Adolescent mothers’ perspectives regarding their own psychosocial and health needs: A qualitative exploratory study in Belgium

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1. Introduction

Teenage pregnancies are increasingly being considered a public health problem, with pregnant teens appearing as doubly disadvantaged by (i) a number of negative socio-economic and psychosocial factors which likely explain the occurrence of an early pregnancy, and (ii) a number of negative predictable consequences and outcomes associated with early pregnancies. By early pregnancy, we mean pregnancies – usually unplanned – that occur in young girls aged less than 19. Factors of vulnerability regarding the risk of an early pregnancy include growing up in a family with lower socio-economic status and residing in a disadvantaged neighbourhood, being a victim of physical or sexual abuse, and growing up in a single family (especially if the adolescent’s mother had an early pregnancy) [1–5]. On the other hand, although the results of different studies are sometimes inconsistent, the phenomenon of early pregnancy has been described as having important negative socio-economic and psychosocial outcomes, both for mother and child: school drop-outs, lower income, lower levels of self-esteem, depression, poor parenting skills, etc. are generally associated with early pregnancies [6–9]. Moreover, sexually active pregnant or mothering adolescents may be at increased risk of sexually transmitted diseases and repeat pregnancies [10,11].

Health education efforts aimed at reducing the incidence of teenage pregnancies tend to address the issue of contraception as the main cognitive and behavioural factor involved in teenage pregnancies. The occurrence of a pregnancy in adolescent girls is therefore predominantly considered an accidental phenomenon, which needs to be prevented by informing better on contraception methods to avoid further pregnancies. Adolescent mothers need to be supported in their transition to parenthood, and special care should be provided to girls who are socially isolated.

Practice implications: We identified several avenues for health education and counselling to adolescent mothers, from primary prevention to reduce incidence of early pregnancies to tertiary prevention to reduce negative health outcomes for both mother and child.
The aims of our study were twofold: (1) to better understand the perspective of young mothers (or mothers-to-be) on their own experience of teenage pregnancy and motherhood; (2) to explore the perspective of teenage mothers regarding their health and health education needs.

2. Methods

We used an exploratory qualitative approach and conducted in-depth interviews with teenage mothers and mothers-to-be. Our interview guide was flexible, and built around 2 categories of open-ended questions, relevant to the above-mentioned research objectives.

2.1. Recruitment of participants and sample characteristics

Like other authors [1], we found that adolescent mothers are a difficult group to reach. We relied on a general practitioner and two social workers from three independent centres for the inclusion of the first 7 participants, and used a snowball procedure to include 5 more participants.

We included not only mothers who were currently teenagers, but also women with older children who had had a teenage pregnancy. We hypothesized that these women would be less defensive about their difficulties and more willing to explore with us their own needs at the time of their early pregnancy and parenthood.

All young women who were contacted, save one, accepted to participate in the interview, and turned up as scheduled. The characteristics of our sample (n = 12) are presented in Table 1. The interviews lasted from 40 min to 2 h and 30 min, with an average duration of 65 min.

2.2. Ethical considerations

All the participants were over 17 at the time of the interview. One participant only was still living at home with her parents. However, she visited the clinic by herself when we met her. As has been discussed by other authors regarding research with adolescents on sexual health issues [16,17], we considered that the purpose of our interviews with this particular group of participants did not require the permission of the parents. Indeed, we considered that the young mothers had the capacity to consent to participate in the research project, although they had not all reached the age of 18.

2.3. Analysis

All our interviews were transcribed verbatim. Our transcripts were analysed, using the constant comparative method [18,19], an inductive process of analysis through which significant themes are developed directly from the data, and not from predetermined theories and hypotheses. To ensure the validity of the findings and interpretations, data analysis was collaborative between 2 researchers (IA and FL), who independently coded the transcripts, and met at regular intervals during the analysis to discuss the themes that emerged from the data. Our results are presented hereafter according to four categories which correspond to four different points in time, which may require specific interventions from the healthcare providers: (i) before becoming pregnant; (ii) being pregnant; (iii) delivering the baby; (iv) becoming a mother.

3. Results

3.1. Health education needs before becoming pregnant

Apart from two participants, all had received some information on sexual and reproductive health at school. However, the information received was generally considered too technical, because it emphasized mainly the combined used of the pill and condom, without inquiring about the teenagers' emotional needs. Moreover, we noted cases of persistent inadequate beliefs: I have a friend at school who became pregnant while she was on the pill. Her doctor wondered how it happened. She had never stopped to take the pill ... I believe that sometimes it's the contraceptive that is not strong enough for the person.

