Primigravida Experience of Childbirth and Parenthood: Part I - Avis Schreier, Debra Danilewitz, Amelia Smyth

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Summary

There has been a steady increase in the number of unwed mothers in the community, but a decrease in the number of children being placed for adoption. A comparative study was undertaken at two Johannesburg hospitals of a selected sample of matched married mothers and unwed mothers, keeping their babies. A third group was identified ie those married after conception. Significant differences were found in age, education and occupational status, as well as family background between the single and married mothers. Fathers too differed significantly. Reactions to the pregnancy, incidence of contraceptive usage, smoking, alcohol and drug taking also differed significantly between the three as well as some differences in the self perceptions of the mothers. It was concluded that they were a neglected group who required much counselling and support. Single mothers were a more "at risk" group than married mothers.

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KEYWORDS:
Pregnancy; Pregnancy unwanted; Mothers; Marital Relationship; Single Person; Adoption

Introduction

Adolescent Pregnancy has received much attention in the last few years both in the lay[1] and professional press.[2,3,4,5] Not only do the health risks to mother and child increase both prior to and post delivery,[6] but there is some indication that there are more neonatal complications with increased mortality and morbidity in these infants.[7] The young age combined with unmarried status in many mother exposes the infants to increased risk of infant deaths due to a greater prevalence of respiratory infections and accidents than in the infants of their married counterparts.[8] Illegitimacy and single parenthood appear to be major risk factors for child abuse and neglect.[9,10]

Unmarried parenthood appears to be an ever increasing phenomenon, possibly because the punitive attitudes of society have changed to a more tolerant and permissive outlook. In the USA during the period 1960-1978 out of wedlock births to women under 20 years of age rose from 15,3 to 25,0.[4,11] In 1986 11,1% of all White births in Johannesburg were to unmarried mothers.[11] This represented a 5% increase in births to single women since 1979 and an 8% increase since 1956.[12] A random sample of births at Baragwanath Hospital during 1987 showed that 73,5% were to unmarried women.[13] Concomitant with this increase in out of wedlock childbearing is the reduction in the number of White children placed for adoption. In 1986 11,6% of White mothers in Johannesburg placed their babies for adoption, whereas 22,9% placed them for adoption in 1979[11] and 62% during the years 1953-1956.[12] This trend has also been noted in the USA and Britain.[14,15] Thus the majority of unmarried mothers are now keeping their babies.

This study was undertaken to ascertain the socio-demographic background of these mothers, their support systems, risk factors, their experience of childbirth and their coping ability.

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Subjects and Methods

All unmarried mothers (S) at Johannesburg and JG Strijdom Hospitals from November 1986 - March 1987 delivering their first babies, were interviewed and a questionnaire was administered during their post partum stay in hospital. Married women (M) were matched according to the age on the bedletter and parity of the single mothers during the same period.

In 1986 more than 1 out of every 10 white births in Johannesburg was to unmarried mothers.

Single mothers who were giving their babies up for adoption were not included in this study. There were 98 women in each group. Each woman was told that we were conducting a study to ascertain their experience of childbirth and child rearing with the aim of improving services in the community. No divorced or separated women were included. The women were also asked if they would be prepared to be visited at home in a few months time.

It was not realised when the study commenced that there would be quite a number of women who married after conception (S $\rightarrow$ M). For this reason this group (17,8% of the total sample) was considered separately. All results therefore refer to the three groups S, M and S $\rightarrow$ M and will be denoted by these symbols.

The statistical tests used were the Chi-square test, Student's t-test and Analysis of Variance. The Bonferroni Correction for multiple testing was used where appropriate.

