) found that women choosing adoption were much more likely to be European-American, above average education aspirations and had a personal relationship with adoption (was adopted or knew someone who was adopted). Among women 12- 23 years old, internal locus of control and higher self-
Esteem were related to deciding to voluntarily relinquish (Dworkin et al, 1993). Kalmuss et al. (1991) found mothers and partners were the most influential people in an adolescent's adoption decision-making. The adolescent's mother's preference for adoption influenced initial decision-making. The father of the child's preference for adoption influenced the plan for adoption – the more in support he was for adoption, the more the mother was to stay consistent with her plan for adoption. In Kalmuss' study, nearly 20% of the 162 women changed plans through the pregnancy – 32 decided to switch from adoption to parenting and only one switched from parenting to adoption throughout the pregnancy. There is no information about adoption rates among homeless women.

**Parenting**

In the 1990's, the teenage birth rates in California have dropped from 73 per 1000 births aged 15-19 in 1991 to 57 births per 1000 women aged 15-19 in 1997 (Ventura, Mathews and Curtin, 1999). In Frost and Orlak's study of 187 women aged 15-19 years in California, teenagers who are members of an ethnic minority, poor, have lower education and lower educational aspirations were more likely to choose to parent than teenagers who choose to abort a pregnancy (1999). Those choosing to parents were most likely to cite wanting to parent as the most important reason for their decision. About a third maintained custody because they were against abortion or adoption, 19% were against abortion and adoptions and 3% were keeping the baby because other people's influence. In making the decision, 23% stated that the decision was their own, 34% cited their boyfriends as the most influential factors in their decision, 20% cited their mother and 15% cited another relative. Almost one half (45%) describe their pregnancy as a meaningful and positive experience in their life.
For many teens, pregnancy decision-making, particularly the decision to parent, can steer them towards a different life course (Kowaleski-Jones and Mott, 1998.) In a qualitative study of 20 adolescent mothers, Rentschler (2003) found that young women became more motivated to finish school than before they became pregnant. They have quit smoking, drinking and using drugs. They eat more nutritious foods. In addressing responsibility, they have sacrificed being carefree teenagers for the responsibility of being a mother. Overwhelmingly, these adolescent women were committed to being the "best mothers they could be."

*The Decision-making Process*

Most studies of pregnancy decision-making focus on women who choose specific outcomes and then investigate the factors that influenced women to make certain choices. There are many quantitative studies that attempt to construct a population-based assessment of factors influencing pregnancy resolution outcomes (termination, relinquishment, parenting). These studies almost exclusively focus on women. There are only a handful of studies that focus on the birth fathers and their own subjective experience of fatherhood. There are also very few in-depth qualitative studies that investigate the decision-making process, not just outcome. There is evidence that the process is important in post-decision emotional state. Ambivalence in the decision-making process is a predictor for post-abortion emotional problems (Tornborm et al, 1999). The strongest predictor of emotional distress post-abortion is pressure from male partner (Broen et al, 2005).

In three small, phenomenological studies of women and their pregnancies, all the researchers found that the decision-making process was an intensely emotional time when personal values and evaluation of current relationships to self and others became
very important. Lena and Hammarstrom (2004) investigated five Swedish women's (19-33 years old) experiences of choosing to terminate their pregnancies. Other people, particularly mothers, partners and friends, profoundly influenced the women’s decisions. However, all the women stated that the final decision was their own. Seibold's study (2004) of five young (17-23 year old) pregnant Australian women choosing to parent focused specifically on how these women navigated their pregnancies. These women used their pregnancies to signify their passage into womanhood. In negotiating the decision to become mothers, these young women balanced the positive aspects of maturation and increased self-confidence with the ambivalence of accepting the responsibility of caring for a child and losing their individual identity to motherhood. Hanna (2001) found similar themes in a study of five, white Australian mothers under 20 years old, particularly the idea of pregnancy as a transformative event, opportunity for change and a pathway for dealing with their own tumultuous and disrupted childhoods. These women also realized that their decision had resulted in abandoning social supports (termination of family support, loss of friends as a result of the pregnancy) and leading publicly scrutinized lives. Unfortunately, there were no studies available on the decision-making process of American women.

*Pregnancy Decision-making among Drug Addicted Women: A Comparison*

While there is little information on homeless women and their pregnancy decision-making process, some comparison may be drawn from drug-addicted women who also have high rates of unplanned pregnancies, troubled childhoods, and risk for pregnancy complications. Murphy and Rosenbaum interviewed 120 drug-addicted or recently drug-addicted women (1999). Some were homeless or were temporarily
housed with friends and relatives. Once they discovered they were pregnant, many of these women were simultaneously excited and fearful at the prospect of becoming a mother. All the women acknowledged that drugs were dangerous to their developing child. The prospect of motherhood provided an opportunity to both change their lives by attempting to stop, or at least decrease, drug use. They were fearful that they would be unable to stop using drugs and cause damage to their child. They were also fearful that the authorities would discover their pregnancy and drug use and taken custody of the child because they are "not good enough" to parent. For some women, the pregnancy was the catalyst they needed to change their lives – they used their developing child as motivation to create a better life for themselves and for their child. While many women expressed the desire to change their lives, not all were successful. However, even for those women that were not able to completely quit using drugs, they described a harm reduction approach to their decision-making. Many paid more attention to getting enough to eat, taking prenatal vitamins and sleeping. Others tried to substitute what they perceived to be less harmful drugs such as marijuana for more dangerous drugs like heroin and crack cocaine. They would use goldenseal, vinegar and pickle juice as methods for clearing drugs faster and provide a clean urine sample to their care provider.

Murphy and Rosenbaum argue that many of these women have had difficult lives characterized by poverty, racism, childhood abuse, domestic violence and mental illness. Many attempted to overcome these barriers to a fulfilling life through a pregnancy. As they interacted with social services agencies, many of these women found it difficult to obtain non-judgmental services that will help achieve their goal of raising their child. In interacting with social and health providers, these women were
simultaneously fearful of "baby-snatchers" and looking for approval as "fit" mothers. While this study does not focus on homeless women, drug-addicted women must also navigate through less than ideal circumstances for a pregnancy, judgmental attitudes about their worth as mothers and the fear of having their child taken away if they do not meet expectations of social services.

**Male Partner Decision-Making**

While there is some information about the subjective experience of pregnancy from a woman's perspective, there are very few studies on male decision-making in pregnancy. In a Swedish qualitative study of 18 men aged 15-26 year involved in a pregnancy that ended in abortion, overwhelmingly the men stated that they wanted to be involved in the decision-making process. The quality of the relationship with his partner, consideration of his partner's wishes and psychosocial factors such as his own education goals and ambivalence about fatherhood were all the most important factors cited in making the decision to abort (Holmberg and Wahlberg, 2000). In deciding to adopt, Canadian 74 adolescent men also stated that they wanted to be included in the discussion and stated that their partner's wishes and their parent's opinion were the most important factors in their decisions (Redmond, 1985).

Peterson and Jenni (2003) make the interesting observation that male involvement in reproductive decision-making is often characterized as a problem or an obstacle for women. In their study of six men aged 20-44 years old who are involved with their first pregnancy, these men cited that the decision to become a father was overwhelmingly characterized by ambivalence, most intensely at the beginning of the process. When coming to term with the limits of personal control and change, these men were able to embrace the change that fatherhood would bring. In the process of
the pregnancy, these men constructed new identities for themselves around fatherhood and integration with their partners. All these men stated that the decision-making process did not end with deciding to father a child, but was an ongoing journey of transformation and acceptance of a new self and a new life.

The Role of the Service Provider in Decision-making

There are not many studies on the perception of individual, pregnant women and their social service provider during pregnancy decision-making. In Frost and Oslak’s study of 260 California pregnant adolescents aged 15-18, 56% of the women stated that they discussed pregnancy options with clinical staff. However only 4-5% stated that clinical staff or at any other facility were important in their decision-making process. No studies have been published reporting pregnant woman’s (or man’s) perception of social service providers as helpful in helping them realize their decisions.

In contrast, there are several studies that discuss options counseling from the provider’s perspective. Many of these studies conceptualize the ideal pregnancy care provider as a non-judgmental individual who provides information and facilitates her client’s own decision-making process. These studies also acknowledge that many providers are biased towards certain decisions and may influence their clients consciously or unconsciously.

Levy (1999) observed 12 British midwives engaging in prenatal care. Researchers identified “triggers” that were thought to facilitate decision-making and the midwives were asked about these cues in a subsequent interview. Midwives saw themselves as engaging in “protective steering,” an attempt to meet needs of the woman while steering way through potential dilemmas. They had to balance providing enough information but not too much as to avoid intimidation. The midwives
acknowledge that if they made a mistake in assessing the needs of their clients, they could be perceived as patronizing and unsafe. These midwives assessed their clients' needs through "territory mapping" – a combination of making assumptions about a woman's life experiences, exploring the individuality of the woman and then adjustment of approach to meet the client's needs. These midwives saw their role as raising awareness about pregnancy choices and protective gatekeeping to information that facilitates a woman's choice but protecting against intimidation or fear. Singer (2004) recommends that providers counseling women with unintended pregnancies acknowledge that ambivalence on the part of the women may have less to do with confusion about choices and more to do with the realizations that her life circumstances may be less than ideal. Surman (2001) advises providers to acknowledge that young women may have limited experience in making important life decisions but this does not mean that they are incapable of making these decisions.

While these studies do not specifically address the homeless population, these authors unanimously agree that the role of the pregnancy care provider is crucial in providing a safe space for the obtaining information to facilitate the pregnancy decision-making process. This may be particularly true for homeless women who may not have other safe places available. The authors also agree that a provider's role is difficult as they must balance providing objective information, subjective assessment of the needs of the individual women and their own emotional reactions to a woman's particular situation. This balance may be particular relevant for providers dealing with the young, homeless woman who often lack resources, need tremendous amount of support but may be distrustful of the provider's intentions. There are no studies that
focus on the role of the service provider in a man's pregnancy decision-making process.

The Little That Is Known: Pregnancy, Decision-making and Homeless Youth

There is little that can be said for certain about pregnancy decision-making among homeless youth. We know that many young homeless women and men will be confronted with pregnancy while homeless. Except for those that miscarry before they know they are pregnant, these women and men will have to contemplate their options and make difficult decisions about their future. When confronted with these decisions, young homeless men and women have essentially the same choices as the rest of the population: terminate, relinquishment, parenting or fostering. In one study of 203 homeless youth, 53% of the women had a history of pregnancy and many had a history of multiple pregnancies. A majority, 69%, had experienced a miscarriage. At some point, 43.3% had had an abortion, 23.3% had a live birth and 9.5% were currently pregnant (Halson and Lifson, 2004).

In considering their choices, ease of access to care is absolutely imperative. Ensign (2000) found that of the twenty women aged 15-23 years old interviewed, sixteen reported hearing about and four reported trying abortive methods such as “beating it out of me” by self or partner, intentional overdose on substances and herbal abortificants including pennyroyal, blue and black cohosh and motherwort. While this data may point to the need for increased access to health care, particularly pregnancy related services, it also points to the need to understand the decision-making process of homeless youth and how social and health services can help facilitate this process.

Among young homeless women, there is very little information about the
decision-making process. Saewyc (2003) is the only researcher that focused on subjective experiences of young (17-19), homeless pregnant women. In a focused ethnographic study exploring the life experiences and environmental contexts associated with pregnancy among “out of home” adolescents, the eight participants emphasized several domains in making sense of their pregnancies, their homeless status and their decision to parent. Like most of the literature on homeless youth, these women’s narratives describe patterns of conflict, violence, abandonment and loss. And like most of the literature on pregnancy decision-making, these women emphasized their past, present and future relationships with their families and partners. Childhood experiences were crucial in considering how they would provide for their child. Every participant mentioned family break and loss of parents as an important factor in making sense of their pregnancies and their futures as mothers. Interestingly, while they had very tumultuous relationships with their mothers, they often defended them as doing the best parenting they could under difficult circumstances. None of the women had any relationships with their father. All eight of these women had experienced sexual violence and six were molested as children. These women have had the experience of growing up with parents who were mentally unstable and had substance abuse problems, including suffering from Fetal Alcohol Syndrome. They had unstable housing situation growing up with constant flux in housing, histories of homelessness as children and being thrown out of their homes early in life. None of these women had finished high school.

Saewyc argues that many of these youth women used pregnancy as a coping strategy “to mitigate the psychological and physical damage of developmentally toxic environment and experience.” A pregnancy can be seen as a step away from risky
behavior and towards a new life with a child. As expectant mothers, half of the women had reentered school and the other half would like to return. Finally, six out of eight women mentioned spirituality, not necessarily religion, as providing them with the strength to continue living and grow as individuals. While this study does not address how these women chose to parent over other options, it does provide an excellent understanding of these women’s childhood, present situation and their vision of the future. With information about the major influences on young, homeless and pregnant women’s lives, perhaps we can begin to understand the factors that influence women to choose parenting, fostering, adoption or termination.

**Meeting the Needs of a Challenging Population**

While we know that many homeless youth will experience an unplanned pregnancy, we know very little about the process of decision-making in young, homeless pregnant women and their partners. On the one hand, homeless youth have experienced an incredible amount of stress at a very early age, which may affect their cognitive development and ability to process information. On the other hand, homeless youth are often incredibly resilient and utilize a wide variety of resources, including social services, their own homeless youth community and personal strength to survive on the streets. We know that the pregnancy decision-making process is an important life altering moment for many women and men and that pregnancy care providers can be important gatekeepers to information and services. However, we do not know how homeless youth, a population that is notoriously weary of authority and institutions, make decisions and then find the resources to follow through with their decisions.

Knowledge of this process could be vital in improving services for this population. A deeper understanding of homeless youth’s perceived choices, process of
deliberating these choices and the experience of following through with the decision could provide invaluable information to pregnancy care providers, social workers and outreach workers interacting with expecting homeless youth. Not only could this information be vital in understanding pregnancy within the life cycle of the homeless youth but it could also provide information about other situations in which homeless youth are motivated to engage with social and health services, such as drug overdose or mental health crisis. For many men and women, pregnancy is a powerful motivator for change and self-evaluation. For homeless youth, pregnancy may also serve this purpose by providing an opportunity for transformation. Let us not miss the opportunity to support homeless youth because of lack of insight into their decision-making process.
CHAPTER II

Homeless and pregnant, now what? — A introduction to gap in the knowledge

Based on the preceding literature review, we know that homeless youth as a population have high pregnancy rates compared to their housed peers. The literature describes their pregnancy outcomes, including high rates of abortions, children in foster care and poorer outcomes for children of homeless women. However, there is very little known about the pregnancy decision-making process of young homeless pregnant women. Furthermore, young homeless men have been completely excluded from the discussion of pregnancy. There is a gap in knowledge regarding the subjective experience of being pregnant, or having a partner who is pregnant, and homelessness. While we can speculate about the difficulty of pregnancy as a homeless person, we lack information about the priorities, fears or expectations of young, homeless women and men when confronted with a pregnancy. We also do not know how homeless youth implement their decisions and negotiate their available resources.

This research aims to answer the following questions:

1. What is the experience of pregnancy and pregnancy decision-making of street youth in Berkeley?

2. What is the role of homelessness in influencing this decision-making?

3. What resources and services do young homeless women and men access to implement their decisions?

Methods

Study Design

This study used a mixed qualitative methodology including participant-observation and semi-structured interviews to investigate the experience of pregnancy
and decision-making of young, homeless women and men. Field research was an important component of understanding the context of pregnancy in this population. Fieldwork was conducted at places where street youth congregate including Telegraph and Shattuck Avenues, People's Park and the Suitcase Youth Clinic. Telegraph and Shattuck Avenues are main streets in Berkeley where youth often congregate on the sidewalks in small groups. People's Park is a piece of land, owned by the University of California – Berkeley (UCB) that has historically been an open area where homeless and non-homeless individuals congregate. People's Park is a venue for some homeless services including free lunch and a clothes box. The Suitcase Clinic is a weekly drop-in clinic aimed at providing a safe place for homeless youth aged 18-25. However, individuals who are older than 25 but are socially part of this group are welcome to attend. Suitcase Clinic is staffed mostly by UCB undergraduate students who coordinate and organize services including a hot meal, foot-washing, hair-cutting, creative activities such as art projects, free clothing and some referral services such as dental care. There are also graduate students, including medical, social work and law students, and community professionals (doctors, lawyers, homeopaths and mental health counselors) who volunteer to provide health, legal and other services. Suitcase Clinic has an official memorandum of understanding with Berkeley Primary Care Access, a local clinic that provides health care to uninsured, Medi-cal and insured clientele. Referrals from Suitcase Clinic, including prenatal visits, are referred to this clinic. I volunteered for two years in the medical division of the Suitcase Youth Clinic before formally recruiting for this project.

