A PSYCHOEDUCATIONAL PROFILE OF THE UNMARRIED MOTHER

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ABSTRACT

The purpose of this study was to outline a psychoeducational profile of the unmarried mother. The primary aim of the present study was therefore to investigate retrospectively sociodemographic factors, both psychosocial and educational that could contribute towards women becoming unmarried mothers. A subsidiary aim of this study was to examine the level of depression in unmarried mothers six months after the birth of their baby and to ascertain how these women cope with their situation.

The subject population consisted of 196 white, primagravida, English or Afrikaans speaking women from different socio-economic and religious backgrounds. All primagravida unmarried mothers, keeping their babies were recruited during the puerperal period in hospital. Married women, matched according to parity and broad age categories were similarly recruited during the same time period. Each woman was interviewed as well as Questionnaire A administered to them. The subjects were then re-interviewed six months later and a further Questionnaire B plus the Beck Inventory for Depression administered. Additional research questionnaires, investigating these same subjects' past school experience and prior sex education were mailed to them.

The statistical analysis consisted of the BMDP and SAS Statistical packages. The statistics computed therefrom included the Pearson Chi Square, Fisher's exact two-tailed test, as well as a one-way Analysis of Variance and the t-test. The Bonferroni adjustment was made where sub-groups were compared.

At a significance level of ,05 it was found that a significant difference existed between the unmarried and married mothers in terms of sociodemographic factors. The profiles of the unmarried mothers and those mothers who married during their pregnancy were found to be similar. No significant difference was found between the groups studied with regard to their level of depression six months after the birth of their baby. The present study examined retrospectively the past school experience and prior sex education. Although no significant differences between the groups was found, it was evident that there was a paucity of sex education in both the school and home situations.

DECLARATION

I hereby declare that this research report is my own, unaided work. It is being submitted for the Degree of Master of Education (School Counselling) in the Division of Specialized Education, Faculty of Education at the University of the Witwatersrand, Johannesburg. It has not been submitted before for a degree or examination at any other University.

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I INTRODUCTION

"The psychology of the unmarried mother, what she is like and why she becomes an unmarried mother, is an infinitely complex question. Its roots are deeply embedded in those powerful emotions of early childhood which form the basic pattern and structure for the individual's total life." (Young cited in Roberts, 1966, p81). There is an inevitability about the chain of emotions climaxing in the pursuit of the pregnancy of the unmarried mother. The purposefulness of the girl's behaviour, her determination however unconscious, to have not just a baby, but specifically a baby out of wedlock, is evident. A number of writers hold the view that the unmarried mother aims to achieve a specific goal through her pregnancy.

Being an adolescent parent requires taking a particular path at four crossroads; becoming sexually active, not using or incorrectly using contraceptives, carrying rather than aborting a pregnancy and parenting rather than placing a child for adoption. Factors that influence adolescent behaviour at multiple points on the path to parenthood indicate areas particularly relevant for preventive intervention (Flick, 1986).

Adolescent pregnancy places the mother and baby at a social and educational disadvantage. It is estimated that 70% or more of women who have borne children before age seventeen do not finish high school and as a result opportunities for job training and

employment are less likely both because they lack education and because child care services are unavailable (Carey, McCann-Sanford and Davidson, 1981). The impact of the pregnant adolescent was studied by La Barre (1977) who found that adolescent mothers need but do not have preparation for parenthood in the present educational system. Attempts to deal with such complicated adolescent issues as pregnancy or contraception must be understood in the context of the process of adolescence.

The biopsycho-social changes accompanying pregnancy suggest that the transition to parenthood is a challenging and vulnerable period (Cronenwett and Wilson, 1981; Hobbs, 1965; Tilden, 1980 cited in Brown, 1986). Research and clinical observations suggest that first pregnancies are somewhat stressful and can result in the onset of depression in mothers. Furthermore the emotional state of the unmarried mother who keeps her baby is influenced by her support systems or lack thereof as well as her preparation for parenthood.

