Patient Education and Counseling 81 (2010) 448–453

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

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

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ARTICLE INFO

Article history:
Received 2 April 2010
Received in revised form 26 October 2010
Accepted 28 October 2010

Keywords:
Teenage pregnancies
Adolescent mothers
Sexual and reproductive health needs
Qualitative study
Transition to parenthood

ABSTRACT

Objectives: We looked at early pregnancy and parenthood as an opportunity to broaden our understanding of the reproductive health education needs met by adolescent girls.
Methods: We conducted an in-depth interview study with 12 adolescent mothers.
Results: To become a mother at a young age was perceived as meaningful to all the participants. The participants expressed a need to be addressed as adult parents, who want the best for their child. A variety of psychosocial and health needs emerged over a time span ranging from starting to be sexually active to after the child was born. Social isolation was found to be an important factor of vulnerability.
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. 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.

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 issues [12,13]. However, whereas current policy approaches tend to pathologise early pregnancy and childbearing [1], over 50% of pregnant adolescent girls in Belgium and in other industrialised countries do not decide to have an abortion, but choose to have their baby instead [14,15].

This article looks at early pregnancy and parenthood as an opportunity to broaden our understanding of the sexual and affective health education needs of pregnant or mothering teenage

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doi:10.1016/j.pec.2010.10.028

girls. 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. Given the small size of our sample and the large amount of details presented in Table 1, we have chosen to quote the participants without citing their reference number in order to maintain the confidentiality of some intimate pieces of information that were shared with us.

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 systematically presented 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