Field research was conducted as 'hangout” sessions during the Suitcase Youth Clinic or at main gathering areas of this community, including People’s Park and
Telegraph Avenue. Important events and conversations, both pregnancy and non-pregnancy related, were recorded as field notes. I also participated in facilitating care for homeless youth including pregnant women outside of Suitcase clinic. This facilitation included driving to appointments, listening to concerns and referring when services were requested. As a result of working closely with many homeless youth, I am recognized as a member of the youth-service community.

Semi-structured interviews provide the bulk of data about the experience of pregnancy decision-making within this community. I began the formal interviewing and recruiting in June 2005, after receiving Committee for Protection of Human Subjects (CPHS) approval. Women who were currently 18-26 years old or had been 18-26 years old during their pregnancies were eligible. The male partners of these women were included regardless of age.

*Recruitment*

I recruited women primarily through contact at Monday night Suitcase Youth Clinic as well as at People’s Park and Telegraph and Shattuck Avenues. At Suitcase Clinic, women were handed an informational flier (Appendix I) during the intake process and were asked if they were interested in participating. Fliers were given to women who received a positive pregnancy test during a medical visit or revealed on standard medical information question that they are or were pregnant in the past four years. Fliers were posted in other youth specific service sites in Berkeley. In addition, subjects were recruited through the “snow-ball” method, in which women referred me to their partner or a friend for participation.
Interviews

From June - December 2005, I conducted 21 unduplicated interviews with homeless youth. A majority of the interviews (11) were conducted with women alone. Some interviews were conducted with men alone (4). Five interviews were with couples and one interview included two women. Women and their partners who were currently pregnant were interviewed more than once, usually at one-month intervals, to provide a more longitudinal perspective on their decision-making process.

Before the start of each interview, the nature of the research was explained to each potential participant. Each participant was asked if he or she had any questions about the research and/or how the material they provided would be used. Because of the sensitive nature of some of the topics discussed, I was prepared to provide appropriate referrals to mental health and other services if necessary. Participants were assured that the information they provided would be kept confidential but there were some limits to this agreement. If the participant expressed any intention of hurting themselves or others, they would be reported to the appropriate authorities. Each individual was asked to read and sign an informed consent form (Appendix IIa and IIb).

Each interview lasted approximately 1-3 hours and was conducted in English. Interviews took place in comfortable and convenient locations for the participants including local cafes, restaurants, parks and sidewalks that were agreed upon before the interview. A free meal was provided as compensation for participant’s time. All interviews were audio-recorded. A professional transcriber transcribed all of the audiotapes.
The interviews were semi-structured and conversational in tone. An interview guide was used to assure that certain themes were discussed including homelessness history, pregnancy, childhood experiences, factors that influenced their pregnancy decision-making and their experience with social services (Please see Appendix III for interview guide). In follow-up interviews, issues that were ongoing (e.g., social service involvement in the custody of children) were explored.

*Analytical Approach*

Grounded theory is useful to inform the data collection and analysis of a social process that is not well understood (Auerswald and Eyre, 2002). Grounded theory is particularly helpful in generating theory about how individuals “interpret, take action or engage in a process in response to a phenomenon” (Strauss and Corbin described in Creswell, 1997). The process of developing the initial set of salient categories is called open coding. Categories represent a unit of information that inform a certain event or instance. For example, relationship to partner is a category used to inform the process of pregnancy decision-making. Through open coding, multiple perspectives are gathered that saturate the information known about an important theme. Categories are added, removed and altered inductively as additional emerging themes are revised and refined. Thus, as unexpected them emerge, they are added to the set of preliminary codes and codes that do not appear to be relevant for most participants are removed. Simultaneous data analysis and ongoing research allow for emerging hypothesis to guide the semi-structured interviews and codes are iteratively altered to reflect new data.

The next step in this process is axial coding, the interconnection of different categories to a central phenomenon. In this study, the central phenomenon is
pregnancy decision-making. The axial codes inform how certain conditions and strategies address this central phenomenon. As the axial codes emerge, the important conditions of influence and the consequences of using certain strategies over others are connected to the central phenomenon. For example, in the process of pregnancy decision-making, the initial code of relationship to partner becomes connected to relationship with service acquisition as these two categories influence the experience of the central phenomenon. The next step in a grounded theory approach is to build a "story line" (Creswell, 1997, p. 57) through selective coding. This story describes how the different layers of interaction (axial codes) fit together in one conceptual model. This story line answers the question of how the relationship with partner, service acquisition and other axial codes form a common narrative about the experience of pregnancy decision-making for homeless youth. Finally, a researcher can develop a conditioned matrix that contextualizes that social, historical and economic conditions influencing the central phenomenon. In this study, this involves situating pregnancy decision-making within the resources and conditions present in Berkeley for Telegraph street youth.

Using these methods, the field notes and interview transcripts were first read and hand coded. Important concepts were recorded and were used to generate the emerging codebook that was entered into the qualitative research software program, Nvivo ®. As axial codes emerged, the interconnections between important categories were recorded in analytical memos. Interviews and field notes were reread and selectively coded with pregnancy decision-making as the central phenomenon. The emergent concepts and categories were then organized into a conceptual framework that is presented in this paper.
Fieldwork Results

The Telegraph "Street Kids"

Much of the initial fieldwork and participant observation was spent observing the culture of homeless youth congregating around Telegraph Avenue. Berkeley is the home of approximately 850 homeless individuals (Alameda County Homeless Continuum of Care, 2003). According to the official survey based on attendance at homeless service, youth (defined as individuals aged 24 years and under) makes up only 6% of the homeless population. Because homeless youth generally avoid these kind of services, the Continuum of Care Council believes that the survey undercounted the number of homeless youth in Berkeley (personal communication, Jane Micallef, 2006).

Berkeley has been a haven for homeless people since the 1960’s. In the past decade, Berkeley has become part of a network of cities including New York, Seattle and Austin, TX (Finkelstein, 2005) that are popular homes and/or temporary way station for a number of “street kids” and “travelers” (Berkeley Health and Human Services, 1998). In characterizing Berkeley homeless youth, there is a geographic and ethnic division. Those youth who tend to congregate in the Telegraph/Haste area are more often European-American, from out of the state and left home because of problems with parents. While there is no data available on other homeless youth, service providers at YEAH! believe that homeless youth who reside in West and South Berkeley are often originally from Alameda County and report poverty as the primary cause of their homelessness. These youth are more often African-American (personal communication, Sharon Hawkins Leyden, 2006). This study focuses on Telegraph Street youth.
The following information is based on my field observations of Telegraph street youth. Telegraph homeless youth most often refer to themselves as "street kids" and rarely use homeless in describing themselves. These youth are a discrete population with a distinct culture. Approximately 30-40 youth inhabit the Telegraph/Haste area at any one time. Most are male and most are older than 18 years old. About half of these youth stay in the area for most of the year, while the other half is constantly changing as youth leave and arrive from all over the country. The "travelers" live nomadically by hitchhiking or hopping trains. Most have lived on the streets for 1-5 years.

*Reasons for Leaving Home*

Most Telegraph street youth are not from the Bay Area and left home at very early ages. Their childhoods were characterized by multiple moves, difficult time in school, abusive relationships with parents and traumatic events.

"It was rough for me. It was just rough. For a while, my mom was on a lot of drugs...all kinds of abuse. Physical and mental. [My stepbrothers and I] were pretty sexually abused. I was pulled into a car by a bunch of Mexicans but that was like a while ago...a lot of things happened to me in my past, which are reasons why it makes it hard for me to be normal every day."

- 23 year old woman

"Q: How many people do you know are sexually abused here?
A: Everyone. I barely know anybody who has never been molested."

- 24 year old woman

Although many left home because of conflict with parents, they often describe a sense of rebellion and pride in living on the streets. Regardless of the route to homelessness, most youth describe a sense of independence and empowerment in living on the streets.

"I chose this. It was my responsibility to be out on the street and take care of myself. I'm old enough to where I can support myself, take care of myself if I
want to and I'm choosing not to. So it's not my parent's fault it's mine if I get in trouble or I end up getting hurt somehow.”

- 18 year old woman

Despite troubled relationships with parents including abuse, many maintain regular contact with their families.

“I talk to my mom. I don’t talk to my dad. My mom and I have a really good relationship. I call her at least once a week and every time I hitchhike before, during and after. She’ll freak out.”

- 24 year old woman

Social Organization

Generally, individuals use a street name that they acquire during the process of initiation into street culture. Most youth associate in groups of 4-8 individuals, the predominant social unit. Typically, each group sits together on Telegraph Avenue asking for spare change, or “spanging,” for money. The cash is then pooled and used to buy alcohol, drugs and cigarettes. Food is usually obtained through services, “dumpster diving” or “scavenging” for leftovers. If money is used to buy food, it is usually spent on dog food for one or several pets that travel with the group. There are a few lone individuals that do not associate with a particular group. These individuals are often the most mentally disturbed. Sometimes men will travel and/or sleep by themselves but it is extremely rare for women to sleep by themselves at night. Most often, women either partner with a man or travel with another female companion for protection.

Mental Health Issues, Drug Use and Safety Issues

While the most mentally disturbed individuals were isolated from small groups, many street youth described significant mental illnesses. Many of these illnesses presented in childhood.
"I was in and out of mental hospitals...I was really depressed and I was suicidal...I realized that the only reason I felt that was because nobody could tell me the truth; nobody could tell me that what I was learning in school was shit. Nobody could tell why my parents broke up...nobody could tell me why I was going to all these therapists. Why they were giving me these drugs. I didn’t want the drugs and they couldn’t really tell me why. Not a good enough answer."

-24 year old woman

"I’ve been to like a different school in almost every city in the Bay Area. And ever since kindergarten I’ve been moving around a lot. In kindergarten I moved around so much they made my mom hold me back so I did kindergarten two years. And I was prescribed with attention deficit hyperactive disorder, which was really hard for me to deal with in school, especially when they drugged me up on pills...I was in my seat but I couldn’t focus on my work because I was numb in brain."

- 24 year old man

As children, they were unwillingly medicated for mental health problems ranging from ADHD to bipolar disorder. As young adults, many currently use drugs regularly. Virtually all of the street youth use alcohol, cigarettes, and marijuana regularly. Many also use harder drugs including heroin, methamphetamines and crack cocaine. Some youth “just want to party” and “have a good time” with drugs and alcohol. However, for many youth, the mental illnesses they experienced as children have not disappeared; the prescription Ritalin® has often been replaced with street methamphetamines.

"It makes it so when I do speed it does mellow me out and calm me down...as far as I can tell the only difference between methamphetamines and amphetamines is that fact that methamphetamines have a lot of really nasty toxic chemicals in them...But the nasty chemicals are what make it so that people with ADHD take speed and mellow...I love doing a hit of speed and going to sleep."

- 24 year old woman

Unanimously, street youth acknowledge the dangers of drug use. While many are unwilling to give up their drug usage, they do try to moderate their levels, even for
brief periods of time to reduce the strain on their body. Homeless youth are also keenly aware that their heavy use of drugs has often affected their development.

"I'm not very good at socializing all the time. I have a hard time reading. I think it's because I did a lot of drugs. Like when I was in the rave scene I did way too many drugs. I get really paranoid with people sometimes and really self-conscious about what I say to some people. Reading is definitely hard. I space off. I don't really hear voices but sometimes there is weird shit in my head...I have a hard time understanding what people want me to do when I'm working with them. It's like a big block. I imagine it will get better. It's been getting better."

- 24 year old woman

As we have seen, high rates of drugs have been correlated with high rates of survival sex (Greene, Ennett and Ringwalt, 1999; Tyler et al., 2004). Research with homeless youth across the United States has consistently reported high rates of survival sex in this population. Within the Berkeley street youth population, no woman or man I spoke to ever reported engaging in direct exchange of sexual favors for money, shelter, food or drugs. However, all knew of someone who had. Many of the women stated that they had been propositioned for sexual factors but that their male peers were more likely to be propositioned and to participate in this type of exchange.

Primarily because of past experiences, there is a widespread mistrust of authority and institutions in general. Most youth describe police officers as sources of fear rather than sources of protection.

"I don't really have a fear of a lot of things like the ghetto or whatever. The worst thing is the cops. That's the thing that I'm afraid of."

- 18 year old woman

For the most part, street youth try to stay out of trouble with law but are often cited for trespassing, failing to register pets and failing to appear in court.

"You know there's a million open benches – they'll come up and give you a ticket "obstructing park benches" and you're like, 'Obviously I'm homeless, I have no money. I can't pay this ticket. I'm not going to pay it. Obviously I
travel and I'm going to leave. Why are you doing this? You're just an easy target.”
- 23 year old woman

Perspective on Berkeley

Telegraph youth identify Berkeley as a relatively safe and friendly city in which it is relatively easy to survive. They would often choose to come to Berkeley because there were abundant services, tolerant people and youth-specific services.

"Berkeley - it's easy to live. Food is abundant. It's easy to live outside. It's like inner urban camping. There are a lot of people and having such a lot of people in a little space. The leftovers are easy to live on. Elsewhere it's not like that. If you go to Oregon, like Salem where I'm from, people would look down on you a lot more. You don't have the interaction.”
- 23 year old woman

Interestingly, many youth described an unwillingness to spend extended period of time in San Francisco. While there are more youth-oriented services in San Francisco, Berkeley street youth described too much competition and the "sketchiness" of San Francisco.

"I don't like San Francisco. People over there are too intense. They're more extreme over there. Like over there you won't have a person that doesn't like AIDS, you have gay bashing. Over there you won't have somebody that doesn't like blacks, they kill kinda thing. Instead of just having an opinion, they have to totally act on it.”
- 36 year old male

"San Francisco I don't sleep out there. I feel actually safer in Berkeley. Over there you're much more open to rapes and drugs and weird stuff.”
- 23 year old woman

Like homeless youth in other cities, Telegraph homeless youth do not identify with the older, African American homeless population, often referred to as them "crackheads." Because of this cultural separation, the Berkeley street youth generally avoid the adult services. The notable exception to this was one couple that had been homeless only three weeks when I first interviewed them. They did use adult services
but as they became more familiar with homeless youth, they began to frequent youth services more often.

*Homeless Youth Services*

Because of the increased need and visibility of the youth population, many youth-specific services were established in the past five years including the Berkeley Ecumenical Chaplaincy to the Homeless (BECH) Homeplate Drop-in, the Suitcase Youth Clinic, Jubi-Spot Drop-In Clinic, Homeless Youth Consortium Drop-In and the Youth Emergency Advocacy Hostel (YEAH) and the Berkeley Primary Care Access Youth Drop-In Clinic. For most Berkeley youth-specific agencies, “homeless youth” is defined as 14-25 years old. However, most services will accommodate older members of the homeless youth community in order to serve as an inviting and useful venue for this community. Unfortunately, within the last year (2005-06) most of these services have closed for a variety of reasons including funding and not meeting pre-determined goals such as obtaining housing for a requisite number of homeless youth. Currently, there are only two services available specifically for homeless youth – the once a week Suitcase Youth Clinic drop-in and the YEAH shelter, which is only open from December – April. The youth have also noticed that these services are becoming scarce and are concerned.

“There’s a few good programs but they cut HYC [Homeless Youth Consortium], which was good, especially with getting kids into housing. They cut that out. I seen it all coming down and I’m surprised it lasted for so long. Then they cut Jobs Consortium down. And that’s a big “fuck you Mr. Homeless guy.”

- 24 year old male
Interview Results

Interview Participant Demographics

Table 1 shows the participant's demographic characteristics. The demographic information was collected from identifying information asked at the beginning of the interview as well as responses to probe questions about important themes including drugs, history of childhood, education and mental illness. Thirteen women between 18-28 years old were interviewed; five were under the age of 20; six were between 20 – 24 years old and two were older than 24 years old. The eight men interviewed were aged between 22-36 years of age; one was 22 years old, one was 24 years old, four were between 25-29 and two were 30 years old or older. All of the women identified as “White,” except one who identifies as Irish African-American. Two of the men were African-American and the rest were “White.”