1.1. The Family of the Unmarried Mother

The unmarried mother has always been studied against the backdrop of her society and her behaviour interpreted in terms of current social values. The family system is yet another vital context in which to examine the unmarried mother. It is generally accepted that a child's early experiences in the family have an important influence on the development of his/her personality and especially on emotional development. Van Andel (1948), Loots (1951), Cronje

(1957) and Schreier (1960), all of whom have done research in South Africa, found broken or discordant homes to be an important contributory factor in unwed motherhood. Young, more than other authors, stresses poor family functioning in the aetiology of unwed motherhood. Young's interpretation is that the unmarried mother hopes to solve her conflicts with her parents through the illegitimate pregnancy. Young, 1954 (cited in Gill,1977, p237) "stresses that women who bear illegitmate children are reacting to pressures often unconscious, which lead them to illegitimate reproduction as a partial solution to their problem. As a result of unsatisfactory relationships with their parents during childhood and early adolescence, girls go on to produce an illegitimate child in part to 'punish' their parents." Montgomery,(1983) (cited in Horn and Rudolph, 1987) proposes that a specific family syndrome increases the likelihood of early teenage pregnancy. The pregnant girls they studied lacked a warm relationship with their fathers but had a good relationship with their mothers. However, clinical evidence suggests that many of these relationships appeared to be overprotective.

One plausible approach to pregnancy prevention involves optimizing the relationship with the young woman's parents. Sex education is a continuous process from early family upbringing where attitudes are formed in the preschool years and on throughout life. Therefore it is the parents' responsibility in the family situation to communicate relevant matters concerning sex and sexuality. "Hepburn (1983) found that mothers played a more significant role

in the transmission of sexual information to their daughters than did fathers. Rosen (1980) reported that communication between teenagers and their parents about sexual activities is usually minimal and the situation seems to be due as much to parental desires as to the adolescent's reluctance. Similarly Lindeman and Scott,(1981) (cited in Horn et al,1987, p596) found that "adolescent mothers sought information about sex, pregnancy and birth control from sisters and/or friends, which often is a source of misinformation." In a study carried out by Timberlake, Fox, Baisch, Goldberg (1987), the findings reflected the limited use the teenagers made of their parents for information about sex (9,3%). Thus communication between parent and teenager needs to be enhanced where information on sex-related issues can be dealt with openly.

1.2. The Psychological Factors of Teenage Pregnancy

More than 1 million teenage girls become pregnant each year in the United States of America. (Timberlake et al, 1987). Of the 96% who keep their babies fewer than half marry, thus the largest percentage of these girls become single parents (Black and De Blassie, 1985). The largest number of teenagers who become pregnant each year do so through gross misunderstandings and ignorance of the menstrual cycle and conception (Darabi, Jones, Varga and House, 1982). In surveys conducted by Smith,(1982) (cited in Black and De Blassie, 1985) 87% of the sexually active teenagers interviewed did know where to get birth control devices,

although only 11% used them occasionally. There are other reasons adolescents fail to use contraception. For example "magical thinking" may play a role in which the younger or middle adolescent feels she is special and somehow will be protected from pregnancy despite coital activity" (Greydanus, 1981). Denial is apparent in a wide range of decisions and actions associated with unmarried motherhood. For example, despite adequate knowledge of reproductive functions, the unwed mother seldom makes use of contraceptive devices since this presupposes conscious knowledge of intended sexual relations. Moreover, since most teenagers wait almost a year after becoming sexually active before they seek medically supervised contraceptive care, almost half of first teenage pregnancies occur within six months of an adolescent's first sexual encounter (Koenig and Zelnik, 1982.) Teenagers often engage in sexual intercourse for non-sexual reasons. The adolescent may perceive sexual intercourse as enhancing his/her acceptance by peers, thus allowing for greater independence from adults and their values. Such independence may be far broader than issues related to sexuality and be more associated with feelings of parental rejection, poor self concept, past experiences with social and or academic failures and isolation from peers. Adolescents also may be motivated by conscious needs to express hostile feelings or to gain parental attention. Pregnancy and parenthood, therefore cannot be understood without considering how the adolescent is attempting to cope and adapt. Adolescents according to Friedman and Phillips (1981) may thus find that becoming a mother provides them with an identity and a purpose. Teenage

parenthood can be viewed as a coping strategy possibly the only one which the adolescent anticipates will enhance her self esteem.

In order to administer complete and comprehensive treatment of the problem of teenage pregnancy, the total needs of the pregnant adolescent, the potentially pregnant adolescent and the adolescent male must be addressed.