Three participants complained that pregnancy was systematized as an undesirable event that ought to be avoided: Instead of presenting pregnancy as the end-point to be avoided, they (health educators at school) should acknowledge that some of us do want to have a baby. However, as long as we have not actually had the experience, we do not know what it is like. Some insisted that the health education messages should not be addressed to them alone, but to their parents as well. These participants felt sorry that they had never been able to discuss sexual and reproductive health issues with their parents. Yet at the same time, they acknowledged their parents' own need to be helped to that respect. Most parents are reluctant to talk about sexuality with their children (...) if they were invited to participate in meetings with other parents, they could learn how to talk about these issues with us?

Two participants mentioned the role that healthcare providers, and more specifically general practitioners, could play in order to prevent early pregnancies. These participants stressed that general practitioners should systematically initiate discussions about contraception and sexually transmitted diseases with their adolescent patients.

3.2. Psychosocial and health needs while pregnant

A diversity of possible meanings associated to having a baby at a young age emerged during the analysis of the transcripts. A few mothers conveyed that they perceived their baby as a support to their sense of self-worth. To have a baby was associated with an enhanced sense of maturity and responsibility, which they were proud of: Since I have had my baby, I feel much better, and I am doing well. I am proud of myself that I am coping so well ( ... ) Most of my friends are still adolescents. I feel that I have become more mature and I get on better with adults now. A few participants stressed that having a baby would put an end to their feelings of loneliness and emptiness. The baby was going to be something just for me in the end ( ...) it would stop me from being lonely. Moreover, in three cases, the decision to have the baby was consciously or unconsciously part of a strategy to escape a situation perceived as unbearable: For me, to have a baby was the only way out. If I had not had my daughter, I think I would be homeless by now. Had it not been for her, I would not have stopped messing around. It's a good thing for me that I had her. Another participant: My relationship with my father has always been awful. I would have done anything to escape home ( ...) I was happy when I got pregnant ... .