Women also described troubled family relationships. Most of the women had left home for the first time earlier than the men. Women left between 11-20 years old (average age = 15 years old) and the men had left home between 17-25 years old (average age = 18 years old). All of the youth described troubled relationships with parents including neglect, physical abuse, parental drug problems and/or multiple moves as children. Six women (46%) reported sexual abuse whereas one man (12.5%) reported sexual abuse. Five women (38%) had been in institutional care such as foster care or a psychiatric hospital before leaving home and while leaving on the streets compared to one man (12.5%). Ten women had received a mental illness diagnosis compared to two men (77% vs. 25%). Finally in terms of education, the women were less likely to have graduated from high school or completed a GED than the men.
Table 1 – Participant Demographics

<table>
<thead>
<tr>
<th></th>
<th>Women = 13</th>
<th>Men = 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages (years)</td>
<td>18-28</td>
<td>22-36</td>
</tr>
<tr>
<td>First Left Home (years)</td>
<td>11-20</td>
<td>17-20</td>
</tr>
<tr>
<td>History of Sexual Abuse</td>
<td>46% (6)</td>
<td>12.5% (1)</td>
</tr>
<tr>
<td>Institutional Care</td>
<td>38% (5)</td>
<td>12.5% (1)</td>
</tr>
<tr>
<td>Mental Illness Diagnosis</td>
<td>77% (10)</td>
<td>25% (2)</td>
</tr>
<tr>
<td>Educational Status</td>
<td>23% (3) High School</td>
<td>38% (3) High School</td>
</tr>
<tr>
<td></td>
<td>38% (5) GED</td>
<td>50% (4) GED</td>
</tr>
<tr>
<td></td>
<td>38% (5) Quit school</td>
<td>12.5% (1) Quit School</td>
</tr>
</tbody>
</table>

Table 2 shows participants’ reported use of drugs and alcohol before or during any pregnancy. There was significant drug use in both the men and women. Most used alcohol and marijuana regularly. Harder drug use (including methamphetamines, cocaine and heroin) was reported less frequently. During pregnancy, some women reported that they continued to use drugs and alcohol but there was a notable decrease in use. Interestingly, there was no reported decline in marijuana use before and during the pregnancy.

Table 2 – Participant Drug Use

<table>
<thead>
<tr>
<th></th>
<th>Women = 13 (Before pregnancy)</th>
<th>Women (during pregnancy)</th>
<th>Men = 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>70% (9)</td>
<td>23% (3)</td>
<td>100% (8)</td>
</tr>
<tr>
<td>Marijuana</td>
<td>70% (9)</td>
<td>70% (9)</td>
<td>87.5% (7)</td>
</tr>
<tr>
<td>Methamphetamines</td>
<td>23% (3)</td>
<td>8% (1)</td>
<td>20% (2)</td>
</tr>
<tr>
<td>Cocaine</td>
<td>15% (2)</td>
<td>8% (1)</td>
<td>12.5% (1)</td>
</tr>
<tr>
<td>Heroin</td>
<td>15% (2)</td>
<td>0% (0)</td>
<td>0% (0)</td>
</tr>
</tbody>
</table>

Pregnancy Status

At the time of the interview, four women and their partners were currently pregnant between 8 weeks – 38 weeks pregnant. All four women were interviewed
multiple times, including one who was also interviewed after delivery. Nine women had been previously pregnant. They had been pregnant between 3 months – 3.5 years prior to participation. Only one man was not interviewed with his female counterpart. His partner had delivered one year earlier.

For many of these youth, this was not their first pregnancy. Five women (38%) and four men (50%) had experienced multiple pregnancies. Two women (15%) reported two pregnancies, one woman (8%) reported three pregnancies and two women (15%) reported four pregnancies. All four men who reported multiple pregnancies reported fathering two pregnancies.

This sample of young homeless men and women has experienced a total of 26 pregnancies. Eight pregnancies (31%) were terminated. Three (12%) ended in miscarriage. Fifteen pregnancies (58%) were continued and resulted in the birth of a child. Three couples were able to maintain custody of their child permanently, although two of these couples had had custody initially removed. Twelve children currently live with grandparents, the former partner or in foster care. None of the children were given up for adoption.

**Table 3 – Pregnancy Outcomes**

<table>
<thead>
<tr>
<th></th>
<th>Abortion</th>
<th>Miscarriage</th>
<th>Live Birth</th>
<th>Long-term Custody</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couples (7 men, 7 women)</td>
<td>3</td>
<td>1</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Single Woman (5)</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Single Man (1)</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>3</td>
<td>15</td>
<td>3</td>
</tr>
</tbody>
</table>
Conceptual Framework

While each of the pregnancy experiences of Berkeley street youth were unique in the particular details of circumstance and emotional quality of the relationship with the pregnancy, it was clear that there were striking similarities in paths taken to resolve their pregnancy. This issue of resolution is central to understanding the experience of pregnancy decision-making in homeless youth because the common thread that weaves these stories together is that a pregnancy is a major destabilizing event for a homeless youth. As reviewed earlier, Auerswald and Eyre’s life cycle model (Figure 2) describes a crisis that can place a homeless youth at disequilibrium with their environment.

Figure 2 – Pregnancy as Crisis in Life Cycle

![Diagram of the life cycle model of youth homelessness.](image)

Fig. 1. The life cycle model of youth homelessness.
The central phenomenon that emerged from this data is that pregnancy is an example of such a crisis because it places the youth in disequilibrium at multiple levels of their existence: their personal priorities as individuals and couples, their street kid community and the greater society (Figure 3). Within each of these spheres of existence, homeless youth experience the crisis that pregnancy, specifically having a child and parenting, is not compatible with their current lifestyle. The ways in which this incompatibility manifests fundamentally impacts pregnancy decision-making.

**Figure 3 – Three Tiered Model of Influence**

As Berkeley street youth attempt to resolve this crisis, they move through these three spheres of influence as depicted in Figure 3. They first consider their personal priorities and current situation, including their relationship with their partner. Expecting youth are then confronted with a change in status within their street kid community. Street youth must interact with the members of the greater society to realize their
decision-making. The following sections have been structured to reflect the
experiences of homeless youth as they work through the process of resolving the crisis
of pregnancy. The sections present the factors that were part of a common experience
of Berkeley street youth. The notable exceptions to these common experiences are
presented to illustrate the ways different strategies of dealing with the central
phenomenon of pregnancy as crisis.

Pregnancy as Crisis at the Individual Level

Partnership and Personal Priorities

In Figure 3, the most interior sphere of influence in pregnancy decision-making is
the couple. To begin to understand how homeless youth experience pregnancy
decision-making is to understand that young women and men make this decision
together. Homeless youth do not usually live in isolation – their primary social unit is
usually at least two people for purposes of companionship and protection. For young
women and men who are involved in an intimate relationship, often the couple
becomes this primary social unit. Ironically, while many of Berkeley street youth
espouse anti-authoritarian and anti-institution values, most youth who are in long-term
relationships consider themselves “street married,” referring to their partners as “my
husband” or “my wife.” The use of marriage and monogamy terminology is most
prominent during a pregnancy as a way to establish legitimacy of the relationship.

“I started cussing at [another homeless woman]. Do you know this is my man? I’m
not a slut. This is my man. I married him. I’m pregnant. I’m definitely not slutty.”
- 18 year old woman
Decision-Making as a Couple

Homeless young women and men overwhelmingly framed their pregnancy decision-making as a collaborative effort. However, this did not mean that the decision-making process is always cooperative. Because of previous childhood and relationship histories, homeless youth often discussed profound relationship difficulties that arose during pregnancy decision-making. Often the process was rife with conflict, disputes and struggles over the pregnancy decision-making. Participants mentioned difficulties in balancing the needs of both partners and fully trusting each other during this process.

“Now you know my background and his background is not stable. So it’s kind of obvious that we’re not going to be the perfectly compatible couple immediately...[while making the decision] was the only time in our relationship that violence between us was involved.”
- 23 year old woman

“I think she doesn’t trust men naturally because her dad died in front of her. So she’s abandoned and her uncle raping her and she’s had horrible boyfriends.”
- 29 year old man

Violence and arguing was particularly prevalent among couples that had disagreements about how to resolve their pregnancy. This was particularly true for those who had split up before or during the pregnancy decision-making process. Despite the dissolution of some relationships, even these couples cooperate during the decision-making process of the pregnancy.

“Because [the pregnancy] kind of drew us together, like closer, and we just kind started seeing each other a little a bit...and then it was like “Okay let’s just get this done with and deal with us after this.”
- 29 year old man

While the fundamental negotiation of pregnancy occurs within the couple, the “final word” is not shared equally. Regardless of the outcome of the decision, the locus of decision-making is the woman. The male partners interviewed corroborated this idea.
While they do not always agree with their partners and were sometimes concerned for the safety of their children or partners, they unanimously state that their partner's choices trumped their own choices.

"I'm for her but my own personal opinion -- I want to have a kid with [her]."
- 29 year old man

"It wasn't really up to me. I wanted to do what was best for her and what was most comfortable for her. So that was basically her own decision. I was there to support it and take her tea and massages."
- 22 year old man

All the men that were directly interviewed support the view that they were making decisions with their partners. However, some women whose partners were not interviewed directly describe pressure from their partners. These women are younger and most often decide to terminate the pregnancy.

"My boyfriend is pretty convinced it wasn't his kid. So he was like 'You're having an abortion I'm never talking to you again.' I knew it was the best for me. But in mind I was like, "Someone will actually be there and love." Someone I can love and someone who can love me..."
- 18 year old woman

"He was bummed because he wanted a kid and there was no way I was going to have a kid with him because he was just shit. I'd been trying to break up with him anyway at the time but he wouldn't let me."
- 24 year old woman

Despite problems and conflicts within individual relationships, in conceptualizing decision-making among Berkeley street youth, collaborative processing between men and women is the dominant paradigm for decision-making. There was one important exception to this pattern. The only woman who did not specifically mention her partner as an important factor in making her decisions was the most mentally disturbed individual in this sample. This young woman, whose was interviewed after the birth of her third child, was also one of the few women within the Berkeley street kid
community who spends her time primarily alone, including at night. Her partner was minimally involved in the pregnancy and did not attend the birth and has not seen his daughter.

"No, he wasn't really involved in the decision. I'm Catholic so I'm against abortion and birth control. Once I get the millions of dollars due to me, I'll get my daughters back and we wouldn't need him."

- 26 year-old woman

This lone young woman also does not fit the pattern of other street kids in terms of the social interaction and partner relationships. In discussing her support for making decisions, this young woman rarely described other people except within the context of an elaborate story about how her money was stolen and that after her money was returned, she would be reunited with her daughters. While there is no way to speculate about other lone women, her severe mental illness seemed to be related to her separation from her partner and her community.

Among Berkeley street kids, whether the intimate relationship between men and women may be strained or strong, most couples approach decision-making together. While women hold the final decision-making, men are - and want to be - involved in this process.

Ambivalence

Once a young woman discovers that she is pregnant, couples frame their next step as answering the question—"do they want to paren: or don't they?" (Figure 4). In making this decision, both men and women's first stage of resolving the crisis was characterized by ambivalence about parenting. In coming to terms with a pregnancy, both men and women considered their past, present and futures.
In considering how to proceed in the pregnancy, Berkeley street kids looked at their past and reflected on their traumatic childhoods, strained relationships with their families and ability to parent.

"Kids! The kind of childhood we had, that was the last thing that we ever thought about of having...we have no role models for parenting."
- 22 year old woman and 30 year old man

They examined their present and assessed their current situation. Most often they mentioned lack of money, housing, a job and security as problematic in considering their ability to parent.

"Obviously, I am struggling to take of myself right now."
- 23 year old woman

"We got pregnant and then we started thinking about doing things right. You do things right and then decide to have a kid. House, job, dog, cat, yard, car, insurance, bank account – all the good stuff. And then think about it."
- 18 year old woman
And finally, they looked to future in coming to terms with the idea that the decision to continue a pregnancy means drastic lifestyle changes. Overwhelmingly, they wanted to avoid replicating the troubled childhoods they and their peers experienced.

"I'm not going to be one of those people. I'm not going to contribute to more fucked up kids. Because I want to be able to take care of that kid."
- 24 year old woman

As youth considered past, present and future trajectories, there was a distinct branching point in the decision-making. For the eight pregnancies that were terminated, the common theme was unwillingness to give up their lifestyle.

The Decision to Terminate

In discussing their decision to terminate a pregnancy, the four women and three men either thought they were too young or not able to take care of a child. Compared to those who decided to carry their pregnancy to term, the women and men who choose to terminate tended to be younger than those who chose to parent. They were more likely to be traveling regularly and using drugs and alcohol more heavily and more regularly than youth who chose to parent. Of note, one woman had four abortions and her partner for two of these pregnancies was also interviewed.

In reflecting on their decisions, these young people emphasized their present state of mind as incompatible with raising a child. They took the responsibility of raising a child seriously and framed their decision to terminate a pregnancy as a better solution for themselves and for their unborn child.

"I'm very selfish; I don't want to give up my lifestyle and I don't — I feel like I wouldn't be a good mother and I don't want to mess up some little kid. That's pretty much it. I can't take care of a kid and I don't want to."
- 23 year old woman
Self-reflection on their current capabilities and maturity was often the factor that pushed women and men to choose to terminate their pregnancies. This ability to accept the gravity of the situation was simultaneously an acceptance of current immaturity and the ability to make a mature and realistic decision.

"I think that what I should have done is I had the thought in mind that I was pregnant, so I should just take really good care of my body while I had it to make it pleasant for myself and for this other being inside of me. It's probably at least better for everything if I just laid off the drugs but I didn't do that. And I feel bad about it because it proves that I wasn't ready to have a kid anyways because I wasn't even taking care of it. So I wasn't taking care of it while I had it so that proves that maybe I definitely wasn't ready.

- 19 year old woman

"I want to be a dad, and I want to be a father. And I was cool with keeping the baby but that's also unrealistic and I'm very unrealistic when it comes to that. I'm like, 'Fuck it. We'll make it happen.' But that's not fair to [my partner] or the kid."

- 29 year old man

One woman represented four of the eight abortions in this sample. Her partner for two of these abortions was interviewed. For this couple, the recognition of both their inability to avoid pregnancy and their lifestyle was also central to their decision to terminate.

"The second [abortion], I still didn't want a kid. If I ever did have a kid it would probably be at the time I'm 35...I'm way too crazy right now. Not like mentally insane but I like to party way too much and take the train and hitchhike.

- 22 year old man

A unique aspect of this couple's experience was the role of the health care provider in influencing future behaviors. In this case, the woman experienced both supportive and judgmental providers that prompted her to find a birth control method that was both effective and empowering to her.

"I got the feeling [from the last abortion services] like, 'you're a dirty whore' type thing. Like 'we're all dirty whores and we're just going to kill these babies because that's what we do to get paid.' That was the last time. But after that I
looked into all kinds of different kinds of birth controls and I just felt really weird about putting some weird IUD (intra-uterine device) thing in me or birth control or a shot or a patch. All that shit was whack. I wasn't happy with it. And so finally I just learned about fertility awareness and that has kept me not pregnant since then, and it's been like two years...I really would like to go to the doctor here in Berkeley and let her know that I use that now. Because she's told me I'm pregnant three times and she's always, "what are you doing?" I really like her and I think she would be happy that I am doing this now."

- 24 year old woman

Interestingly, no service providers engaged the male partner in this couple on issues of contraception even though he attended the abortion and was instrumental in follow-up care.

*Family Support*

A common occurrence among the four women who terminated their pregnancies was that each one told at least one person in their family who was identified as supportive. Most women told their mothers or sisters. While they were not necessarily asking for help in the decision-making process, female family support was identified as an important factor in the experience of terminating the pregnancy.

"She feels like I'm doing the same thing she did when she was younger. Because I am, I'm traveling. We both were into the same lifestyle "punk rock" and stuff. She just doesn't want me to make the same mistakes she did that really screwed her over. Like not finishing high school and having kids really young with mom money and no support whatsoever."

- 18 year old woman

Of the three men who were involved in an abortion, only one communicated with his family about his decision-making process and this was because he felt a responsibility to pay for the abortion procedure. In relying on his family for financial support, he was also able to access some emotional support during this period.
"I was talking to my family and I said, "I'm on self-destruct here." And they said, "Just get out here and we'll take care of you for awhile. [I went to] my sister [in Colorado]."

- 29 year old man

For Berkeley street youth who chose to terminate their pregnancies, their family members, particularly their mothers and sisters, did not play a large role in the decision-making process but rather in the implementation of their decisions. As sources of emotional support, mothers and sisters were important in the experience of the abortion but the decision to terminate or not was primarily a process that that occurred between a woman and her partner.

*Ignore it and it will go away*

For most of the youth who did not want to parent, the decision to terminate the pregnancy was resolute and clear. However, another group of participants were not so decisive in their decision-making. Although they did not want to parent, three women, two of whom had a miscarriage and one had an abortion, described themselves as having an "ignore it and it will go away" attitude to pregnancy decision-making. The common characteristic among these women was a strong sense of wanting to live for the present and "party." These young women were among the heaviest alcohol and drug users. They recognized that their lifestyles were completely inappropriate for a pregnant woman. Whether consciously or unconsciously, they helped that this lifestyle would be so toxic to their bodies, and to their developing fetus, that they would miscarry.