Many unmarried women have not finished the developmental tasks of emancipation from family, adult relationships, education and attaining jobs and the unplanned pregnancy complicates these tasks (Barnett and Balak, 1986). The number of teenage parents and their children in itself demands attention to adolescent sexual activity and resultant pregnancy (Friedman et al, 1981). Statistics indicate that by age 19, 46% of the female population have experienced sexual intercourse (Kantner and Zelnick, 1972, cited in Brashear, 1976). The availability of contraception, abortion and sex education in the adolescent population is very limited. Lack of such services requires the adolescent female to assume the health risks of pregnancy and delivery and to suffer curtailment of educational opportunities forcing her into a parenthood role for which she has little or no preparation (Brashear, 1976).

1.3. Educational Aspects of the Unmarried Mother

Cross-sectional and longitudinal research indicates that teenage mothers in contrast to older mothers and "nonmother" controls will

generally reach a lower educational level and be less successful vocationally (Friedman and Phillips, 1981). In South Africa the level of education among unwed mothers as assessed by Cronje (1960, p 42) was found to be as follows: "87,8% attained Std 8 or lower and only 12,2% progressed to Std 9 or higher. In a study carried out by Gunston (1986) during 1980-1984 at Somerset Hospital in the Cape, of a total of 16 332 patients who delivered, 441 (2,7%) were aged 13-16 years at the time of delivery. Over 50% were in primary school (Std 1-5) at the time of conception. The incidence of early adolescent pregnancy was 2,7% in Gunston's study and 2% at Peninsular Maternal and Neonatal Services and 4,86% at Paarl Hospital. Adolescent pregnancy is given as the major cause for girls leaving school. (Lieberman, 1980). In the USA no more than 50% of school aged parents graduate from high school. Therefore these girls lack sufficient skills and resources to repair the damage done by poorly timed births and the ability to enter the job market competitively (Black and De Blassie, 1985). In addition young mothers today are less likely to give up their babies for adoption, so that adolescent parents are usually caring for an infant at the same time as they are seeking to acquire a basic education. Researchers assert that both dropping out of school and pregnancy are symptomatic of adolescents' failure to succeed in their current educational environment. Researchers who study teenage pregnancy have observed that pregnant teenagers are often less successful academically than their non-pregnant peers.

There is sometimes a certain amount of correlation between educational level attained and intelligence. In the past, low intelligence in illegitimate motherhood has often been given as a predisposing factor to this phenomenon. "A modern perspective indicates however, that either earlier reports were not adequately substantiated, or that a different type of unmarried girl is falling pregnant in our present society" (King, 1970, p 67). Pearson and Amacher, (1956) (cited in King, 1970,) obtained intelligence test results from 3594 unwed mothers, who comprised 40% of the unmarried mother population of the American Sate of Minnesota over a period of five years. They found that the average intelligence quotient for the group was 100. This is the variation for the population at large, so it appears that unwed mothers show no statistical deviation with regard to intelligence.

Consideration should be given to pregnancy prevention approaches tailored to developmental ages and stages. In the school situation a substitute or surrogate parent, the guidance teacher, social worker or teacher can provide the emotional base absent in homes where parent-child relationships have deteriorated or are non-existent. A pregnancy prevention approach based upon Welches' work is this concept of the professional acting as a parent (Proctor, 1986). It was believed that by providing contraceptives, family planning, counselling and abortion, teenage pregnancy could be prevented. It cannot be said that these techniques have failed. However, maturity and self-discipline are required to use these services properly. Yet neither maturity nor self-discipline

is a major component of the adolescent's life style. Traditional sex education is not enough. Sex education must be expanded beyond a two week session in high school, to become instead, a part of a 12 year learning programme with a broader agenda that includes encouraging young people to set long term goals and to think beyond the present. Programmes must be imaginatively geared to the individual and community needs. It is essential that male adolescents be included in all prevention programmes as they are less aware of the risks of pregnancy, less informed about contraception and are more likely to learn about sexuality in the classroom than any other sources. (Flick, 1986). There is an effort to promote health education for parents and children and to involve the parents in as many activities as possible in the schools and in the community. Sex education programmes for adolescents should be accompanied by parallel programmes for parents. There must be continued education for all concerned (Harris, 1986). This concept has further been extended to programmes that enable teenagers to continue their education and help them cope with the demands of school and pregnancy (McClellan, 1987). Research also points strongly to the need to link education and health services : contraception in the case of preventive programmes and pre-natal care for teenagers who are already pregnant. In a study conducted by Lineberger (1987) pregnant adolescents who chose to remain in regular school classes instead of entering an alternative programme or dropping out of school were examined. This willingness to continue in school seems consistent with Zellman's (1981) (cited in Lineberger, 1987) view that today's society and especially