FIGURE I: *Ages of mothers*

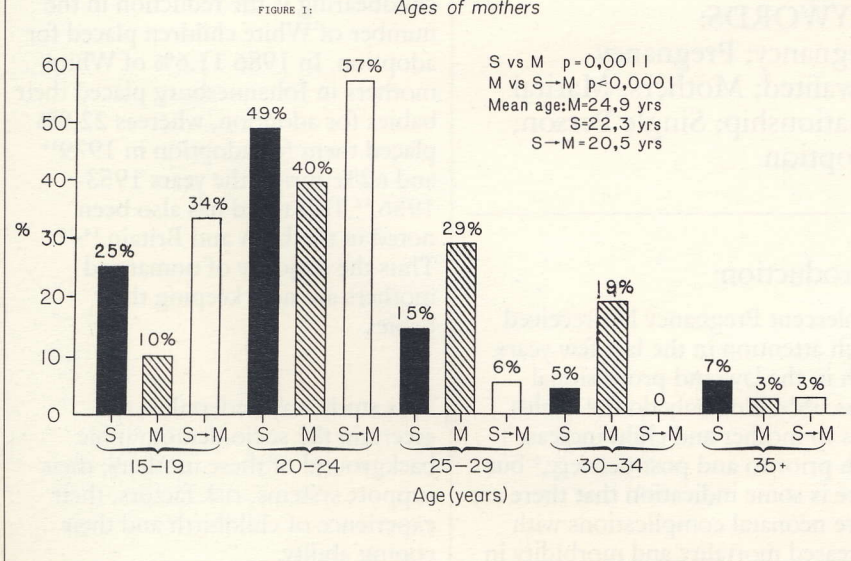
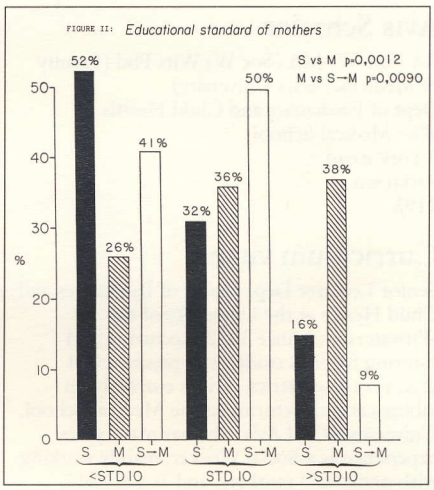


FIGURE II: *Educational standard of mothers*



Results

Mother's Characteristics

The mothers were matched according to broad age categories at the time of the delivery on the medical record. However, in computing the results, the actual birth dates were used. The age range was from 15-40 years with a mean of 22,96 years. Married women were found to be significantly older, (mean 24,9 years) than both the S women (mean 22,3) ($p=0,0011$) and S $\rightarrow$ M (mean 20,5 years) ($p<0,0001$). See Fig I.

More health risks to mother and child in adolescent pregnancies

Religion

The majority of the mothers belonged either to the traditional English or Afrikaans Christian churches. Five mothers belonged to the Greek or Jewish faith, one was Moslem and three belonged to Jehovas Witness.

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Educational Status

The educational status of the mothers was divided into three groups 0-Std 9, Std 10 and > Std 10. There was a significant difference in the educational status of the three groups of mothers (p=0,0005). The M mothers were better educated than either the S mothers (p=0,0012) or S —> M (p=0,009). There was however no significant difference between the S mothers and S —> M. Thirty eight percent (38%) of M mothers had a University or Technical College education as compared to 16% of S mothers and 9% of S —> M. See Fig II.

Occupational Status

Occupations were varied. Thirty percent (30%) of M mothers had professional/managerial positions as opposed to 4,7% of the S mothers

At Baragwanath Hospital 73% of the birth were to unmarried women

and 5,7% of S —> M mothers. Of the total sample 4,6% were scholars at the onset of their pregnancy, none of whom were married.

Family Background

The family backgrounds of the mothers revealed a significant difference between the three groups. (p=0,0069). Significantly more S mothers came from broken homes ie divorced/separated than the M mothers (p=0,0061). S —> M mothers also came from significantly more broken homes than the M mothers (p=0,0023). There was no difference between S and S —> M. See Fig III.