Four participants in our sample described situations of physical or sexual abuse during childhood or early adolescence. Moreover, 4 participants spontaneously reported repeat pregnancies, and explained that they had had an abortion in the year preceding or following the birth of their child. Three of the participants had experienced both abuse and abortion. One of them described abortion as a very violent and disempowering experience, which reactivated a sense of powerlessness over her body. The decision to have a baby later on was interpreted by this participant as a way of
<table>
<thead>
<tr>
<th>Participants</th>
<th>Age when pregnant</th>
<th>Age at interview</th>
<th>Gender and age of child at interview</th>
<th>Context of living at time of interview</th>
<th>Mother is supported by family of origin</th>
<th>Mother lives or used to live with the baby’s father</th>
<th>Other children</th>
<th>Place of interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>17 years</td>
<td>20 years</td>
<td>Girl 2.5 years</td>
<td>Mother, father and child live together in an apartment</td>
<td>No</td>
<td>Yes</td>
<td>/</td>
<td>Home</td>
</tr>
<tr>
<td>P2</td>
<td>16 years</td>
<td>21 years</td>
<td>Girl, 4 years</td>
<td>Mother and child live in a mother-and-child hostel. Mother is on a waiting list for social housing</td>
<td>No</td>
<td>No</td>
<td>/</td>
<td>Centre for mothers with special needs</td>
</tr>
<tr>
<td>P3</td>
<td>16 years</td>
<td>17 years</td>
<td>Baby boy, 4 months</td>
<td>Mother and child live at a friend’s house. Mother is looking for an apartment. Married with father of her second and third child. Mother, father and children live in an apartment.</td>
<td>No</td>
<td>No</td>
<td>2 other children (first child at 14)</td>
<td>Centre for mothers with special needs Clinic</td>
</tr>
<tr>
<td>P4</td>
<td>17 years</td>
<td>17 years</td>
<td>8-month pregnant with 3rd child (baby girl)</td>
<td>Mother has left the father of her first two children at the age of 22. Has lived since then with the father of her 3 other children</td>
<td>Yes</td>
<td>Yes</td>
<td>4 other children</td>
<td>General practice</td>
</tr>
<tr>
<td>P5</td>
<td>15 years</td>
<td>19 years</td>
<td>Girl, 3 years</td>
<td>Mother, father and child live in an apartment</td>
<td>No</td>
<td>Yes</td>
<td>/</td>
<td>General practice</td>
</tr>
<tr>
<td>P6</td>
<td>14 years</td>
<td>45 years</td>
<td>Girl 31 years</td>
<td>Mother lives on her own in a one-room flat and receives visits from the child’s father</td>
<td>No</td>
<td>No</td>
<td>/</td>
<td>Home</td>
</tr>
<tr>
<td>P7</td>
<td>17 years</td>
<td>17 years</td>
<td>7-month pregnant with 1st child (baby girl)</td>
<td>Mother lives on her own in a one-room flat and receives visits from the child’s father</td>
<td>No</td>
<td>No</td>
<td>/</td>
<td>Home</td>
</tr>
<tr>
<td>P8</td>
<td>16 years</td>
<td>17 years</td>
<td>Baby boy, 3 months</td>
<td>Mother, father and child are staying at the mother’s parents home.</td>
<td>Yes</td>
<td>Yes</td>
<td>/</td>
<td>Clinic</td>
</tr>
<tr>
<td>P9</td>
<td>17 years</td>
<td>20 years</td>
<td>Girl, 2.5 years</td>
<td>Mother and child live in an apartment. Mother has left the child’s father and a new partner has recently moved in.</td>
<td>Yes</td>
<td>Yes</td>
<td>/</td>
<td>Home</td>
</tr>
<tr>
<td>P10</td>
<td>17 years</td>
<td>24 years</td>
<td>Girl, 6 years</td>
<td>Mother lives on her own. Girl has lived with her grand-parents since she was born, and sees her mother at week-end</td>
<td>Yes</td>
<td>No</td>
<td>/</td>
<td>Home</td>
</tr>
<tr>
<td>P11</td>
<td>17 years</td>
<td>28 years</td>
<td>Girl, 11 years</td>
<td>Mother and father got married but are divorced. Child lives one week with her mother, and one week with her father.</td>
<td>Yes</td>
<td>Yes</td>
<td>/</td>
<td>Home</td>
</tr>
<tr>
<td>P12</td>
<td>16 years</td>
<td>35 years</td>
<td>Girl, 17 years</td>
<td>Mother lives with a partner who is her second child's father.</td>
<td>Yes</td>
<td>Yes</td>
<td>1 other child</td>
<td>Participant's worksite</td>
</tr>
</tbody>
</table>
regaining a sense of control over her own body and her own life: I really wanted to be pregnant (…) I was so angry with my parents. My mother wanted to force me to have another abortion, but I was able to refuse this time. I really wanted to take revenge and make my own decision, as so to feel in control again.

All the participants described the counsellors encountered at the time they had to make a decision about the outcome of the pregnancy as friendly and neutral regarding the decision to be taken (have abortion vs. have the baby). Not one participant expressed any difficulty in identifying and locating the relevant facilities. To receive accurate information on medical, social and financial issues in order to be able to make an informed choice was seen as a very important aspect of the counselling received. To actually have a sense of choice was greatly valued: They (the counsellors) explained a lot of things to me. But the most important was that they told me nobody could take the decision for me or oblige me to do things I did not want to do.

The role of healthcare and social services was perceived as particularly important in situations where the young mother was not supported by her family of origin (n = 5). The young girls expressed very practical needs, such as being informed on bodily changes, when to consult, information and preparation about the delivery, etc. Two of them stressed the importance of a continuous relationship with a professional during the whole pregnancy.

3.3. Health needs at the time of delivery

Again, the participants who were not supported by their families of origin (n = 5) reported greater needs regarding the time of delivery. One participant reported that she had had no idea what contractions would be like, and that the idea was terrifying. Another participant said she had had no idea of what the place where she would have the baby would look like. Although information sessions for young parents-to-be are organised in most hospitals, they were not usually attended by the participants, who thought they might feel “out of place” when confronted with more traditional couples. Three participants expressed feelings of loneliness and extreme anxiety over what was going to happen around the delivery. At the beginning of my pregnancy, I was scared because I did not have any money. When I was 6 months pregnant, I still had not bought anything for the baby. (…) I stopped eating to keep my money, and I got problems. So they (the social services) put me up in a mother-and-child hostel. But I didn’t know anybody around, and I was scared to have my baby here. So I went to (another town), and I stayed at a friend’s until my baby was one month old.