adolescents' peers are more accepting of single pregnant girls as students than they were in earlier years. Education on sexual matters should be presented to teenagers without fear that it will encourage more promiscuous sexual attitudes. Issues related to teenage pregnancy are becoming increasingly important to the schools. Effective programmes combine the best efforts of schools, social service agencies, health care providers and other community groups. School based programnes have shown that they can prevent or at least reduce the effects of teenage pregnancy (McClellan, 1987). Schools would be well advised to develop and implement programmes with broad community, parental and student involvement.

1.4. Post-Natal Emotional Sequalae of the Unmarried Mother

The birth of a baby represents the fulfillment of the biological goal of the species and at the same time, it is an event with profound psychological implications. Increased depression among women who have recently given birth has been frequently documented, with the best estimate of the prevalence of moderate to severe non-psychotic post partum depression being 20% (Paykel, Emms, Fletcher and Rassaby, 1980, cited in O'Hara, Campbell and Rehm, 1982). "Many potential etiological factors have been implicated in the development of post partum depression including delivery of an at risk infant (Blumberg, 1980), marital problems (Tod, 1964) and lack of social support (Paykel et al, 1980)," (O'Hara et al, 1982 p457). In a study carried out by Panzarine (1986) on a group of adolescent mothers during their first month at home after the

delivery, the findings suggest that the puerperium was not a time of major distress. Factors contributing to a relatively smooth transition to motherhood were the adolescent's use of anticipatory coping prior to the birth, their extensive reliance on family support once at home and their past experience with childcare. The onset period of post partum depressive symptoms has been variously described. In order to acquire the label of post partum depression, symptoms must appear within the first year following birth (Loenderstad and Hilverink, 1983 cited in Cooke, 1985). A number of social factors have been explored in their relationship to post partum depression. Culture, socioeconomic factors, marital status, religion, parity, age and employment being the major dimensions that have yielded relatively cohesive findings. The general view is that primagravidae are at greater risk than multiparous women (Breen, 1975, Rich, 1976, cited in Cooke, 1985). This is largely explained by the fact that first time mothers have greater changes to negotiate in the transition to parenthood than their more experienced counterparts. Brown et al,(1975) reported that among women the single most powerful factor mediating negative life changes and serious clinical depression is having an intimate, confiding relationship with a boyfriend or husband. "Women without an intimate who experienced life stress were almost ten times more likely to manifest serious depression than those similarly stressed who had a confidant who need not be of the opposite sex." (Brown et al, 1975, p 225). This report led to other studies on depression (Miller Inghan, 1976, Paykel et al, 1980, Roy, 1978, Slater and Depue, 1981, Surtees, 1980, cited in Cooke, 1985). It

is clear from the literature that the quality and quantity of social support received by women is a significant factor related to psychological adaptation in the post partum. Emotional support is repeatedly cited as a correlate of emotional health. The influence of social support is particularly significant for adolescent mothers because early parenthood creates an immediate crisis for them and their parents (Giblin, Bland, Sachs, 1987). There appear to be wide individual differences in the ways people utilize their support networks. Certainly personality differences contribute significantly to the variation. Positive self esteem seems to be an important psychological resource that directly affects the wellbeing of single mothers. (D'Ercole, 1988).

Summary

The nature of the unmarried mother's behaviour which brings into being an illegitimate mother-child relationship accompanied by emotional, social and sexual implications seems to suggest the significance of family influence. The evidence in the literature suggests that the home backgrounds of unmarried mothers are problematic in that they come from either broken or discordant homes. The emotional immaturity of young teenagers and the social problems and interference with educational plans which result from a pregnancy at this stage are issues for concern for professionals and parents as findings indicate that unmarried mothers have a lower level of education. Responsible sex education is lacking in many schools and families. Not only is there a need for this to be remedied, but responsible sex education is required in primary

schools and in the family before children reach their teens. The impact of being an unmarried mother on both the mother and the child is stressful. However the social network and support systems available to that mother and child dyad have implications for the unmarried mother's coping ability and subsequent level of depression.