Fathers

The information on the fathers was

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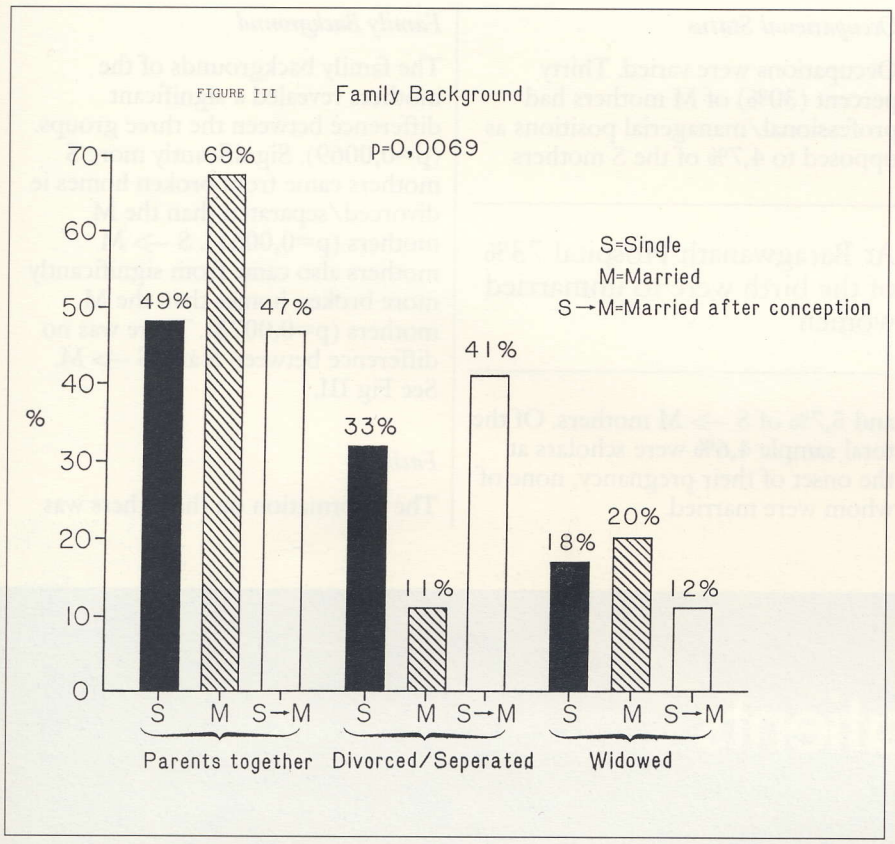


obtained from the mothers. The educational and occupational backgrounds of the fathers were found to resemble that of the mothers. There was a significant difference in the educational status between the M fathers and S —> M fathers (p=0,0005). In terms of occupational status 31,1% of married fathers had managerial/professional positions as opposed to 12,6% of S fathers and 5,7% of men who married the women after they became pregnant. The early family background of the fathers did not show any significant differences.

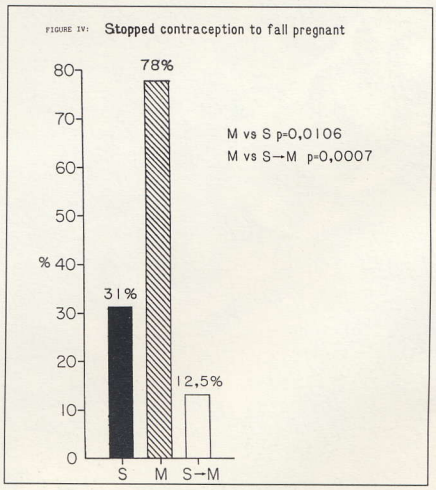
Reactions to the Pregnancy - Planned/ unplanned pregnancies

Seventy three percent of all the mothers reacted with happiness to their pregnancies. However, there was a significant difference between the three groups (p=0,0001). In particular more S women were indifferent or unhappy about the pregnancy (p<0,0001) than M women. There was also a difference between the M women and those S —> M (p=0,018). There was, however, no significant difference between S and S —> M. This finding is not surprising for the married women as 67% stated that the pregnancy was planned and 78% had stopped contraception usage in order to fall pregnant. However only 17,8% of both S mothers and S —> M mothers stated that the pregnancy was planned. Yet 31% of S mothers and 12,5% S —> M stopped using contraceptives in order to fall pregnant but 66,7% never used any contraception. See Fig 4. There was a significant difference in contraceptive usage between S & M married mothers (p=0,0106) and between S —> M (p=0,0007). However there was no difference between S & S —> M.

There was a significant difference between the M & S mothers (p<0,0001) and between M & S —> M (p 0,0001) with regard to stopping contraception to fall pregnant. No significant difference was found between the S & S —> M.

A significant difference existed between the S & M mothers (p<0,0001) and between M & S —> M (p<0,0001) in terms of their statement that the pregnancy was planned. All information was obtained from the mothers and therefore these results reflect the mothers perceptions.