"I think it happens to a lot of girls but they don't know what to do so they kind of ignore it and then it gets really fucked up. That's pretty much what I was doing and I think I just like had in the back of my mind that I just got pregnant so if I like was drinking and like living my lifestyle maybe I would have a miscarriage."

- 23 year old woman
Unfortunately, sometimes this strategy did not work initially. For the youngest woman in the study, “ignoring it and it will go away” resulted in a tragic end to her pregnancy.

“At first...I really wanted to get rid of the baby. We didn’t have enough money for an abortion and I didn’t really want the state to step in and I didn’t want too many people to find out. And I was like, “Well I’ll get this done”... and then eventually after time you can’t put off a pregnancy. It doesn’t stop. And I learned that when it got too late for me to have an abortion. I wasn’t even trying to miscarry at all. I was so stressed out and everything was hitting me so hard and so fast. You don’t realize – like I didn’t realize five months had gone along until I was about this big. And I’m sitting there and I can feel kicks and movement or whatever it was, her rotating and stuff. Like I was so stressed out and I freaked out. I was like, “Oh my God!” It was like my whole life flashed in front of me. All my friends, “What am I going to tell people after she is born?” “How am I going to handle this?” “Am I going to have to get a second job?” “How am I going to do that with an infant?” “Is M’s family going to help me?” “Is my family going to help me?” I just wanted like a fifteen minute – hour escape. Just a little chunk of time to not think about it and that was just enough time to ruin it all. And I should have done something else, like gone and sat in a hot tub or something. I figured one drink wouldn’t hurt me. And they only put like one shot of Vodka in it. And they’re like, “Calm down. Smoke a cigarette. Have this drink.” Before I knew it I had done some heroin and really shouldn’t have and found myself cramping and in some of the most pain I’ve ever felt in my whole life...And I was bleeding and cramps, and I was going in and out because I was high on heroin. ...Well they put me on inducers and I ended up in seven hours of premature labor and lost a lot of really good relationships with my friends because they felt like I betrayed them because I didn’t tell them. Now I’m clean from heroin but they feel bad because they feel like they’re the ones that killed my kid. She is my reason for being clean. When I lost her and I realized it was because I did dope I went cold turkey. She will always be my reason for staying clean. Because I ruined every chance that she had to be alive, and on top of it I lost a lot of really, really close relationships that I know I will never be able to fix.”

- 18 year old woman

For these few women, “ignoring it” was a strategy that demonstrated an unwillingness or inability to deal with their pregnancies directly. In conceptualizing the crisis of pregnancy for these women, the decision to ignore a pregnancy is a very risky means of forcing a re-equilibration with street kid lifestyle. For these three young women, the enormity of the situation may be beyond their ability to cope. By using
drugs and alcohol, they attempted to deal with the crisis of pregnancy by making their lifestyle even more extreme and incompatible with a pregnant body.

"That's my baby!": Decisions against adoption

Although some couples considered voluntary relinquishment as an option for the pregnancy, no one chose this route. Three individuals (one couple and one woman) discussed adoption as option that they seriously considered and even began paperwork. At first, adoption seemed like an attractive option for these three individuals for whom abortion was not an option.

"I didn't even think I could get pregnant...it was more like I didn't really want to deal with having to become a mom and all the stuff that surrounded it. And setting up the adoptive family was just easier. I guess I wanted to have somebody else take care of it."

- 23 year old woman

In describing their understanding of the adoption process, all of these youth described their children as being valuable and able to be adopted into "good homes." They framed this understanding both in terms of class and race. Because their babies are European-American, these expecting parents discussed their children as having access to families that were not only "White" but also wealthy.

"My baby is going to be with an adorable gay couple in San Clemente. I looked through the book but this couple just stood out. They already have a 2-year old son and are excited so excited about having a sibling. The view from the backyard of the house is amazing and it's a four bedrooms. This is an open adoption so I'll be able to have some limited involvement. I know my little one is special and I want her to have a better life than I had."

- 22 year old woman

"I'm blond and blue-eyed. All my other daughters are blond and blue-eyed. This one will be too and I don't want her to be in a poor environment where people envy her for it. I want her to grow up rich."

- 26 year old woman
While these individuals considered adoption as a way of assuring their children’s future, they all decided against this option because they felt attached to their children and felt a responsibility to fulfill the role of parent.

“The thing is in my heart there was part of me that knew I would never be able to allow my kid to be adopted out. And I was just kind of going along with that like just in case. I want this already set up and if I do freak out and just can't deal with this, I want there to be someone who will take care of her. And my kid must be taken care of at all costs.”

- 30 year old man

While adoption was one way to deal with a crisis of pregnancy, for all three that considered this option of permanently relinquishing custody of their child, it meant relinquishing the opportunity to care for their child and assuring their protection. In making this decision, Berkeley street kids made the important choice to step into the role of parent.

Figure 5 – Decision to Terminate
The Decision to Parent

While many Berkeley street youth returned to equilibrium by terminating their pregnancies, the majority of youth chose to continue their pregnancies and ideally, parent. All of the individuals in these fifteen pregnancies were at first ambivalent about their ability to parent. These young women and men emphasized the relationship between their pasts as children and their futures as parents.

"My biggest fear was that I would be even halfway as evil to my kids as my parents were to me... We were convincing each other like, 'No you'd make a good parent. I see what you do with this and it's way cool.' And for me it took meeting my little sister again and her telling me "Look you took care of me when I was a little baby and dad was evil and mom was on drugs. And you came to the house even when you ran away and snuck in during the day and cooked for me and taught me to read. You take care of animals and you have all your pets."

- 30 year old man

His sister's assessment of his nurturing skills was important in developing the confidence to parent. In reality, he already had experience in parenting and caring for children. While certainly not all of the participants had a similar experience, many did need a source of confidence that they could parent. Often this source of confidence did not come from a past experience but from hope that the future would offer new opportunities for change.

A child was seen as an opportunity to have a new childhood. By providing a better life for their child than they experienced, homeless youth hoped to relive this part of their life through their own child. Those who had lost children into custody also framed their pregnancy as a means of redemption, a way to reclaim past unsuccessful attempts to be a "good parent."

"I'm going to have an amazing childhood start for this child. It's going to be a wonderful process for me... It opens a whole new channel of possibilities. It's
kind of like having your childhood handed back to you. There's responsibilities but then you also get so much more amazing stuff along with it.”

- 28 year old woman

Overwhelmingly, those youth choosing to continue their pregnancy conceptualize parenthood as implicitly connected with leaving homelessness. In evaluating current resources, homeless youth described themselves as needing to get prepared for parenting – to “get my shit together.” This exact choice of words was repeated over and over. “Get my shit together” reflects the idea that life on the streets may have been acceptable for themselves, but not for a child. Unlike an abortion that has to happen sooner rather than later, the decision to “get my shit together” also means that Berkeley street kids have some time to reintegrate into the mainstream – to be able to parent.

“I don’t feel like the baby is going to be raised on the streets...the baby's inside the tummy getting all cozy and we're going to be getting our shit together and have it all figured out...a nice place and a nice job.”

- 18 year old woman

In orienting to the future, these street kids said were willing to make radical changes to their lifestyle to reach this goal. They used their children as the motivation to leave homelessness and reenter the mainstream.

“She’s my foot when I kick myself in the ass. Many people will kick you in the ass and try to get you together and tell you something but you never really start knowing until you actually kick yourself in the ass. She’s really put me into gear. All of a sudden I was like “I got to get married. I got to get a house.” Because before that wasn't in mind at all. I don't need a house for myself but a kid needs a house. In the first stages of their lives, they need a solid foundation. I gotta get my shit together. Can't be a street kid forever. I'm a father now.”

- 24 year old man

“Without having the incentive of a baby, I could never be an indoor person at that point in my life. Because my whole life was geared towards traveling, going where I wanted to go; not having permanence because it had been denied to me for so long that I just you know sort of went with it...And if I
don't have a kid I would still be out there...But living in a house actually is very depressing for me. It's the fact that I have a daughter that makes up for it."

- 30 year old man

Foster Care and Fear

For most Berkeley street kids, the option of placing kids in foster care if they were not able to "get their shit together" was one of the most frightening experiences. The root of the fear was often their own experiences in foster care, both being removed from their families and their time in foster care.

"A1 (mother): And I don't want my daughter to go to foster care even for a day....When I was a kid, it was like you never knew when the stranger who was driving by was going to call the police and get your parents arrested. And I'd been taken away when I was a little kid and I hated that. That was the worst thing that ever happened to me...I'd been through a lot of abuse but that was nothing compared to having my family taken away from me."

A2 (father): I was really unlucky as a foster kid. I was hospitalized because of it...the older boys there molested me and beat the living crap out of me, tortured me in various way which included tying me up and dragging me along behind a bicycle tied with a rope on the pavement."

- 22 year old woman and her 30 year old partner

While most youth acknowledged the necessity for a foster care system, they did not trust that their children would be safer in the care of the state than with themselves or, if need be, their own families.

"I think there is a definite necessity for something like foster care. There has to be places for abused kids to go. But I think the way foster care is run and the people get into, I know how heavily they screen them and it's still not enough; it really isn't...particularly in places like Alameda County where social workers just don't have the time."

- 22 year old woman

"I don't believe in foster care...I was in foster care and it was a really bad situation...A lot of people are in just for the check. So I don't necessarily approve of it but it is a good system for people that really need it. I prefer children be with the family."

- 23 year old woman
Alternative Lifestyles

As they come to the realization that they want to parent and that their lifestyle is not compatible with this decision, many homeless youth become ready to put aside their street lifestyles and become parents. While they buy into society's basic ideas that children need to be safe, dry, fed, clothed and educated, they know that many of the jobs available to them are low-end, dead-end service job. Most saw this lifestyle as oppressive and not fulfilling their needs as human beings. This unfortunately provides very few options for Berkeley street kids.

"With my [previous] daughter, I finally snapped and ended up going "Fuck this playing the money game. If you try to be good and try to live within your means and you try to pay off your goals and shit you're still going to get fucked. This whole thing is set up for you to be fucked...I do not want to fucking do this to my kids! I want to be my kid's mom. I don't want to be like somebody who shows up at the end of the fucking day of in the middle of the day at some point you're not just nor here. Like it was all set you for my kids to be going to everybody else to get taken care of an so in the meantime I'm just never there...I have no idea how long it would take for me to get my shit back together...I would be a year maybe two year before I even have some machines and actually any kind of business...I'm going to find a bread truck or bus and have it converted and do creative things...like fabric making and construction of clothes...I do not feel like slaving and toiling for anybody else."

28 year old woman

Street youth are willing to move back into the mainstream population. But ideally, they want to maintain an alternative lifestyle. Homeless youth were also resentful that their wishes to live an alternative lifestyle were not respected. All agreed that a child should be cared for properly but they also wanted to maintain an aspect of traveling in their life as parents.

"That you should necessarily have a house and not be able to have a child. Three or four centuries ago people were living in tents with their children and that was fine...as long as you keep them fed and warm, having a roof and walls should not be mandatory. I think they should make a natural habitat for humans where I can raise my kids outside."

23 year old woman
Figure 6 is a summary of the main features of decision-making at the level of the individual and couple.

Figure 6 – Individual Decision-Making Model

Pregnancy as Crisis within “Street Kid” Community

Thus far, we have discussed personal priorities of Berkeley youth and how they shape these decisions. However, these decisions are also made within the context of the street kid community. As a community, street kids recognize pregnancy as directly conflicting with the prime directive of their lifestyle – to have fun and live for the moment. Street youth recognize the dangers of their lifestyle and specifically state that pregnancy and their dangerous lifestyle are not compatible.

“There’s too many things that can happen when you’re homeless. Besides like just temptation of drugs. Here [in Berkeley] you eat really well but some places you don’t eat all day or all night and all kinds of crap happens. I’ve been walking through a town and some crazy dude just punched me in the face...anything can
happen to you and it'll happen to your kid too. I'm not really down with pregnant travelers...it's not cool at all...I won't hang out with a girl who just like doesn't take care of herself and is like, "I'm going to have this baby and squat with my baby." It's kind of fucked up. And I have met girls who do squat with their kids and take a hit [of heroin] before their kids eat breakfast. I think it's fucked up. But yeah, I've met lots of girls who get knocked up on the road and most of them get rid of it or they settle down and have it."

- 23 year old woman

Of all of the vices on the streets, most homeless youth were very specific about their opinion on use of drugs during pregnancy.

"If you are doing drugs, get an abortion. Because I know women out here who are like "Yeah, I'm pregnant. I'm going to quit doing drugs." And they couldn't. Like I know women who used drugs all throughout their pregnancy and their kid suffered a lot."

- 23 year old woman

Community Expectations of Pregnant Peers

The street kid community holds different expectations for pregnant peers. They passionately argue that women and men who are not ready to have children should not because often they have personally experienced the strife of having parents who are unwilling or unable to prioritize children. Street kids who are expecting a child can no longer afford to be self-oriented and live for the moment – they must look to the future and consider the life of another person. Street youth explicitly encourage their expecting peers to consider their lifestyle and make a decision that considers both the individual's ability to change their lifestyle and the well-being of the child.

"Are they ready to give up the life that they have now and turn it into a new one? Are they willing to support a child? It doesn't have to be through money, but it has to be through something though. Are they going to be there? Is their partner going to be there? If their partner's not going to be there how are they going to make it all work?"

- 24 year old woman
As indicated in this previous quote, street kids value and respect the importance of partner cooperation in making the decision to have, or not have, a child. While there is no data on the numbers of Berkeley street kids' family life, 75% of street youth in Los Angeles were raised in single parent households (Hyde, 2005). Within the Berkeley street kid community, youth acknowledge the advantage of a two-parent household in raising a child.

"I definitely know that if I'm going to have a kid with somebody I'm not going to do it myself at all. Especially three kids. Like that was my mom's choice....But uh-uh, I'm not going to have kids and be a single mom. That's not good."

- 18 year old woman

This sentiment translates into a status change for a couple once they become pregnant. In recognizing the dangers of living on the streets, the street kid community attempts to protect a woman and her partner. The protection is specific to the relationship of potential parents. This is a quote from a young woman who miscarried.

"It was like [our relationship] wasn't as cemented or grounded. Or at least that's what they thought. But in actuality it was actually more...the girls used to look at him like "You're such a good boyfriend. Wow! You're taking care of your girlfriend and she's pregnant" and now they're like "Fuck that white bitch! Why are you with her?" ...Now I get offered drugs for sex."

- 18 year old woman

For those who decide that they are not ready to take on this responsibility, the street kid community is generally supportive.

"My friends knew. Some of them, not all of them... They were like, 'Right on. Don't have a kid.' They were totally supportive. Some of them didn't believe in it but they were like, "That's your choice."

- 24 year old woman

"They have their kids, how come I can't have mine?" Street Kid Community Reaction

For those who choose to parent, or attempt to parent, the homeless community is not necessarily as supportive. Because there is a rich lived memory of men and women
within the homeless community who had their children taken away by Child Protective Services, homeless youth also compare experiences. Many do not understand why they have had their children taken away while others have been able to keep their children.

"I don't get it. I watch crackheads walk around and have their kids, how does it make you feel? When I walk past a kid who's walking their 2-3 year old kid take off running. They're not holding hands and they're not - why is that person a better parent than me?"

- 25 year old man

In comparing themselves to their peers, homeless youth express feelings of jealousy, frustration and anger towards other youth who are either able to keep their children.

"[She] did shit all the time that would hurt her kid but nobody took her kid. Like smoked constantly, slept outside with a fucking newborn baby but nobody said shit to her because she didn't ask for help. Yet I was doing everything right. I was indoors, I was going to school, I was taking care of myself."

- 22 year old woman

"And it made a lot of enemies from a lot of these street parents who lost their kids because they see us getting our kid back so easily in their eyes. It made me feel like - it's hard to describe. But there were people who claimed to be my friends as long as I'm in the same boat as they are. And when my kid is being taken away from me they're like, "Oh yeah, we know how it feels. You're our buddy, our pal. And then as soon as we get our kid back at least one couple started yelling and screaming at me and swearing at me."

- 30 year old man

Pregnancy is a crisis that leads to disequilibrium because pregnant streets kids are in conflict with the acceptable parameters of being a member of their street kid community. The result is that the street kid community pushes peers who choose to parent out of the community. This tension places the expecting individual at disequilibrium with their environment. Individuals who choose to terminate a pregnancy are able to self-equilibrate back into a relatively supportive street kid community. However, those who choose to parent are often examined with a critical
eye, particularly by those members of their community trying to make sense of the loss of their own child while watching one of their peers struggle through a similar situation.