2. METHOD

2.1. Basis for the Study

2.1.1. Rationale

Few systematic studies have examined the unmarried mother in South Africa. As this phenomenon is currently on the increase there is the need to approach this problem with the emphasis on prevention rather than reacting to the situation. In the Black cultural setting in South Africa, pregnancy out of wedlock is a socially accepted norm. As the incidence among the White population is catapulting, this population group was examined in this study as the first catchment area.

The purpose of this study is to outline a psychoeducational profile of the unmarried mother, by examining her age, family background, schooling, sex education, occupational status and psychological/ emotional state. The primary purpose of the present study is therefore to investigate retrospectively sociodemographic factors, both psychosocial and educational, that could contribute toward women becoming unmarried mothers. A subsidiary aim of this study is to examine the level of depression in unmarried mothers six months after the birth of their baby and to ascertain how these women cope with their situation, taking into consideration their age, educational level, support systems and motivation for their pregnancies.

Hypotheses

The underlying hypotheses which guided the present study based on white English and Afrikaans speaking, interdenominational, female subjects aged 15-40 years, from different socioeconomic groups, were that:-

Ha1 There is a difference between unmarried and married mothers in terms of sociodemographic factors such as age, socio familial background, educational and occupational status.

Ha2 There is a difference between unmarried and married mothers on their levels of depression as tested by Beck's Depression Inventory six months after the birth of their baby.

Ha3 There is a difference between the past school experience of unmarried and married mothers.

Ha4 There is a difference between prior exposure to sex information/education in the unmarried and married mothers.

2.2. Subjects

2.2.1. Sample Selection

In selecting the present unmarried mother sample all primagravida, unmarried mothers keeping their babies who delivered at the Johannesburg and J G Strydom Hospitals during the period of November 1986 - March 1987 were recruited. Married women (the control group) were matched according to broad age categories, and parity during the same specified time period. The sample population consisted of 88 unmarried mothers, (s), 73 married mothers, (m), and 35 mothers who married during their pregnancy, (s → m). Subjects were thus selected by means of probability sampling. "The critical aspect of any probability sampling procedure is that each element in the population has some specifiable probability of inclusion in the sample". (Neale and Liebert, 1980, p68). In the present study a simple random sampling technique was adopted whereby each element had an equal probability of being included in the sample.

2.2.2. Sample Description

The subjects were all white, female, primagravida, English or Afrikaans speaking, from different socioeconomic and religious backgrounds. The age range was from 15yrs-40yrs. The final sample consisted of 196 subjects.

2.3. Procedure

All primagravida unmarried mothers, keeping their babies were recruited during their post natal stay in hospital. Married women, matched according to parity and broad age categories were similarly recruited during the same time period (Nov 1986-March 1987). Each woman was interviewed as well as questionnaire A administered to them. Informed consent was obtained and their confidentiality assured. The subjects were then re-interviewed and a further Questionnaire B plus the Beck Inventory for Depression administered. This took place 5-8 months later in the mothers' own homes. (May 1987-July 1987). Despite taking precautions, 35% of the women could not be traced and 5% refused or cancelled the follow up home visit. Therefore the attrition rate was 40% of the total sample. 118 subjects completed Questionnaire B. The Beck Inventory was completed by 104 mothers. The profile of the mothers who dropped out of the study was compared with those who completed it. There was no difference in the distribution of the mothers in the three groups. There was also no difference in the educational status in the three groups. There was however a significant difference in the age distribution of the married women. Those who dropped out of the study were significantly younger ($p < 0,001$) than the married women who completed the study.

Additional research questionnaires, investigating these same subjects' past school experience and prior sex education were mailed to them. A total of 118 subjects were sent

questionnaires, that is those that could be traced from the follow up interview six months after the birth of their baby. Fifty subjects completed the questionnaire, one subject refused to, sixty seven did not reply due to subjects' addresses having changed or failure to complete the questionnaire. Thus the return rate for this part of the study was 43%

2.4. Measuring Instruments

The measuring instruments used in this study were as follows:

1. The systematic personal interview (two, one in the puerperal period and the second approximately six months later).
2. Questionnaire A - "Mother's Experience of Childbirth & Childrearing". (Appendix D).
3. Questionnaire B - Six months follow up. (Appendix F).
4. The Beck Inventory for Depression. (Appendix G).
5. The Distributed Questionnaire on School experience.(Appendix I).