One participant among those who were not supported by the family, stressed how important the help provided by a social worker had been to her: (After the delivery), I realised I was all by myself and did not know how to get out of hospital. I was frightened to take the train with my baby because I had no push-chair. So I called the social worker, and she came to pick me up with my baby. I could count on her and she really helped me out.

Quite a few participants in our sample admitted to having experienced bad feelings immediately after their child was born, but most of them had concealed such feelings from themselves and others. Our results suggest that there is a need to more systematically inform young mothers about the possibility of a postpartum depression: I remember very well being at hospital after delivering the baby. I remember feeling proud and happy. My boyfriend was present, we looked good as a family, and I was glad. However, I also remember that I was crying all the time like an idiot… not knowing why I was crying. I didn’t know at the time about the hormonal breakdown (…). Nobody told me. I used to think I was not normal.

3.4. Health needs after the baby is born

Apart from one participant, who was expecting her third child at the age of 17 when we met her, no participant said that she had wanted to be pregnant again. The participants stressed how much they needed to be offered the opportunity to have respectful discussions around sexuality and contraception issues. As one participant clearly put it, they wanted to be counselled in a way that did not make them feel that their pregnancy, and the subsequent choice to have their baby, had been a mistake: Nobody was going to tell me what I was supposed to do or not to do. What I appreciated in my gynaecologist’s attitude when she proposed that I might try the transdermal patch is that she inquired first about my needs, and whether I needed or wanted contraception at all. She was open for discussion.

Although some of the participants in our study were facing difficult economic and social conditions, most of them conveyed that they were or had been proud and happy to become a mother, to do things with their children, and to be seen in the company of their children. To become a mother was automatically associated with being an adult, and some participants insisted that they would like to be addressed as adults, refusing to be called adolescents or teenagers. One participant particularly complained about the fact that people would look badly on her because of her young age: If I am on the metro and my daughter cries, everybody will look at me, thinking “oh, she’s young, that’s why she can’t manage her child”. Whereas with other mothers, people would be more indulgent, and just think that children like to drive their mothers mad.

All the young mothers we met reported to have been very eager to learn about handling skills, such as how to feed the baby, how to bathe the baby, etc. By contrast, the emotional and relational needs of a baby appeared as being underestimated by some girls. For instance, in one interview, which happened in the presence of a child who was about to start nursery school, the young mother was not aware of the possible impact of this first social experience to her child, but kept talking about the need to train the child over the weekend to use the toilet. As one of the older participants well explained, a young mother may love her child, yet not realise that the child is an individual person with specific needs: Thinking back, I think I was happy to have my daughter, and I loved her… humm… let’s say that I loved her like I would have loved a doll. It’s hard to describe (…). I had feelings for her from the beginning but I would say she was more like my little doll. She was cute and all, but…

The need to support parenthood by raising awareness on the emotional and relational needs of the baby as a separate person may be even more important in the presence of existing early pregnancies in the history of the young mother’s family. This was the case for three participants in our study. When she talked about herself, her mother and her little daughter, one participant seemed sometimes confused about who exactly was who: It’s a bit as if I were my daughter, and my daughter were me. She looks exactly like me. My mother tells me: “When I hold her (the baby), it is as if I were holding you. It makes me remember what it was like”. It’s good for her: I can see that she is better after a weekend with my daughter. If she is not well, and I leave my daughter with her, she gets better! Two participants in our study explicitly conveyed that they would like to be offered the opportunity to attend parenting-support programmes with their partners: It would be nice if we could go to some places where other young people would go too. And there we could ask questions, share ideas, and learn how to take care of our kids.

As far as the young mothers’ own developmental needs are concerned, all but two young mothers in our sample had or were about to drop out school. Most of them seemed to be living in a quite isolated manner, even if they had a partner who was taking care of the child with them. Our results suggest the need for
affordable places where young mothers could leave their child for a few hours in order to be able to attend a course, to meet friends, to visit administrations, and so on. The two girls who did not stop to go to school when their child was born had their parents look after their child. These two participants described themselves as bright students who had perceived it as a challenge to get good school results and to do well in subsequent studies despite being the mother of a young child. The other participants mentioned either the difficulty to find suitable and affordable places to have their child looked after, or the fact that they felt so different from schoolmates that school was not an option anymore. I tried one day (to go back to school), I realised I didn’t like it, and I decided to go home and stay there with my daughter. (…) I felt such a gap between me and the rest of the class. I was the only one in my situation, and I felt like I were from Mars.