The reactions to the pregnancy by the fathers bore a striking resemblance to the reactions of the mothers (although this may be biased). In the



case of M fathers, this was exactly the same as the reaction of their wives, and the reaction of S –> M group was similar to that of their wives. However there were more S fathers (24,1%) who were unhappy about the pregnancy than S mothers (13,6%). There was an overall significant difference to the reaction of their partners' pregnancy between the three groups (p=0,0007).

There was also a significant difference in the reactions of the families and friends of the mothers to the pregnancy (p<0,0001) which was not an unexpected finding.

Medical Aspects

Pregnancy

The majority of women attended ante-natal clinics at the hospitals for their ante-natal care (80,6%). The remainder went to a specialist or obstetrician (12,2%), general practitioner (5,6%) and a private midwife (1,5%). However, there were a large number of M women (23,7%) compared to S women (5,8%) who at some stage during their pregnancy had consulted a private obstetrician. A high proportion (91,3%) of all the women had had at least six visits for ante-natal care. Attendance at ante-natal exercise classes however, showed a significant difference between the groups (p=0,0002) with more M women attending such classes.

Questions were asked relating to the intake of alcohol and medication not prescribed by a doctor. Although differences were not statistically significant, 15% of both S and S –> M were taking drugs not prescribed, as compared to 4% of M women. As regards alcohol intake there was a significant difference between the three groups (p=0,0369). In particular the difference was that

married mothers drank more than those who married during their pregnancy. M & S –> M (p=0,0142).

Table I. Alcohol

Status	Yes	No	
S	25	61	86
M	30	46	76
S –> M	5	28	33
	60	135	195

There was a significant difference between the three groups regarding their smoking habits (p=0,0025) with 52,9% of S women and 26,3% M women smoking. (p=0,0006)

Table II. Smoking

Status	Yes	No	
S	46	41	87
M	20	56	76
S –> M	13	21	34
	79	118	197

Self Perceptions During Pregnancy

Mother were asked to report on their feelings regarding their being feminine, proud or ashamed and insecure. There was an overall significant difference between the three groups (p=0,0021).

Table III. Feelings (Status)

	S	M	S –> M
Feminine	70,3%	84,3%	84,6%
Attractive	40,9%	55,7%	37,5%
Proud	82,9%	98,6%	96,0%
Afraid	56,5%	52,4%	69,6%
Ashamed	15,7%	4,8%	9,5%
Insecure	47,9%	23,4%	25,0%

Delivery

Only 3,6% of the total sample were unbooked cases, ie did not attend ante-natal clinics at either hospitals. The perception of women regarding their labour as being difficult, satisfactory or easy was explored. There was no difference between the three groups. The majority of women (61,3%) regarded their labour as difficult despite the fact that 40% had labours that were less than six hours, ie times given by the mothers themselves. Eighty two percent

The majority of unmarried mothers are now keeping their babies

(82%) of women had vaginal deliveries and 17,8% had caesarean sections. Forty seven comma four percent (47,4%) of all women had an epidural anaesthetic administered during labour. There was also no significant difference between the groups.

The mothers were asked if there was anything wrong with their babies at birth. Twenty comma nine percent (20,9%) S mothers, 23,5% S –> M and 5,3% M mothers noticed that there was something wrong. There was a statistically significant difference between the groups (p=0,0075). See Table IV.

Feeding

During the puerperium 80% of the mothers were breastfeeding, ie at the time of the first interview.

Discussion

The most salient finding appears to be that the S mothers and S –> M were younger, had a lower educational status, were less qualified professionally and came from more discordant backgrounds than their married counterparts. This confirms the finds of other studies in SA and USA.[12,16,17,18,19,20,21]

Table IV. Abnormalities in Babies as perceived by the Mothers

The following is a list of what was wrong with the babies	n	M	S	S –> M
Oxygen given/intubated/cord around neck	8	2	3	3
Haematoma	1		1	
Low temperature	4		2	2
Low birth weight	4		4	
Elongated head/bruised head	2		2	
Extra digit on hand	1			1
Bowel problem	1		1	
Congenital dislocation of hip	1		1	
Meconium Swallowed & suctioned	3	2		1
Jaundice	2		1	1
Pneumothorax	2		2	
	29	4	17	8

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The group of mothers S —> M who were treated in the hospital as married women, were found to be more similar to the S mothers than to the M mothers in terms of socio-demographic factors. This similarity was also evident in their reactions to the pregnancy, contraceptive usage and planning of pregnancy as well as the incidence of smoking, alcohol and medication taking. The S —> M group were also significantly different from the M mothers in terms of noticing something wrong with their babies. The mothers from both the S and S —> M groups were possibly more aware and willing to talk about their babies problems at birth than the M mothers.