Taking cognisance of the personal nature of the data obtained in this study, the researcher introduced the consent forms into the present study.

2.4.1. Questionnaire Compilation

Questionnaire A and B were compiled jointly by the author and a colleague. The questionnaire on School Experience was compiled solely by the author.

2.4.2. The Systematic Personal Interview

The systematic personal interview served as a spring board for obtaining the relevant information for Questionnaires A and B. It is an effective survey technique and helps reduce some of the bias one attains when using a questionnaire (Neale and Liebert, 1980). In addition to securing reliable data, personal interviews that involve the co-operation of the respondents may also permit obtaining data on the validity of the information gathered.

2.4.3. Beck Inventory for Depression

The Beck Depression Inventory (BDI) Beck et al, (1961) was used as the primary measure of depression on the subjects approximately six months after delivery. "BDI has been viewed as one of the better self-report measures of general depression and has become a widely used measure in clinical research" (Reynolds and Gould, 1981, p 306). "Self report measures are not intended to serve as diagnostic devices, they are nevertheless used as a convenient means of screening the severity of depression related phenomena in epidemiological surveys of the general population." (Boyle, 1985).

The Beck Depression Inventory was developed by Beck and his associates in 1961, in an attempt to measure the behavioural manifestations of depression. It consists of 21 categories of symptoms and attitudes. Each category consists of a graded series of 4 or 5 self evaluative statements. The statements describe specific behavioural manifestations of depression and are ranked

from 0-3, which indicates the degree of severity of each symptom. The statements reflect overt behavioural manifestations of depression and thus are not grounded in a particular theory regarding the etiology of depression (Beck et al, 1961).

"The BDI was subjected to a variety of tests to determine its reliability and validity. Beck et al,(1961) reported split half reliability of ,93). The high correlation coefficient on the split half item analysis and the significant relationship, between the individual category scores and the total scores indicate the instrument is highly reliable. The ability of the inventory to approximate clinical judgements of intensity of depression offers a number of advantages in its use for research purposes.

1. It meets the problem of the variability of clinical judgement of nosological entities and provides a standardized consistent measure that is not sensitive to the theoretical orientation or idiosyncrasies of the individual who administers it.
2. Since the inventory can be administered by an interviewer who is easily trained in its use, it is far more economical than a clinical psychiatric interview.
3. Since the inventory provides a numerical score, it facilitates comparison with other quantitative data.
4. Since the inventory reflects changes in the depth of depression over time, it provides an objective measure for judging improvement resulting from psychotherapy, drug therapy and other forms of treatment. (Beck et al, 1961).

Some problems exist with many self-report measures of depression. For example a study by Meites et al,(1980) demonstrated that the BDI appears to tap an emotionality factor of stability-instability, rather than being primarily a measure of depression (Boyle, 1985). The single biggest criticism of self-report inventories is that they are susceptible to faking. Self-report inventories are objective in that they are recorded and scored in a standardized fashion (Brown, 1976). they are quick to administer and interpret and remain one of the most frequently used methods of assessment in research (Haynes, 1978).

2.4.4. The Distributed Questionnaire

Personal contact with the subjects had been made on two prior occasions, thus it was felt that the questionnaire on school experience could be distributed by mail. The main disadvantage however of the distributed questionnaire is self selection bias among respondents; that is, those who did not have a positive school experience may not have responded at all.

2.5. Methodological Design and Statistical Analysis

2.5.1. Design

The investigation consisted of a descriptive study where the researcher recorded findings by obtaining data and ratings from questionnaires and interviews in order to describe and compare

population groups in terms of sociodemographic and educational factors as well as the mothers' levels of depression. In addition the research also involved an ex post facto design, a retrospective approach, utilizing a between-group design to compare the different groups of mothers with regard to their previous school experience and sex education.

2.5.2. Statistical Analysis

The nature of the data indicated that it was appropriate to treat the data as descriptive. A descriptive study was carried out on sociodemographic variables, mothers' level of depression during the post-natal period, six months after the birth of their babies, as well as their prior school experience and related sex education received during adolescence.
Hypotheses were tested at the 5% level of significance.