**Pregnancy as Crisis in Society**

The street kid community fundamentally relies on the larger society. Society, and Berkeley in particular, tolerates homeless youth under certain parameters. Once a woman becomes pregnant, society places different expectations on a woman and her partner to become “fit” parents. Providers at homeless services communicate this social priority by treating pregnant women and their partners differently. The following is a quote from a woman who was initially interviewed early during pregnancy and then after she miscarried.

“When we first came in pretty much all the staff didn’t know I was pregnant and didn’t know our situation or anything...And they changed. Once everybody realized I was pregnant they were like “You need this? I’ll help you out. You know a place where you can stay? Let me tell you.” And now they’re just like “Do you need to find a place to stay? Wow! That sucks!” Kinda like “There’s other people that need more help.”

- 18 year old woman

"It's not so bad" Obtaining Abortion Services

Youth who choose to terminate their pregnancies viewed obtaining services as generally easy and supportive. Berkeley service providers were considered much more supportive and services more readily available. Drop-in services in Berkeley were specifically mentioned as particularly helpful in getting connected with appropriate services and financial help.

“These ladies are really amazing here [in Berkeley]. They made me feel really welcome and treated us like a really welcome feeling.”

- 22 year old man
While some youth favored abortion services over others, particularly those that offered woman-centered care and non-pharmaceutical pain relief, neither the women nor their partners reported feeling that abortion services were unavailable or that service providers were judgmental or hostile. Women consistently stated that it was relatively easy to access abortion services in California, particularly in Berkeley, and Oregon. No one described being unable to get an abortion because of financial problems or lack of access. Women and men stated in receiving services for the abortion.

"Go to the welfare office, get emergency Medi-Cal, tell them that you’re pregnant and you want to get rid of it." And they’ll give you a list of the places that will do it and you can pick them out and they’ll give you emergency Medi-Cal."

-24 year old woman

"[The nurses and doctors] were really friendly. They were really nice. They were very supportive. They were really cool. If I were to an abortion again, I would go there."

-19 year old woman

At the level of interaction with the larger society, homeless youth understand that there is an expectation of fit parenthood, which they do not currently meet. To meet the requirements of fit parenthood – housing, income, health care - means they must reach out to society to access these resources. But this increases their vulnerability to potentially severe consequences of having their child taken away. For those that do not want to continue the pregnancy, the path to service is less intimidating and these youth are supported in their choice to resolve their disequilibrium with society – terminating the pregnancy.

"It’s been a world of helpfulness to me. Because I went there for Plan B [emergency contraceptives] and they gave me one of those packet of like 12 refills for the birth control, which is like really cool. They’re really on the ball about that, like “Don’t get pregnant again” And it’s kind of scary to see how many girls were in there though. It’s like kids lining up to get abortion. That what I think I’m like
"Damn I'm one of these girls." And I talked to this girl and she's had 2. That was right before I went in and I'm like "You had 2 of them? Is this fun for you?" And I didn't say that to her. But it was like a world of helpfulness because as far as I it's not catching up to me in the funding issue part. And also they were really supportive and they let me know everything I needed to do, which is of course what a doctor better do. But they were really helpful. And the fact there's a MediCal situation, that's really cool. Because otherwise I would have been really a lot more discouraged to go in there and have this happen. Because then I'd have to give them $400 or something...and it was really helpful because they gave the birth control and that didn't cost anything."

- 19 year old woman

Interestingly, one woman mentioned alternative ways of inducing an abortion as methods that she has recommended to her pregnant traveling companions.

"Sometimes if you make like a tampon out of parsley and you stick it up there that will also bring on bleeding. Large doses of pure vitamin C help a lot. There's a thing you can do with Pennroyal and Blue and Black Cohosh, but I don't really like to recommend that to people because it's really toxic on your body and you could really fuck up. And you can only do it a couple times, maybe even just once. And I don't know the exact remedy you're supposed to do. Most people don't. So I try to get people not to do that one. And if the herbs don't work, which they usually don't, just to go and find a nice women's clinic and Oregon's usually got a really good one. I don't know any where in California that has a women's clinic like that. So I just tell them to go there."

- 24 year old woman

Importantly, this woman acknowledges that these methods are potentially dangerous and that clinical care is safer.

"It's really hard": Obtaining Services and Parenting

Homeless youth perceive that if they choose to have a child, they must live up to the expectations of a "fit" parent – they have to "get their shit together." By the nature of their existence, homeless youth do not meet requirements in their current state and this is a source of disequilibrium. In order to "get their shit together," expecting parents wanted to integrate back into society but saw many barriers to reaching this
goal. They desperately wanted help from social services but simultaneously they did not trust that these services could either help them.

"I wish CPS could help me somehow. I am really turned off by the idea of proving to the state my right to be a parent unless I've done something like really dangerous to the kid. Like if I've been hitting it or mistreating or not feeding it or something like that. I have no desire to be like that at all... I think it would be really cool if they could do housing things. Or have different people who could make it easier for me to be able to get healthcare for my kid or get education or different programs and stuff. But I mean everything I've ever seen with CPS is they turn a blind's eye when it needs to not be turned and they get themselves all embroiled in people's shit right around the time that like it kind of stems from one thing. Some neighbor goes, "That kid's really screaming over there. I should call CPS. Sounds like he's being beaten." There's just too much freedom for people to get the wrong kind of attention I guess... I really wish that I could believe that CPS could help me find housing and find different kids of things. But most often when CPS gets involved, their primary goal is to separate the kid from the parent if they see anything that is outside of the norm. They're like "This kid's not going to [public] school, this kid's not getting immunization. This kid's not getting the regular things that the mainstream does with their kids. So then, you're not a fit parent and you can't have it."

- 28 year old woman, 4th pregnancy

Fear was the most common theme of interaction with services: fear of having to conform fully to society's values and expectation; fear of failing to meet these expectations; and fear of having one's child taken away.

"You can't get all excited when you've got worries and things you've got to take care of....like making sure they [CPS] don't abduct your children if you don't live the way they want you to."

- 36 year old man

**Gender Roles and Services**

There were gender differences in dealing with social services that replicated traditional gender roles — men as providers and women as caretakers of the baby. For the most part, men discussed looking for employment as a means for supporting a family. Men most frequently discussed how services that allowed them to enter the job market were the most lacking.
"Now how do I go about getting a resume? There’s no more Home Plate. There is not HYC. There’s no Job Consortium. There’s no Jubi-Spot. Where do I go for a resume right now? Maybe if I pull somebody a side and as real nicely and have a whole bunch of information, maybe somebody will take it to their house and do it for me? I don’t know. Where do I go to use a computer now to type it up? Where do I go online to search for all my past employer’s addresses and phone number to put on my resume if I was to make it myself? If I did have a job and all my saving was together who is going to help me find housing?...Hopefully MASC has something...I’ve haven’t been to MASC in a long time. It’s not very comfortable for younger people."

- 24 year old man

Disappointingly, it seems that services completely ignore the role of the father in pregnancy. In fact, having a male partner was sometimes considered a barrier to gaining accesses to services. Unlike women, men were not offered or encouraged to apply for welfare programs such TANF or other support services for low-income parents. Many did not accompany their partners to appointments with social services because they felt it would be a waste of time because programs only provide money for single mothers. When asked whether they would be interested in welfare, all responded that they would happily accept this aid.

"[Services] seem biased. Only moms. Dads don’t mean shit. Moms with dad don’t get anything."

- 36 year old man

Men wanted access to services that would help them provide for their children. This meant that they were willing to accept types of help that perhaps before the pregnancy they were not willing to accept. In some cases, they were even able to use the pregnancy as leverage to gain employment.

"Things aren’t easy to come by but I know how to work. [I told the manager] ‘This is extremely important. So if you give me this job I will give you 250%. He heard it and he looked at my qualifications and he’s like ‘There’s no way I couldn’t give you a job. He gave it to me just like nothing. It seemed almost impossible to get [hired] until I told him [about the pregnancy]."

- 25 year old man
Some men said they were also willing to forgo these traditional gender roles.

"Somebody's got to go to work; somebody's got to watch the kid...it doesn't matter who. We could switch off. I don't care. She can make all the money. I'd much prefer staying at home with the kid."

- 24 year old man

However, not all men were as secure in their ability to care for a child. For some the decision to father was fundamentally tied to the reproduction of traditional roles. It was not just they felt more comfortable in the role of the provider, they feared the role of the caretaker/nurturer as something that was contradictory to the male role in which they were raised.

"I wanted [to have the baby] for me too but I wanted it for me under the condition that it would be us. I had no desire to raise a child by myself. Because I just don't have that confidence. Because I'm afraid I'm incompetent in raising a child by myself. I feel like I have too much boy in me."

- 29 year old man

Providers, Prenatal Care, Partnerships and Problems

Women dealt with trying to obtain welfare benefits, food stamps and prenatal care. Women almost always attended the prenatal visits by themselves, mostly because someone needed to stay on the street to watch the belongings. Additionally, often pets are not allowed inside of buildings and partners would stay with the animals. Thus, women informed much of the understanding of prenatal care.

The relationship with the provider was particularly contentious in terms of emotional charge. Only one woman had a positive interaction with her prenatal care provider and still maintains regular visits with her. It should be noted that this relationship is characterized by understanding and compassion.

"[The midwife] is such an enlightened being. I hope my karma can become as good as hers. She's a relaxed person and makes me feel comfortable around her. She definitely doesn't feel like an official person."

- 24 year old woman
Unfortunately, there were several cases in which the prenatal care provider relationship became the locus of fear and avoidance of future services. Because Berkeley is a relatively small environment, women often have the same prenatal care provider. The following are quotes from two women who saw the same prenatal care provider.

"I'm not sure she was listening. She's geared to one kind of lifestyle I think. I was like "This isn't happening. You live in one world and I live in another. It was becoming really evident off the bat. We weren't compatible.""

- 28 year old woman

"I asked for help...[now after the baby was taken away] I'm untrusting. I've never ever been betrayed by anyone like that before. And I've had those things happen around my life but it's always been easier to forgive. And that is a mind fuck....all of a sudden somebody comes along who...you're comfortable with them, you can talk to them and then all of a sudden they do something like that. It's so damaging."

- 22 year old woman

It is important to remember that these women then return to their community and talk to other pregnant women. Several women I interviewed were specifically scared to go to the clinic where this provider practices because of fear that their child would be immediately taken away by Child Protective Services. In some circumstances, this meant that women and their partners avoid services such as prenatal care in order to "fly under the radar." This is a quote from a woman who specially avoided prenatal care at this specific location because of the experiences of the women in her community.

"I was afraid [that clinic] would find about me being pregnant and try to take away my baby, just like they do to all the homeless - everyone who's been homeless for any time during their pregnancy."

- 22 year old woman
Unfortunately this places Berkeley street kids is a very difficult position. In order to leave the homeless community, homeless youth have to reach out to the greater society and access resources that lie outside of their immediate community. The resources most often discussed include health and social services but can also include friends, relatives and faith-based organizations. Homeless youth recognize that there are services ready to help if they choose to have a child. However, accepting these services comes at a price – revealing a pregnancy to a social service system that is perceived as judgmental and disapproving of homeless youth. While homeless youth often need these services, they simultaneously fear them because of the consequences of failing public judgment – having their child taken away.

When youth did interact with social services, they were often presented with less than desirable options. Most services are tailored to poor women who are usually African-American or Latina. Many homeless youth described discomfort with shelters.

"I don’t think it should be a privilege to live in a home. I believe it should be a right. I think there’s enough space and enough homes...In a commonwealth everybody has a place to live and it becomes a right not a privilege. I’m not asking for the nicest place on the block; that’s a privilege. But everybody should have a place....and not a shelter situation. Hotel rooms, whatever."

- 25 year old man

The closest shelter available for most women was the Salvation Army Shelter in Richmond, CA, a predominantly African-American neighborhood that is a $2.00 bus fare away from Berkeley. Men cannot be housed with the women.

"I’m not going to go there. I’m the only white girl there and people just harass me because I have blue hair. I don’t want my baby in that kind of environment. I got into two fights the last time I was there. It cost a fortune to get back and forth on the bus, which sucked. And not very much time to be out. I had to go to church 3 times a day and they really didn’t want to have any food or anything like that. They’re Christians. “You eat 3 times a day with us, you stay here all day with us you’ll be here.”

- 28 year old woman
Solutions to Pregnancy as Crisis

_Reconnecting with Family: A Bridge out to the Mainstream_

Telegraph youth are interested in leaving homelessness, especially during a pregnancy. Among those who decided to parent, the pregnancy was a major motivating factor that encouraged youth to come up with plans to leave homelessness. But even among those who terminated or miscarried, there were often moments during which they were “sick of all the drama” and ready to leave homelessness. Regardless of their pregnancy outcome, all youth who wanted to leave homelessness described the incredible difficulty achieving this goal.

“The light...it’s still over there. It’s kind of far and there’s bugs and shit...but I have a can of Off and a citronella candle and I’m going for that damn light. I have no choice.”

- 25 year old man

Berkeley has a unique opportunity to provide prenatal and other services to expecting homeless youth. Despite the generally negative attitudes about social services, Berkeley street kids recognize that often services available in Berkeley are less intimidating and more inviting than other locations.

“Q: You came down here specifically because you were pregnant?
A: I didn’t really show up at the doctor’s office that much. But actually they’re good. They came out looking for me...[an outreach worker] walked around town looking for me and they couldn’t find me because I was asleep underneath a blanket in People’s Park.”

- 23 year old woman

However, often the services that they want in Berkeley are not available. Thus it seems that the particularly underserved segment of the pregnant, young and homeless population are those who are choosing to parent. While they have an idea of life in the mainstream, street kids still need to be able to get there. They need a bridge to meet this goal. They perceive a lack of services that are able to meet their needs. Youth
specific services, and even general homeless services, are disappearing. Housing is not available for couples and very often women are unwilling to leave their partners.

"And what the fuck is up with the city not having housing for pregnant women with a father. Am I supposed to leave the father, have a dysfunctional family just because you don't want to fucking give me a house? It took me six months to get through welfare."

- 22 year old woman

However, even for youth who had some income and were trying to secure housing without governmental assistance, obtaining affordable housing in Berkeley was a challenge. Often, the only solution was to leave Berkeley to find housing.

"It was very difficult to find housing once you’re pregnant. We got evicted in the middle of the pregnancy. I was writing emails everyday. We were looking through ads. I was taking down notes from billboards and places. We were going through government assistance and that kind of stuff but that wasn’t kicking in very fast. Most response, 99% of the response we got from people regarding us living with them as housemates was, they didn’t want a child and they didn’t want a couple with a child... if you’re houseless at any point during pregnancy, unless you go to family or you have friends that are open to it, it seems that this area is very much into students and singles....especially we were looking right before August for housing, all the ads that were in our price range, all those were "No sorry. We want single students." So we had no luck. We didn't have a place and we didn’t have a home to take [our baby] to so [my partner] went back up to up to [my partner’s] mother’s house to be a family."

- 29 year old man

For all three of the couples that were able to maintain custody of their children, ability to rely on family for help during this crisis was the most successful method of getting out of homelessness and maintaining custody of their child. For these couples, this meant leaving Berkeley and returning to family located hundreds of miles away.

For all of these couples, the process of reuniting with family was done out of necessity. All of the couples had been estranged from their families because of histories of abuse and neglect for several years. In the process of trying to maintain a new generation, it was the women in these three couples that were able to reunite
with their families. Forgiveness for the past and hopefulness for the future of the new generation of family were key in making this reconciliation:

"One of the most important factors in a person's life is their family. This may imply that one's relationship with one's family comes naturally, but in fact the very opposite is true. The relationships in our lives that require the most focused, dedicated work are the relationships with our immediate family. The upside is that the more we work on them the more they payoff, often in unforeseen ways. For myself, this required coming to terms with 10 yrs of abuse, 8 of that sexual, and the complete denial of all that abuse by the rest of my family. There are things that I am unwilling to compromise on, because of that past. But the truly key word of that sentence is past. Things that happened when I was 15, happened when I was 15. At 23, there isn't really anything that I can do to change what happened. Instead I make decisions on how I am going to live my life, and making sure that I own my choices, and don't live in reaction to what has happened. Negative emotions are common among abuse survivors, often prompting them to become abusers themselves. It is unhealthy mentally, promoting various dysfunctions in future generations, including higher rates of diagnosable mental illness and learning disabilities, and the inability to handle the complex and varied situations that arrive in daily life, particularly when you have a family. And it is extremely unhealthy for children to be raised in that kind of environment. I know that the biggest key to creating a strong sense of family is an ability to forgive. Not forget, or endanger our children, or ourselves but to accept that injuries happen to all of us, and that we move on from them, large and small alike. My recommendation to care providers, social workers, mentors, and to everyone involved with populations of pregnant mothers, from any age group and walk of life is to work with them on understanding and accepting their individual relations to their family, good and bad together. Encourage safe levels of forgiveness, making plans to include the whole family in raising the baby. If a person is determined to be truly harmful to be around, stay away, but don't let anger and resentment color your treatment of others. Remind them that everyone is special and loved, and worthy."