The differences between S and M mothers were not unexpected, however the S —> M group appear to be as "at risk" as the S mothers. They are mostly disregarded as a separate entity as they come into hospital as

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Significantly more single mother came from broken homes

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married women. The fact that they married after conception is not generally known by the medical and nursing staff and the community. Marriage is often suggested as a solution to unwed pregnancy. As these women appear to have the same needs as unmarried mothers, marriage may be a "smoke screen" which prevents them from obtaining help. They probably require as much support, counselling and assistance by the professional team as the single mothers.

The finding that there was a significant difference in the family background of the unwed mothers and those who married after conception, bears out the theory that there are unconscious motivating factors for the pregnancy.[21] These are related to the mother's unconscious needs to rebel and punish parents; attention seeking behaviour; need for a love object; and the need to prove femininity and procreative ability.

Married mothers felt far more attractive and proud and secure than the single mothers

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Origins for these needs are found in poor parent-child relationships leading to low-self esteem; social and academic failure.[21,12,22,19] Pregnancy and parenthood is for these mothers a way of coping and providing them with an identity and a purpose.[23] The fact that most S and S —> M mothers were happy at hearing about the pregnancy appears to support the above theory.

It seems surprising that in view of the fact that contraception is freely available, few of the S and S —> M mothers made use of it. Possible reasons for this could be the unconscious need to fall pregnant; magical thinking "it won't happen to me" attitude and the avoidance of use, because use implies "premeditated sex".[24,25,26] Sex education and easy accessibility of contraception, while obviously important in prevention, is not the only reason for "unplanned pregnancy".

In this study unbooked cases did not seem to be a major problem and the majority of mothers had adequate ante-natal care. Although drug taking during pregnancy is not a major issue in this sample, it is however of concern that there are still mothers taking medication during pregnancy not prescribed by a medical practitioner. Married women tended to drink more alcohol during pregnancy. A possible reason for this could be the need to keep up with their husbands. The high incidence of smoking especially in the S and S —> M groups is disturbing. This may be related to their insecurity and anxiety. Both married and unmarried mothers felt afraid and these feelings are possibly related to fear of the unknown; fear of coping and worry concerning possible abnormality in the infant. Although only 15,3% of the total sample of mothers thought that there was something wrong with their babies, there was a significant difference between the groups. Low birth weight babies were born only to the single mothers, who were

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Marriage after conception seems to be a smoke screen which prevents mothers from obtaining help

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younger and smoked more than their married counterparts. Rothberg in a carefully controlled study at the Johannesburg Hospital also found an association between smoking, unmarried mothers status, stress and low birth weight.[27] However, in our study this information was obtained from the mothers and not from the medical records. It is possible that this is not an accurate figure.

As the sample population were all

primigravida it is not surprising that the majority of women experienced their labour as difficult. For many of them this may be associated with the lack of preparation during the ante-natal period. Single mothers and those who married during their pregnancies were less likely to attend preparation classes.

Conclusions and Recommendations

The profiles of the S and S $\Rightarrow$ M were similar. However, there was a difference between the married mothers and these two groups. Single parenthood has potential risks for both mother and child. This study has shown that women who marry after conception are as much at risk as the single mothers. Medical practitioners should be aware of the circumstances of the marriage and offer supportive counselling themselves, or refer to social workers or psychologists where necessary.

Unconscious motivating factors for pregnancies, eg need to rebel and punish parents, need for attention, etc

Prevention of illegitimate pregnancy can only be accomplished through open and honest communication between parent and child in the early years of life and concomitant ongoing sex education in the home and school situation. There was no difference between the groups in terms of the sex education received in the home situation. However, mothers tended to discuss menstruation with their daughters and seemed reluctant to discuss issues related to sex and reproduction.

During the ante-natal period there appears to be a need for emphasis on the adverse risks of drug and alcohol and smoking intake, as well the benefits of preparation for childbirth.

Parenthood provides the mothers with an identity and purpose

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Parenthood becomes a way of coping