The data was supplied to the Institute for Biostatistics of the Medical Research Council, University of the Witwatersrand. The analysis was done using the BMDP and SAS statistical packages.
The tests that were employed included the Pearson Chi Square, Fishers exact two tailed test, as well as a one-way Analysis of Variance and the t-test. The Bonferroni adjustment was made where sub-groups were compared. Frequency tables were used to describe the data and to show the distribution thereof.

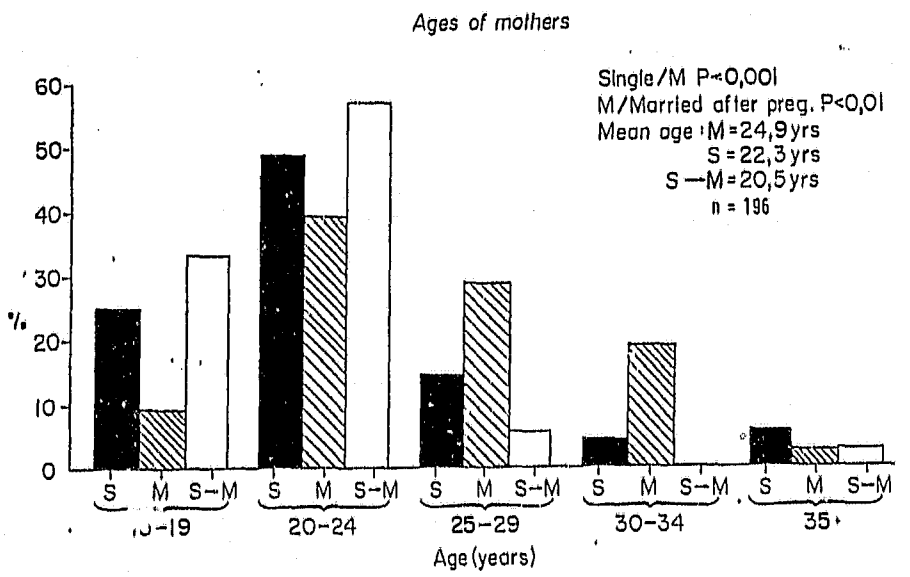
3. RESULTS

3.1. Sociodemographic variables

On analysis of the data obtained from the total sample (N=196) the results on sociodemographic variables between the groups are as follows:-

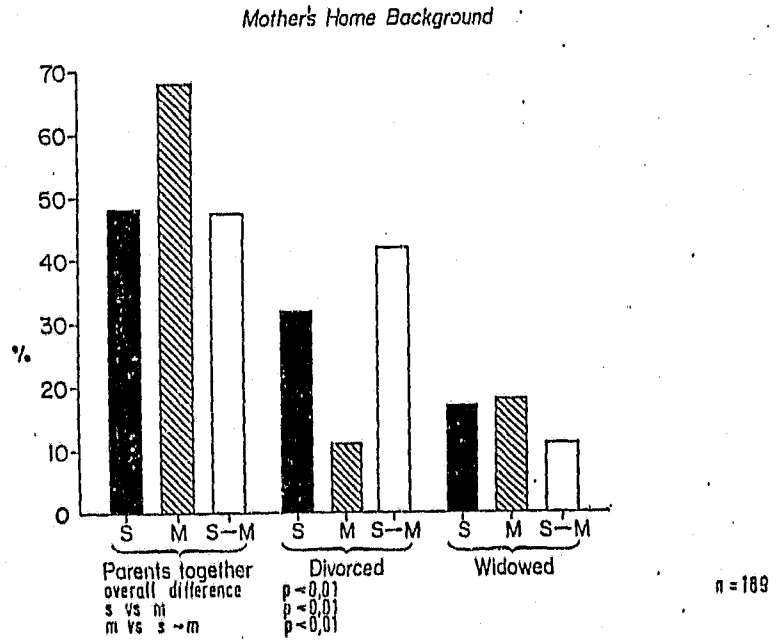
The mean ages of the groups being; married mothers (m)=24,9 years, unmarried mothers (s)=22,3 years, mothers who married during their pregnancy (s→m)=20,5 years respectively. (See Table 1,Appendix J). A significant difference was found in the age distribution of the three groups as tested by the one way Analysis of Variance ($F=11,5816$; $df=2$; $p < 0,01$). The married mothers (m) were significantly older than both the unmarried mothers (s) ($p<0,001$) and those who married during their pregnancy (s→m) ($p<0,01$). There was no significant difference between the unmarried mothers and those who married during their pregnancy.