- 22 year old woman

These women were able to prevent involuntary relinquishment of custody and able to start the process of healing scars from the pasts.

"[The relationship with my mother] has been on again off again. I feel much safer when I'm not around her...I think [my mom] was in the grips of "holy shit, my grandchild just got abducted by the state" which is pretty what I was feeling. But having had all that experience with CPS maybe she just wanted to avert the same thing from happening to me just because I'd been on the other hand like the kid who was put in the foster home...And going up to...be with my mom...I could be going off into anything. My mom jumping into this could have
been a very bad thing for me. Maybe she’s trying to set the past right...and she actually did. I was completely amazed at the difference the time had taken."

28 year old woman

Thus we see that family was the most successful bridge to the greater society from the streets for those youth who chose to parent. However, even for those youth who choose not to parent, a pregnancy can be the motivation to reevaluate their life and contemplate. Family was also identified as a bridge out of homelessness.

“I’m really going to have to fall back on my family on this. They know what my intentions are - to get us out of here. Anywhere but here and start over. Get a job and start doing the things right. And I’m not afraid of it. I’ve just got to fall back on family and hopefully they will come through for me and if they don’t, then well, I just have to make something else happen. But my number one goal right now is get us the fuck out of this town.”

29 year old man

When the bridge is washed out – Inaccessibility of the Mainstream

While three couples were successful in maintaining custody of their child, the majority was unable to do so. Importantly, of the three couples that were able to maintain custody of their children, two of the couples lost custody for the first week of their child’s life. It was the fact that they were able to reunite with their families that most fundamentally separated these couples from those who lost their children. For those that had their children removed permanently, it was the lack of services and inability to rely on family that led to them not being able to meet the expectations of a fit parent. These individuals were much more likely to have significant mental illness and drug problems.

“I was going to go see family. I was missing my first kid. I was pregnant and wanted to be near my family and relatives. And if you show up, your family, at least on of them will eventually break down and let you sleep inside their house for awhile. But my family doesn’t like [my partner]. So they wouldn’t let us both stay.”

23 year old woman
With the goal of parenting, homeless youth needed to make the successful transition from street youth to greater society. Unfortunately, the path out of homelessness was rife with barriers. The barriers were both individual and structural. Because of the profound mistrust of official agencies and authorities, youth choosing to parent almost uniformly described a fear of asking for help because of the possible repercussions of attracting attention to one’s self.

"Because in all my time as a homeless person I’ve learned over and over again that you do not confide in any one with any single bit of authority or ability to report you. [My partner] has grown up believing that you can ask people for help. I learned really early that no one’s going to help you. They’re really going to make your life more difficult."

- 30 year old man

However, because of a poverty of other resources, youth eventually did attempt to interact with the social service sector and apply for available programs including food stamps, Women, Infants and Children (WIC) and housing. Unfortunately in applying for these programs, youth were faced with structural barriers such as traveling to aid offices, lost paperwork and need for an address. The majority stated that they felt uncomfortable in the offices and felt like social workers were condescending during their interaction. The combination of bureaucratic difficulty and discomfort with the system left most wondering whether the work to apply for the services was even worth the result.

"What the hell is this crap? They want me to go through this fucking psycho maze and answer all these ridiculous things...now I’m just like “Okay I already filled out paperwork like 90 times this year and nothing has some through.”...it’s not really worth it...like $200 a month...I could get $200 a month for myself....I understand there’s supposed to be some tradeoff about it but I think that’s only good for some people. I don’t like being trapped and monitored all over the damn place and have somebody like coming out and fucking sticking their nose in my business....it’s almost like being a kid again in that sense.” You’re doing things but you’re not doing it the way that we want you to do it, so you’re going to be totally fucked on your own, we’re going to declare to your face or we’re going to do something to totally fuck you over...They’re like, ‘Here hold you hands out, we’re going to put

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your fucking slave collar on now.' That's how I interpret it...Human beings are treated like cattle. There's a lot of degrading things that people are put through.”
- 28 year old woman

In summary, social services were not accessible bridges to the mainstream, which left family as the only option for homeless youth (Figure 7). For most, reliance on family was not available and many lost custody of their children.

Figure 7 – Bridge to Mainstream

Race and “Baby-Snatching”

For the two couples whose children were taken by Child Protective Services in the first weeks of life, “baby-snatching” was both a way of understanding of the loss of their children and a way to assign blame away from them. Similar to youth who were deciding about adoption, race was an important way that these couples conceptualized
the worth of their children in society. If white children can be adopted into better
homes because of voluntary relinquishment, then white children might also be more
likely to be involuntarily taken and then adopted out.

"It seems like if there’s a market out, there it seems like babies that people really
want are newborns, healthy, closest to Caucasian and if they are a defendant to
something..."You know it really seems like you’re a crazy, homeless, single mother
that’s pregnant, it seems like maybe 1 out of 4 of those women would be more
than happy to walk away from a child at the hospital." And thus, if that hospital or
private adoption agency is able to turn that child around and got it to a family
that’s willing to pay for it. What types of babies are those types of people looking
for? And I don’t want to think this way but fuck dude, if it’s true it’s true."
- 29 year old man

"[During CPS involvement] the bitch from hell got involved. And I’m not racist, not
at all. He’s Native American and my best friend is Black; big fucking deal. And the
social worker was racist. She hated the fact that she was dealing with white
people."
- 22 year old woman

Cycle of Loss

For the twelve pregnancies in which custody was lost permanently, the trauma of
losing a child began a cycle of despair and depression. In this sample, there were four
women and two men who had experienced multiple pregnancies and multiple losses of
their children into custody. The impact of losing custody is profound. Many of these
youth will find themselves left with the sadness and grief of losing another child.

"I started doing speed when I wasn’t living with my daughter anymore."
- 24 year old woman

"[Having my children taken] just destroyed my want, my desire to. I have no
more drive left. I don’t care to move on. I’ll be dead in five years anyway."
- 25 year old man

In only one case did a youth describe acceptance of the loss of her child.
Importantly, this quote comes from the same woman who has a positive and ongoing
relationship with her prenatal care provider.
“And he’s probably better off where he’s actually taken care of and in a house with a person who has a steady job and who has money to take care of him rather than keeping up the happy face that’s genuine but is absolutely inexperienced in a situation that is so full of hardships as life when [my partner] and I were trying to raise him.”

- 24 year old woman

Unfortunately, this was not the predominant emotional reaction to the loss of a child. Most of the parents who had lost children have lost multiple children. Most hope to become pregnant again, or at least do not actively avoid becoming pregnant, as they hope that the next pregnancy will be the opportunity to cross the bridge from street life back into the mainstream.

“Have a baby, don’t have a baby. Maybe they’ll let us keep this one.”

- 25 year old man and 23 year old woman

*A Path Out of Homeless: The Futures of Berkeley Street Youth*

For those youth whose pregnancy was not a crisis that resulted in extraction from homelessness, a return to equilibrium with homelessness was the most typical path. However, not a single youth described his or her future as one on the streets. No one wanted to remain on the streets and become a “crackhead,” a member of the older homeless population. Berkeley street youth desire to leave homelessness. Those who are not ready to leave homelessness predominantly terminate a pregnancy. They see their future as negotiable on their terms.

“I would always like to travel. But eventually I’ll find a place that I like – a home base. I would like to work towards living in a self-sustained lifestyle, like having a farm, growing things. Kind of like communal living.”

- 22 year old man

On the other hand, those youth who wanted to leave homelessness and were not successful in using pregnancy as a way out had more sober ideas of the future.
"Eventually get some mental health care I need so I can keep the job, house and get the kids back eventually and grow old with my husband. Those are the goals. They're long term goals for me. I have to figure out how to do that though. I'll figure it out."

- 23 year old woman

Summary

Regardless of the outcome of their pregnancy decision-making, these youth want to eventually leave homelessness. For the seven individuals who were not ready to make that transition from street life back to the mainstream, terminating the pregnancy was their predominant choice. They found support for their decision from their families, street community and society through easy access to abortion services. And for one woman, the inability to deal with disequilibrium of pregnancy in her life resulted in a late miscarriage. For the twelve individuals who were ready to make the transition to the mainstream, pregnancy was a motivator to leave and to make decisions accordingly. Unfortunately, half of these individuals were unsuccessful in making that transition because of a combination of inability to meet the expectations of "fit" parenthood, individual and structural lack of access to supportive services and the lack of a family as safety net. These youth were also most likely to have had multiple pregnancies all resulting in loss of custody. By trying to have a child, or at least not preventing another pregnancies, these youth hoped that another pregnancy could be a new opportunity to leave homelessness and parent. For those three couples that were able to leave homelessness, the key difference between these youth and those that were not able to leave homelessness was ability to rely on family as a means of transitioning from the street community to the mainstream. Interestingly, the home lives and abuse experiences of youth able to maintain custody of their children were not substantially different from those who lost custody. However, the youth that
lost their children did have more significant drug use problems and mental health problems, which may have played a factor in their inability to return to their family.

Discussion

While pregnancy among homeless youth is acknowledged in the current literature, there is scant information on the subjective experiences of pregnancy among homeless youth. This study has addressed this gap by focusing on the process of decision-making among Berkeley street youth. This discussion will address the specific contributions this study has made by conceptualizing this process as an interweaving of individual, couple, community-level and society level factors that influence the pregnancy decision-making process and by describing the experience of this process among Berkeley street youth.

Adding to the Life Cycle Model

On the level of the individual, this study has corroborated Auerswald and Eyre's life cycle model of a homeless youth. Pregnancy is an example of an existential crisis in which street youth begin to rethink living on the streets. The review of the literature revealed that pregnancy is often conceptualized as an opportunity for evaluation of personal priorities and goals for young women (Seibold, 2004), men (Holmberg and Wahlberg, 2000) and drug users (Murphy and Rosebaum, 1999). For homeless youth, this opportunity is crucial in evaluating their past, present and future. While the experience of pregnancy as a transformative event is not unique to homeless youth, it may be a particularly important event for street youth looking to leave the streets. Even for youth who are not ready to leave street life, pregnancy can be a crisis that allows for personal growth and development in decision-making.
The Importance of Couples

A unique finding of this study within the homeless literature is that pregnancy decision-making is process that occurs fundamentally between the two members of a couple. While the literature does describe the tightly knit, small group organization of street youth, there is minimal information about the role of heterosexual couple relations (Bourgois, Prince and Moss, 2003). Most studies of homeless youth only discuss the risks associated with multiple sexual partners, partner violence and other negative aspects of intimate relationships (Noell et al., 2001; Kidd and Kral, 2002; Rokach, 2005). Very few studies mention support and companionship as key features of any type of relationship among street youth (Rew, 2000; Rew and Horner, 2003). In this sample of Telegraph street youth, homeless couples did exhibit some of the negative aspects of relationships such as violence, yet they were often deeply committed to each other. Couples were the unit of companionship, protection and intimacy. Despite anti-authoritarian attitudes, they often replicated traditional gender relationships. In referring to each other as “husband” and “wife,” homeless couples were not only buying into dominant values of monogamy and commitment, they were often replicating traditional gender roles. Regardless of pregnancy decision, men most often took on the role of protector and provider discussing acquisition of money and employment as avenues available to them to meet the goal of responsible partner. Women conceptualized their role as caretaker, often both for herself, her child and her partner.

The importance of the couple in decision-making is in stark contrast to the available literature on decision-making, homelessness and pregnancy. While there are some studies that address the experience of pregnancy decision-making of housed
women and men (Lena and Hammarstrom, 20004; Seibold, 2004; Hanna, 2001; Holmberg and Wahlberg, 2000; Redmond, 1985; Murphy and Rosenbaum, 1999), there are no studies focusing on the decision-making process of a homeless couple. There is almost a complete absence of discussion of fatherhood for homeless men. While Passaro (1996) does discuss fatherhood within the context of homeless, mostly among African American men in New York, this was not a study on the decision-making process of men in parenting. In fact, most of the men in that study described their role as a father and partner as solely revolving around the provider role.

In contrast to Passaro's results, young, homeless men in Berkeley not only understood their role as partner, father and provider but also were also active participants in the pregnancy decision-making process. Active participation was characterized by difficult negotiations of personal priorities and options with their partners. In understanding the relationship between couples, Bourgois, Prince and Moss (2004) describe the violence and manipulation of street couples using injection drugs. Pregnancy elicited violence and manipulation of the dynamics between the couple. However, women remained the "final say" in decision-making for a pregnancy and men in general accepted this subordinate position. Thus, while men and women maintain traditional gender roles in seeking to leave homelessness when choosing to parent or re-equilibrate by terminating a pregnancy, gender relations in the context of decision-making about pregnancy reflect a more woman-centered paradigm.

The Seriousness of Parenting

Another contribution of this study to the homeless youth literature is the finding that couples were well aware of the seriousness of their situation and took parenting seriously. Homeless youth understood that pregnancy and risky behaviors such as train
hopping, drug use or even sleeping on the streets are not victimless acts. Street youth subscribe to the traditional notion of providing a stable, nuclear family environment for the next generation. For those couples that thought they could not live up to the expectation of “fit” parenthood, their decision was to terminate the pregnancy. For those that who wanted to engage in parenting, they tied their self-identity to becoming a mother or father. They desperately wanted to replicate the nuclear family that is central to the identity of most Americans (Passaro, 1996).

In wanting so desperately to replicate this nuclear family, it became clear that street youth were sometimes not developmentally able to make this a reality. Because of the trauma of their youth and the lack of role models in replicating this ideal, homeless youth were often unable to differentiate between a realistic goal and a fantastical belief that is unrealistically attainable. Dreaming of an alternative lifestyle, homeless youth were able to conceptualize more desirable models for life in the mainstream. However, street youth also had difficulty understanding the complexity of making their dreams a reality. Developmentally, these youth exhibited some of the pitfalls in decision-making among adolescents. They were unable to separate out aspirations from the actual step-by-step process necessary to make this a reality.

*Decision-making and Altered Development*

There are no studies that specifically focus on homeless youth and their cognitive development. The adolescent decision-making and cognitive development literature lay out clear connections between traumatic childhoods, early drug and alcohol use and precocious independence. However, there are no specific studies that investigate the impact of unstable families, early separation from multi-generational family structure, a predominantly peer-based support system and heavy, early drug
and alcohol abuse on the decision-making capabilities of homeless youth. While this study did not specifically focus on these developmental trajectories, it was clear that within the context of pregnancy some youth had difficulties making decisions, particularly those who ignored their pregnancies. In extremely stressful situations like pregnancy, these youth are affected in their ability to process and express emotional information.

While there were a number of youth who had difficulties with pregnancy decision-making, there were also other youth who were able to make decisions, make plans and execute these plans. Within the context of resiliency of homeless youth literature, Rew has written extensively about the internal strength of homeless youth and role of peers and social services in supporting this strength (Rew, 2000; Rew et al, 2001a, Rew, 2002). While the developmental trajectories of early independence can lead to problems with forming relationships of trust with adults and authority figures (Steinberg, 2005), some youth have also developed the ability to cope with tremendous stress and skills to resolve their crises. This study corroborates the findings that some street youth, despite pasts characterized by abuse and neglect, are able to make decisions about their futures, utilize their available resources and occasionally, re-form relationships with families to meet their goals.

Homeless youth who chose to terminate were explicit about their inability to parent at this time. They framed their decisions in the context of their immaturity and lack of experience with responsibility. Homeless youth often responsibly chose to abort in order to avoid accepting a life of responsibility. Additionally, they understood their decision as protecting their unborn child from troubled childhoods that most street youth knew. Their decision to terminate can be understood as an important
developmental step for these youth in their ability to realistically evaluate their past, present and futures. In contrast, homeless youth who chose to parent were more difficult to understand in terms of their development. In general, they were goal-oriented and were committed to leaving homelessness – they were trying “grow-up” and re-enter the mainstream and full adulthood. This study corroborated Saewyc’s (2003) proposal that pregnancy is a means of escape from a “developmentally toxic” environment.

The Importance of Family as a Bridge to Mainstream

Ironically, the youth who were able to successfully make the transition to the mainstream returned to families. Returning to their families meant returning to environments where youth experienced abuse and neglect. In returning to their families, many youth understood this step as a decision that would benefit both themselves and their unborn children. The reunification with family was both the opportunity to keep their child as well as explore a new relationship with their families.