4. Discussion and conclusion

4.1. Discussion

Our study points to some important aspects of sexual and reproductive health education interventions at school, which could be improved by acknowledging more systematically that pregnancy at a young age might be considered a desirable event for some girls, and by targeting not only the adolescents themselves, but their parents as well. Moreover, our findings suggest that healthcare providers should reconsider some preconceptions about contraception failures as the main explanation for becoming pregnant during adolescence. Indeed, we found that pregnancy, even if unplanned, was meaningful to all the young mothers in our sample. Another important finding in our study was the participants’ need to be acknowledged and addressed as young adults. As Breheny and Stephen’s have well demonstrated, healthcare professionals tend to predominantly look at the position of adolescent and mother as intrinsically problematic because they tend to primarily construct teenage mothers as adolescents that are developmentally unchanged by motherhood [20]. As a consequence of such a construction, there is a risk that a positive identity of motherhood – which is what the adolescent mothers in our study claimed for – may be denied to adolescent mothers [21]. The need to be supported in the transition to parenthood and to be helped to identify and meet one’s own emotional and self-actualisation needs are two interrelated processes, which probably represent the most complex challenge in adolescent motherhood [22].

Finally, our results suggest that to have a baby at a young age might be associated with social isolation. On the one hand, 5 out of 12 participants in our study were not supported by their families of origin and therefore relied on social services for accommodation, health insurance, etc. On the other hand, 10 out of 12 participants had dropped out of school as a consequence of having to care for a young child. As social isolation may be detrimental to both the mother’s and the child’s health, it is important to systematically screen for social isolation, as well as to proactively think of alternative means to reduce social isolation, so as to allow the young mother to pursue meaningful social activities.

4.1.1. Limitations

Our study has several limitations, one of which being the characteristics of our sample, which is small (n = 12), and yet not homogeneous. As mentioned earlier, adolescent mothers are a difficult group to reach for inclusion in a research project, and we feel that this restriction did not allow us to include enough participants to make sure saturation at analysis was reached. Our findings and conclusions may therefore not be considered representative of all aspects of the experience of becoming a mother at a young age. Moreover, we are aware that the great diversity regarding social situations and ages at interview, and therefore time elapsed since pregnancy, do not allow us to generalise our results. We believe, however, that our methods have allowed us to gain a deep understanding of individual cases, and that the findings we share are significant and may contribute to a better understanding of the complexity of adolescent mothers’ health needs across a time span from starting to be sexually active until the first years of motherhood.

4.2. Conclusion

The health needs of adolescent mothers extend well beyond counselling around the decision to continue or terminate pregnancy, and subsequent information on contraception methods to avoid further pregnancies. Our study points to the need to maintain a continuous relationship with a professional, even after the child is born, so as to help the young mothers in their transition to parenthood. Moreover, special care should be provided to girls who are socially isolated.

4.3. Practice implications

Our findings suggest several avenues for sexual and affective health education and counselling to adolescent girls, from primary prevention to reduce incidence of early pregnancies to tertiary prevention to reduce possible negative health outcomes for both mother and child.

(1) Primary prevention: our results suggest that (i) health information and education interventions at school need to provide clear information about all accessible contraception methods (not only the combined use of pill and condom), acknowledge the fact that to have a baby at a young age might be considered desirable by some of them, and target not only the teenagers but their parents as well, in order to help them discuss reproductive health issues with their children at home; (ii) general practitioners should systematically initiate discussions around reproductive health issues when they visit female teenage patients.

(2) Secondary and tertiary prevention: our results suggest three important aspects of the healthcare providers’ role with regard to the needs of adolescent mothers: (i) the need to repeatedly inform about very practical issues regarding the medical follow-up of the pregnancy, such as bodily changes, when to consult, how to get material support if needed, information and preparation about the delivery, etc.; (ii) the need to support social integration by helping the young mother to identify significant others and relevant healthcare facilities; (ii) the need to support the transition to parenthood, with interventions aimed at raising awareness of both the child’s and the mother’s emotional and relational needs.

Although these aspects are important for all adolescent mothers, we would like to stress again that the adolescent mothers in our sample who were socially isolated, i.e. separated from their family of origin, appeared as particularly vulnerable and explicitly stressed to have greater expectations toward the healthcare providers and social workers at different stages of the process of becoming a mother.

Conflicts of Interest

None.
Acknowledgements

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References