Those homeless youth who were unable to rely on their families were unable to fully take on the responsibility of parenthood. Sometimes this bridge to the mainstream had been burned long ago with extreme abuse on the part of the parent or drug and mental illness of the youth that made parents unwilling to accept youth back home. Sometimes this bridge was burned because a family was unwilling to accept a partner. With no family to rely on, pregnant homeless youth have only social services to rely on as a means to return to the mainstream. In this study, every child born to parents who wanted to keep their children but had only social services to rely on was removed from the parental custody. Street youth framed the loss of their children as a great injustice perpetrated against them. This injustice was understood as unfair discrimination.
against homeless people and inability to access services, particularly housing. The inability to access housing and other supportive services is particularly troubling. It is tragic that at a time when homeless youth say they are prepared to make an important transition for themselves and for their children, services are unavailable to support their families.

It Takes A Village to Push Youth Out of Homelessness

The push to “grow-up” and assume responsibility was also supported by the homeless youth community. Within the literature of street youth social organization, there is no mention of the role of pregnancy in shaping the relational quality between members. In this study, the couple was not only the unit of decision-making for pregnancy but it was also the fundamental way in which pregnant and expecting Berkeley street youth were understood by their homeless community. The crisis of pregnancy within the street youth community manifests as peers trying to both protect an expecting couple and encourage them to leave homelessness. Couples saw that their relationship was treated as more serious, and was therefore more respected, than before the pregnancy. Street youth were also less tolerant of dangerous and irresponsible behavior on the part of the couple, particularly by the mother. Youth were unwilling to be travel companions with pregnant women or a couple, to tolerate drug use by pregnant women or the idea that children could be raised on the streets. Because of the collective memory of troubled childhoods, homeless youth took the responsibility of having children very seriously. Overwhelmingly, youth were supportive of women and their partners who chose to abort. In the capacity that they could, the street kid community tried to protect their pregnant peers from the dangers of the street but with the clear message – “you can’t stay here.”
Interaction with Services

Much of the literature discusses homeless youth's unwillingness to access services that are frequented by adults. While there is some literature available about the service use pattern of homeless youth, none of this literature is specific to pregnancy. However, during a pregnancy, access to resources becomes an immediate need. Regardless of the pregnancy decision, youth did engage social and health services for the resources to follow through with their decisions. However, there was a significant difference in the level of support from service providers perceived by youth who chose to terminate versus those who chose to parent.

For youth who chose to terminate, accessing abortion services in Berkeley was described as relatively easy. Medi-Cal's emergency coverage of abortion services was seen as extremely helpful and allowed women access to safe, professional medical care. Women and their partners felt supported in their decision to terminate by volunteers at the Suitcase Clinic, other Berkeley youth services and the staff at the clinics. Some young women also described alternative means of aborting a fetus such as use of drugs, alcohol and herbs when abortion services are not accessible or appealing. This is a clear warning that services should be kept safe and accessible for young homeless women seeking to terminate a pregnancy. If abortion services become less available, youth may begin potentially dangerous abortion techniques to deal with the crisis of pregnancy.

The fact that women choosing to terminate felt supported in their decision-making by Berkeley youth services is crucial when situating this experience within the pregnancy outcomes literature. Consistently, researchers have found that unwanted pregnancies, not unplanned pregnancies, are associated with poorer outcomes (Sable
et al, 1997). For this population, access to abortion services has presumably prevented poor outcomes because women were able to terminate a pregnancy that was unwanted.

However, sometimes access to services is not enough. In this sample, women who ignored their pregnancies hoping to miscarry most illustrated this point. These women had unwanted pregnancies and used drugs and alcohol to cope with this crisis with the hope of inducing a miscarriage. While none of these pregnancies did come to term, this suggests that other women who are not successful in terminating pregnancies may deliver children who may be harmed by their mother's risky behavior. This sample represents only a small number of street youth. However, many participants described knowing women and their partners who faced with an unwanted pregnancy, used self-abortive techniques.

For Berkeley street youth who want to parent, fear and apprehension were the dominant attitudes towards services intended to aid poor and/or homeless parents. Youth were scared that their children were going to be taken away and saw this as a major threat to the safety of their own children. Women often avoided prenatal care, particularly at Berkeley institutions reputed as having unsupportive staff. Ideally, prenatal care should be a source of help and support during a pregnancy. Ironically, for young, homeless women in this study, attending prenatal care was an act that exposed the fact that she was pregnant and homeless. Revealing this information meant that she was making herself vulnerable to potentially dangerous forces, such as Child Protective Services. This is not a unique finding among marginalized populations. In Chapman’s study in Mozambique (2003), she found that women avoid prenatal care not because they do not understand its value for the health of their child but because
attending a prenatal clinic announces to a community that one is pregnant and vulnerable to an evil eye or other malevolent wishes of ill-meaning community members. For homeless youth in Berkeley, avoiding prenatal care was a way of protecting their unborn child and themselves from the dangers of involuntary separation and the horrors of foster care.

Youth choosing to parent did interact with services in an attempt to reintegrate into the mainstream. This interaction provided an interesting perspective on the ways in which gender, class and race intersect with the lives of Berkeley street youth and the services available in the Berkeley area. In considering the intersection between gender and class, men were much more likely to be offered job training and to seek out these types of services. Men and women both were willing to work but they were keenly aware that they would only be able to find low wage work that would not provide enough money to pay for child care, housing and the other necessities needed to move from their street community back into the mainstream. While both sexes were willing to work, women were not offered job training. They were offered housing but explicitly without their male partners. Young homeless men were unable to access housing services. As Passaro (1996) describes, the government has replaced the man as provider within the nuclear family relationship and thus, homeless men are essentially excluded from the family unless they are able to fulfill the role of the provider.

*Race and Decision-making*

Race played a very interesting role in the pregnancy decision-making process for these predominantly white street youth. On the one hand, youth felt empowered to consider adoption because their white babies would be adopted into “good,” upper
class, white households. On the other hand, white youth also felt that their children were in more danger of being involuntarily taken by Child Protective Services. Youth speculated that hospitals and governmental agencies might be making money by adopting their children to families willing to pay for healthy, white infants.

In attempting to access services, youth felt discriminated against by social services that were predominantly aimed at African-American and other minority communities. This was particularly evident in having to travel to minority neighborhoods to access services. Young, homeless European-American women felt uncomfortable staying in shelters that were predominantly African-American. Racial slurs were not uncommon and women often returned to the streets where they felt more comfortable with their European-American peer group and safer with their partners.

Helping Youth Realize their Pregnancy Decisions

For pregnant youth who were interested in returning back to equilibrium with homelessness by terminating their pregnancy, the current level of resources and support seems to be adequate. However, for those youth choosing to parent, the current network of social services in Berkeley leaves many youth with few viable options to make the transition from street youth to a housed and stable parent able to care for a child. We know that homeless youth are notoriously unwilling to access services. Unfortunately during a pregnancy when homeless youth are more willing to ask for help from social services, bridges to the mainstream have often been cut off. Homeless youth in the crisis of pregnancy who have no family support are those most vulnerable to sinking before making the transition to the mainstream. Because of a lack of available and acceptable social services including couples housing, inviting
prenatal care and accessible services in Berkeley, those homeless youth who are ready to leave homelessness are instead losing their children to foster care, returning to the streets, and often becoming pregnant again.

In one breath, a pregnant street youth can express desire to access services in order to leave the street life and frustration and fear of these services. The cries of "help me!" and "leave me alone!" communicate the conflicting emotion of Berkeley street youth making decision for their future. On the one hand, they want to feel empowered to ask and receive help in a time of need. On the other hand, they fear the repercussions of asking for this help. Unfortunately, we are losing the opportunity to use the crisis of pregnancy to help homeless youth leave homelessness with their children and develop into "fit" parents. Even with an abundance of resources not all homeless youth who become pregnant would be able to make this transition. However, with a better network of social services with providers who understand the street youth population, many more youth could make the transition to the mainstream than those currently receiving services. Such assistance could avoid a cycle of loss that results in foster children separated from parents and homeless parents on the streets sinking deeper into mental illness and drug use as they attempt to deal with the loss of their children and role as parent. We should hear the cry of "help me!" loud and clear and understand that "leave me alone!" comes from the fear that services that are supposed to help will fail yet again and that they will be left in a worse situation.

Fieldwork Challenges

Perhaps one reason that pregnancy decision-making among homeless youth has not been studied more thoroughly is that this population is notoriously suspicious of authority and outsiders. For this study, I was able to overcome this challenge
because of my two-year relationship with the homeless community prior to beginning field research. Through volunteering at the Suitcase Youth Clinic for two years, I established relationships with many individuals. To many of these youth, I am known as the “med chic,” a person to come to for medical needs at youth clinic or sometimes on Telegraph Avenue. This connection with the entire community was helpful in establishing relationships with potential research participants and served as the first step to building trust. Because of my role as a service provider and research, I also helped facilitate accessing services for some women. I drove women to prenatal appointments and arranged abortion appointments. I believe that my multiple roles within this community strengthened my connection to participants. However, it is possible that for some woman and men, my multiple roles were confusing.

*Issues of Trust*

Trust is key to obtaining candid information about pregnancy decisions, intimate details about drug history and childhood and difficulties with partners. In developing this trust, I relied on personal connections, transparency in the informed consent process and my role at Suitcase Clinic. For the most part, my connection with Suitcase Clinic was an asset in gaining trust of the youth. However, because the Suitcase Clinic is formerly affiliated with one of the clinics that clients have come to distrust, I was initially viewed with some suspicion. Some women were concerned that I was working with this clinic in order to gather information about pregnant, homeless women. For these women, I assured them that my goal was to gather information, my research was not affiliated with this clinic and that I would only report them if I thought that they were a danger to self or others. I was also clear that if I felt the
need to make such a report, I would personally tell the participant that I was doing so. At no time did I feel the need to make such a report.

*Multiple Roles*

While my simultaneous role as researcher and service provider at Suitcase Clinic was helpful in recruiting women, it may have also influenced the type of information women were willing to share with me. Because we developed a relationship based on mutual respect, this may have led some participants to underreport certain embarrassing feelings or behaviors, such as drug use during pregnancy. In addition, women may not have fully disclosed some information for fear of reporting or other consequences.

*Sampling*

Other fieldwork challenges included issues of sampling. A few participants were recruited through hang-out sessions on Telegraph Avenue and People's Park. However, the majority of recruiting of participants was through Suitcase Clinic and referrals from other participants. While this study does focus on Telegraph street youth, not all members of this subpopulation come to the Suitcase Clinic. Some do not access any services and others, particularly the older members of this population, may use adult services. Thus, this study may have been biased towards youth who are already accessing youth services.

One of the major findings of this study was that pregnancy decision-making was a process engaged by two people—a mother and a father. All women attending the Suitcase Clinic from July-December were given an informational sheet during the initial sign-in. Men were not offered a similar sheet. Women were also approached if
they appeared obviously pregnant. Finally some women were referred to me because others knew that they were pregnant. Clearly, men show no external signs of expecting a child. While one man was interviewed independent of his partner, the rest of the male participants were all recruited through their female partners. This may have biased this sample towards couples. A more inclusive recruiting strategy may have included men who were not active participants in the decision-making process.

These fieldwork challenges – trust, service providers as researchers and sampling issues - are important issues to address in subsequent studies in order to gain a better understanding of pregnancy decision-making and other intimate issues for homeless youth.

Recommendations

"Okay what works, what doesn't and can it be fixed? Things that don't work, can we get rid of them? Can we change them? Can we add a new part? Can we modify?"

- 29 year old man

The Telegraph street youth population represents a relatively small and unique segment of the Berkeley homeless population. The following recommendations are based on the experiences of this population. However, these recommendations may support other segments of the homeless youth population, homeless adults and pregnant adolescents. The following recommendations can be grouped as those addressing the issues of Berkeley street youth in equilibrium and disequilibrium with street life and those that are specific to pregnancy decision-making among homeless youth.
Engaging Telegraph Street Youth

Despite the daily hardships, Telegraph street youth are usually very proud that they live outside of the mainstream. They view themselves as survivors of chaotic childhoods and courageous street warriors who reject the oppression of housed life. Because of a history of abuse, violence and discrimination, these street youth are often suspicious of authority figures, the older homeless community and adults in general. They are also a community in profound need of a variety of services that can address issues ranging from basic food and shelter to the complex problems of mental health and drug abuse. Despite this need, youth-oriented services in Berkeley are slowly disappearing. Berkeley needs more youth services, not fewer, particularly if one goal of these services is both to serve the needs of youth on the street and to help youth leave the streets when they are ready to re-integrate into the mainstream.

Currently, the youth-specific services in Berkeley are limited to the Suitcase Youth Clinic, a weekly, evening drop-in clinic and YEAH!, a youth shelter open from December to April. Major Tom Bates has designated the needs of Berkeley homeless youth as a policy priority for the City of Berkeley. Berkeley's youth desperately need a year-round, youth-specific center staffed with a variety of well-trained peer mentors, counselors and other service providers. This center should provide daytime drop-in and nighttime shelter services for youth. Importantly, this center must be an inviting resource for homeless youth who are not prepared to re-enter the mainstream. In creating continuously available and reliable resource, this center will be the obvious place where youth can turn during a crisis. The key to creating such a center to meet the needs of Berkeley street youth is to provide a place of stability and safety. To create such an environment, it is imperative to have trustworthy, well-trained, long-
term staff who can develop relationships with youth and provide support and referrals for other resources when youth are ready to receive them.

Creating a center is only one step in meeting the needs of Berkeley homeless youth. Often those youth who are most in need of services do not attend any of the youth-specific services. Outreach by center staff must be a part of the effort to meet the needs of the hardest to find youth. By building relationships with homeless youth on their terms and in their comfortable environments allows for the development of comfort and trust so crucial for youth during a time of crisis. This crisis may be the result of a pregnancy or some other event. By engaging the homeless youth community, outreach workers could support the broad needs of homeless youth and the specific needs of pregnant youth. For youth engaged in pregnancy decision-making, outreach workers could provide a point of contact into the system of resources that is often intimidating and confusing. Through outreach and easy access to counseling and support, staff could engage women, men and couples and provide referrals to pregnancy-specific services. Unfortunately, the likelihood of creating a collaborative center with devoted staff and outreach workers in the near future is improbable. Thus, I will discuss pregnancy specific recommendations within the present context of available services in Berkeley.

While many of the following recommendations will be service-oriented, the most important recommendation that can be derived from this study is that pregnancy is a time when street kids are open to change. It is imperative that services be easily accessible during this window when street youth are ready for change. As youth services and other homeless services in Berkeley are disappearing, it may become
much harder to use this opportunity to help youth out of homelessness at a time when they are ready.

**Pregnancy Prevention**

The first step in addressing pregnancy in the homeless youth population is to address pregnancy prevention. While not true for all youth, most pregnancies in this population are unintentional. Providing contraceptives must include a variety of methods including condoms, oral contraceptives, Depo-Provera ® and the Nuva-Ring ®. Providers must acknowledge that youth are highly transient and women should be given many months of birth control at a time. Additionally, men should be engaged about pregnancy prevention along with women and encouraged to use condoms. Youth who state that they are unwilling to use hormonal or barrier methods should be taken seriously and offered education on monitoring basal temperature rates and cervical mucosa and avoiding unprotected sex on high fertility days. In fact, one woman was already practicing this method and educating her peers about this method. While pregnancy prevention will not be 100% effective in avoiding an unintended pregnancy, making resources accessible for youth may help prevent some unintended consequences of unprotected sex.

**Maintaining Abortion Service Availability**

For youth choosing to terminate, keeping abortion services available and safe should be a priority. Currently, Medi-Cal covers abortion services and procedures can be performed in clinics located in Oakland. Unfortunately, within the current national political climate, the accessibility of abortion services for many women is threatened. This is particularly true for poor women. If these services become harder to access,
we may begin to see more dangerous abortions that could lead to infertility, serious injury and/or death in young, homeless women and other disadvantaged women.

*Parenting Youth – Meeting the Challenge*

For youth seeking to parent, the recommendations are far more complicated. Providers working directly with homeless youth should support both women and men in their decision-making process by facilitating self-reflection about present situation and future goals. By engaging both men and women, perhaps some of the frustration and violence that characterized the process of youth in this study could be avoided. Once a decision has been reached, youth often know their desired outcome but have difficulties in making the step-by-step process of making goals a reality. A provider could facilitate this process by encouraging youth to plan out smaller, attainable goals that can lead one to successfully reintegrating back into the mainstream and parenting. Providers must be patient with youth as they may be recalcitrant at initial meetings because they expect hostility. Being patient with a youth and setting up more frequent meetings can be helpful in establishing trust and structured method of checking in about progress of meeting goals. Because loss of custody is often central to decision-making, social workers, obstetricians, midwives and other providers should be clear about the role of CPS and mandated reporting in discussion with pregnant youth. It is crucial for providers, particularly those who are mandated reporters, to be honest and transparent about the consequences of certain decisions. Service providers should directly address the central anxiety of many homeless parents – the fear of losing their baby – in order to dissipate suspicions of conspiracy against parenting homeless youth. By addressing the issue directly, homeless youth may have a better
understanding of their responsibility and will be able to develop a more trusting partnership with their service providers.

Homeless youth want help re-integrating into the mainstream as a couple. Providers should be open to supporting reunification with a family if appropriate and facilitate this process by connecting youth to programs such as Homeward Bound. For those who do not have the option of safely returning home, finding housing becomes a more difficult goal for a couple. Currently, there are no emergency or transitional housing available to couples in Berkeley. Providing housing for couples would surely support not only homeless youth but also other families looking for stable living arrangements.

Unfortunately housing is not always the limiting factor for Berkeley street youth who lose custody of their children. Often untreated mental illness, drug problems and lack of experience in parenting are significant barriers for expecting parents. Assisting youth in structured drug programs and mental illness treatment may help some youth who are ready to enter treatment for the benefit of their child. These services should be offered to both men and women. While there are no known programs that allow a family to stay together during drug and mental treatment programs, there are some studies on keeping a mother and child together during drug and/or mental health treatment programs. Results show that women are more successful, remain motivated throughout the program and learn to cope with problems and care for a child simultaneously (Salmon et al, 2003).

Pregnant, transition age youth may also be able to take advantage of extended foster care benefits if they were once foster youth (Kerman, Barth and Wildfire, 2004). Although these benefits are not designed to aid pregnant youth, this could be a new
avenue that could utilize resources available to the transitional youth for the benefit of both parent and child. It should be noted that these resources should be available for both mothers and fathers. These resources could be used for housing, education or other needs that could facilitate transition into the mainstream.

Some youth will have the desire to parent but are not quite ready to take on this responsibility independently. Currently, these situations often result in the foster care placement of the child. For youth who lack the resources and the self-confidence that they can parent, removal of custody without subsequent can severely compromise the ability to regain custody of children. For those youth who need significant help after the birth of their child with housing, parenting skills and other needs, shared family placement of mother-child or even a couple with their child should be considered as an option. In situations outside of the formal social sector, families essentially foster the infant while housing the parents in order to help them with resources and to provide role modeling and support for parenting. The social sector could provide a similar situation that would protect the infant while providing support and role models for homeless youth who need help transitioning into the mainstream and parenthood. There is precedent for this type of arrangement. These shared family arrangements have been shown to be beneficial to both the mother and child (Barth and Price, 1999). This may help to prevent a cycling of homelessness as adulthood homelessness has been strongly associated with childhood foster care placement (Zlotnik, Robertson and Wright, 1999). Unfortunately, there are currently no programs that house an entire family - a mother, father and their child in a shared family arrangement.
Avoiding the Cycle of Homelessness

Most of these recommendations require funding and commitment to addressing the needs of homeless youth parents and their children. Unfortunately, without opportunities for help and support, more children will be born to parents who are unprepared for parenting. This will result in more children being placed in involuntary foster care and distraught parents. We need a system of social services that does not only addresses the symptoms of unintended pregnancy among homeless youth. We need a system that is dedicated to helping to create solutions that protect mothers, fathers and their children. Street youth need bridges to make the crisis of pregnancy an opportunity to leave their situation – if we build these bridges in Berkeley, not all, but many more young people will be able to leave homelessness and reenter the mainstream successfully as responsible and well-prepared parents.

Future Directions

There are several questions that remain unanswered about the Telegraph youth population and their pregnancy experiences. An important finding in this study was the importance of the couple as the unit of social relations and identity formation for homeless youth. A more focused understanding of the couple and other units of identity formation among Telegraph youth would be helpful in understanding both pregnancy decision-making and other important daily decisions. Within the context of couples, young, homeless men are very concerned with fatherhood and their role in a pregnancy. However, in this study, men were recruited primarily through their partners. A qualitative study of young, homeless men and their conceptualization of manhood and fatherhood could provide important information about ways to support both men and women in pregnancy decision-making.
*Other Crises in the Life Cycle*

An important finding in this study was that pregnancy is an example of a crisis that can motivate youth to evaluate their present situation and future goals. It is vital that scarce resources intended to help youth out of homelessness are concentrated appropriately at times when youth are most likely to use these resources. However, pregnancy is only one type of crisis in the life cycle of a street youth. More research is needed on the types of crises described in Auerswald and Eyre (2002) that provoke disequilibrium and potentially self-evaluation for a homeless youth. While obvious examples may include drug overdose, death of a friend or a violent attack, other life crises may not be so obvious to service providers and other people working with street youth. Sometimes a life crisis may not be the result of one dramatic event but rather a series of small incidents that place a youth at disequilibrium. Research is needed to assure that there is adequate sensitivity to the variety of events that cause a homeless youth to be in disequilibrium with their environment.

*Homeless Youth and their Developmental Trajectories*

Much of the contextualization of this study has been around the developmental trajectories of homeless youth and their capacity to make independent and well-informed decisions. Unfortunately, much of the information used to describe developmental issues of homeless youth has been pieced together from small studies about homeless youth and larger studies of housed youth with similar abuse histories. A focused study of developmental issues of homeless youth would be beneficial in understanding the educational and other supportive services that youth need in their current situation and their future development. This information would be beneficial to providers in supporting the decision-making needs of homeless youth.
Exploring Experiences of All Berkeley Homeless Youth

This study has begun to fill a gap in knowledge about the subjective experience of pregnancy decision-making among Telegraph street youth. However, the experiences of this relatively small and unique segment of this population cannot necessarily be generalized to the other segments of Berkeley homeless youth that do not congregate on Telegraph Avenue. These youth tend to be African American and Hispanic and may have a very different perspective on homelessness, social organization of their street youth peers and accessibility to services. A similar study of the subjective experiences of these Berkeley street youth would provide a more holistic perspective of the homeless youth population and the role of pregnancy as crisis at the individual, community and society levels.
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Appendix I – Informational Flier

Are you a woman 18-26 years old? Have you been homeless and pregnant in the past four years? If yes, you are eligible to participate in research that can improve social services for you and other homeless women in Berkeley. You will be asked to participate in one or more interviews and a focus group. Food will be provided at each encounter. All information will be kept confidential. If you are interested in participating in this research or have any questions, please contact Marcela Smid at (510) 528 – 8171. You can also contact Marcela through the medical division at Suitcase Youth Clinic on Monday nights.
Appendix II – Informed Consent Forms

Prospective Participants Consent Form (IIA)

Dear Potential Research Participant,

My name is Marcela Smid. I am a graduate student in the division of Health and Medical Sciences at the University of California at Berkeley. I would like to invite you to take part in my research about pregnancy decision-making by young homeless pregnant women in Berkeley. If you have difficulty reading or understanding this letter, I will read and/or explain it until you feel like you fully understand all the procedures in which you are agreeing to participate.

If you agree to take part in my research, I would like to interview you at least once at a location that is convenient and comfortable for you. We will decide on a suitable location together before the interview. Each interview you agree to participate in will last approximately between 1-2 hours. Some of the questions I will ask you will be of a personal and sensitive nature. The interview will involve questions about your pregnancy, factors that influenced your decision-making about your pregnancy and the types and quality of the social services you received in Berkeley while pregnant. If you agree, I would like to interview you once a month for at least the next three months. I hope to use the information you reveal to me to make recommendations to Berkeley social services in order to better meet the needs of women such as yourself.

I will be audio recording the interviews to be sure I note all of your comments. All the information, including audiotapes, I obtain from you during the research will be kept confidential within the limits of the law. I will not use your name or other identifying information in any reports of the research. I will refer to you by your first name, or whatever name you wish to be called by during the interview. This name may be recorded during the interview. The audio tapes will be kept in a locked cabinet until the research is completed, after which the tapes will be erased. The audio taped interviews will be transcribed by myself or a professional transcriptionist. The transcripts and any notes from the interview will be stored in a locked file, separately from the key to the code of names. Because this consent form has your signature, it will be kept in a separate locked file away from the data.

I will not discuss any information you have revealed to me with anybody else. The only circumstance under which I would break confidentiality is if you expressed a serious intention to either harm yourself or another individual. This is primarily meant to protect you.

You will also be asked to participate in a focus group with 4-6 other women who are or were homeless, young and pregnant in Berkeley during the past year. Please understand that by participating in a focus group, you are agreeing to reveal that you are currently pregnant. You may decide not to participate in the focus group but still participate in the interview.

Your participation in this research is voluntary. You are free to refuse to take part in any portion of the research. You may decline to answer any questions and may stop taking part in the study at any time. Whether or not you choose to participate in this research will have no bearing on your standing or treatment at the Suitcase Youth Clinic.

For every interview you participate in, I would like to offer you a meal during our interview process at a local food establishment. Because we will be discussing very sensitive information that may be disturbing to you, I want to reassure you that at any time during an interview, we
can stop the process. If at any point, you feel unsafe, we can immediately stop the interview process.

Benefits of participating in the research may include providing constructive feedback to Berkeley social services. Your participation in this research may help provide insight leading to improvements in Berkeley’s social services targeted at women like yourself. An additional benefit to participating in the research is the opportunity to tell the story of your pregnancy experience. Potential risks in participating include accidental disclosure of pregnancy status and the possibility that these questions will bring up emotionally disturbing subjects. I will do everything to minimize this risk to you. I will also provide referrals to Berkeley Mental Health or the Wright Center if you would like to be referred for counseling.

If you have questions about this research, you may call me, Marcela Smid, at (510) 528 - 8171. You may also contact my thesis advisor Karen Sokal-Gutierrez at (510) 594-8544. If you agree to take part in this research, please sign below. You will be given a copy of this consent form for future reference.

If you have any questions about your rights or treatment as a participant in this research project, please contact the University of California at Berkeley’s Committee for Protection of Human Subjects at (510) 642-7461, or e-mail subjects@uclink4.berkeley.edu.

The study described above has been explained to me. I understand what it involves, and I agree to participate in it.

Participant

Signature: ___________________________ Date: ___________________________

Interviewer

Signature: ___________________________ Date: ___________________________
Retrospective Participant Consent Form (IIB)

Dear Potential Research Participant,

My name is Marcela Smid. I am a graduate student in the division of Health and Medical Sciences at the University of California at Berkeley. I would like to invite you to take part in my research about pregnancy decision-making in young women who have homeless and pregnant in Berkeley in past four years. If you have difficulty reading or understanding this letter, I will read and/or explain it until you feel like you fully understand all the procedures in which you are agreeing to participate.

If you agree to take part in my research, I would like to interview you at least once at a location that is convenient and comfortable for you. We will decide on a suitable location together before the interview. Each interview you agree to participate in will last approximately between 1-2 hours. Some of the questions I will ask you will be of a personal and sensitive nature. The interview will involve questions about your pregnancy, factors that influenced your decision-making about your pregnancy and the types and quality of the social services you received in Berkeley while pregnant.

I will be audio recording the interviews to be sure I note all of your comments. All the information, including audiotapes, I obtain from you during the research will be kept confidential within the limits of the law. I will not use your name or other identifying information in any reports of the research. I will refer to you by your first name, or whatever name you wish to be called by during the interview. This name may be recorded during the interview. The audio tapes will be kept in a locked cabinet until the research is completed, after which the tapes will be erased. The audio taped interviews will be transcribed by myself or a professional transcriptionist. The transcripts and any notes from the interview will be stored in a locked file, separately from the key to the code of names. Because this consent form has your signature, it will be kept in a separate locked file away from the data.

I will not discuss any information you have revealed to me with anybody else. The only circumstance under which I would break confidentiality is if you expressed a serious intention to either harm yourself or another individual. This is primarily meant to protect you.

You will also be asked to participate in a focus group with 4-6 other women who are or were homeless, young and pregnant in Berkeley during the past year. Please understand that by participating in a focus group, you are agreeing to reveal that you are currently pregnant. You may decide not to participate in the focus group but still participate in the interview.

Your participation in this research is voluntary. You are free to refuse to take part in any portion of this research. You may decline to answer any questions and may stop taking part in the study at any time. Whether or not you choose to participate in this research will have no bearing on your standing or treatment at the Suitcase Youth Clinic.

For every interview you participate in, I would like to offer you a meal during our interview process at a local food establishment. Because we will be discussing very sensitive information that may be disturbing to you, I want to reassure you that at any time during an interview, we can stop the process. If at any point, you feel unsafe, we can immediately stop the interview process.
Benefits of participating in the research may include providing constructive feedback to Berkeley social services. Your participation in this research may help provide insight leading to improvements in Berkeley's social services targeted at women like yourself. An additional benefit to participating in the research is the opportunity to tell the story of your pregnancy experience. Potential risks in participating include accidental disclosure of pregnancy status and the possibility that these questions will bring up emotionally disturbing subjects. I will do everything to minimize this risk to you. I will also provide referrals to Berkeley Mental Health or the Wright Center if you would like to be referred for counseling.

If you have questions about this research, you may call me, Marcela Smid, at (510) 528 - 8171. You may also contact my thesis advisor Karen Sokal-Gutierrez at (510) 594 – 8544. If you agree to take part in this research, please sign below. You will be given a copy of this consent form for future reference.

If you have any questions about your rights or treatment as a participant in this research project, please contact the University of California at Berkeley's Committee for Protection of Human Subjects at (510) 642-7461, or e-mail subjects@uclink4.berkeley.edu.

The study described above has been explained to me. I understand what it involves, and I agree to participate in it.

Participant

Signature: _______________________________ Date: __________________________

Interviewer

Signature: _______________________________ Date: __________________________
Audio Consent Release Form (IIC)

Audio Consent Release Form

As part of this project, I would like to audio record our interview so that I may spend less time taking notes and more time listening. I would like you to indicate below what uses of these records you are willing to consent to. In any use of these records, your name will not be identified.

The audio tapes will be kept in a locked cabinet until the research is completed, after which the tapes will be erased. The audio taped interviews will be transcribed. The transcripts and any notes from the interview will be stored in a locked file, separately from the key to the code of names.

I intend to use the audio tapes in the following way:

1. The records can be studied by the research team for use in the research project.
   Audio 
   
   Initials

2. The records can be used for scientific publications.
   Audio 
   
   Initials

I have read the above description and give my consent for the use of the records as indicated above.

Participant

Signature: __________________________ Date: ___________________
Appendix III – Interview Guide

Semi-structured interview guides for currently or previously pregnant homeless women

**Identifying Information**
- Name (choose a name that you are comfortable being recorded)
- Age, gravity, parity, children in custody

**Homelessness**
- How did you become homeless?
- How long have you been homeless?
- How long have you lived in Berkeley?
- How do you meet your basic needs (food, etc.)? How do you gain access to money?
- How do you feel about being homeless?
- What is your daily life like?
- How do you feel about being a young homeless woman in Berkeley?
  - Do you feel safe? During the day? At night?
  - Is your experience similar or different than other homeless people in Berkeley?

**Pregnancy**
- When did you become pregnant?
  - If multiple pregnancies: what happened with your other pregnancies?
    - How did you feel about the outcome?
- How did you find out you were pregnant?
- How did you feel about it? Where did you go?
  - If feeling/felt ambivalent: How did you make a decision about your pregnancy?
  - If not: Tell me about what made you sure in your decision.
- What were some of the factors that influenced your decision-making?
  - Probing questions: parents, partner, economic situation, drug use, previous pregnancy, own childhood, family situation, mental health, physical health

**Social Services in Berkeley**
- Have you received any services in Berkeley?
  - Which services have you received that were specific to pregnancy?
    - Probing: Medical, Welfare, Housing, WIC, Substance Abuse
  - Which ones?
- How do you feel about these services?
  - Are they convenient and available for you to access?
  - How do you feel about the providers?
  - What is your current relationship with the providers?
  - Have you had any significant previous relationships with providers in Berkeley?
- Has anyone from these services helped you make decisions about your pregnancy?
What did they say?
Did you want them to help you make these decisions?
How did you feel about the help that they did or did not provide during your decision-making process?
Where you satisfied with the help that you received from your providers during your decision-making?
What would have been helpful to you during your decision-making process?
What do you most want to get out of the social services?
When have your needs been met?
When have they not been met?
What would you want improved?
Is there anything else you want to tell me about your experience with social services and providers related to your pregnancy decision-making?