Figure 1



The family backgrounds of the mothers were investigated as is indicated in the figure below, 33% of s mothers, 11% of m mothers and 41% of s→m mothers came from broken homes.

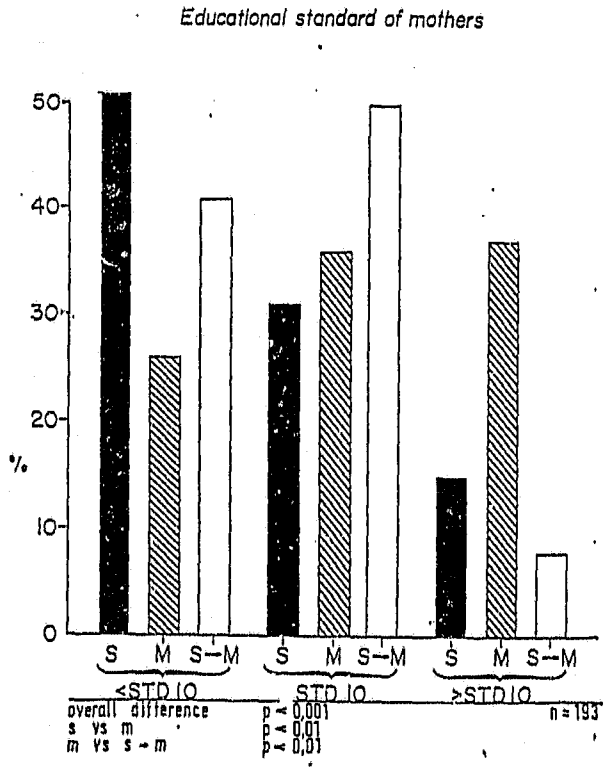
Figure 2



A significant difference among the three groups was found. ($\chi^2_{4;0,05}$ =14,118, p<0,01) (See Table 1, Appendix J). Unmarried mothers came from more broken homes (divorce/separated) than the married mothers (s vs m p<0,01). Mothers who married during their pregnancy, when compared to married mothers also came from significantly more broken homes (s→m vs m p<0,01). There was no significant difference between the unmarried mothers and those who married during their pregnancy.

When the educational status of the mothers was examined, 38% of married mothers were found to have a University or Technical College education as compared to 16% of unmarried mothers and 8% of those who married after conception as is evident in Figure 3.

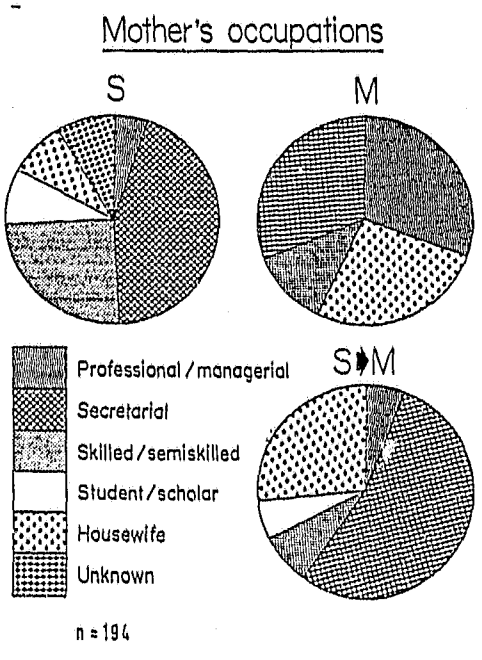
Figure 3



There was a significant difference in the educational status of the three groups of mothers, ($\chi^2_{4;0,05}$ = 19,841; p<0,001). The married mothers were better educated than either the unmarried mothers (m vs s p<0,01) or those who married during their pregnancy (m vs s→ m p<0,01). There was, however no significant difference between the unmarried mothers and those who married during their pregnancy (See Table 1, Appendix J).

Occupations were varied, (See Table 1, Appendix J). A higher percentage of married mothers held professional/managerial positions. Thirty percent of married mothers had professional/managerial positions as opposed to 5% of the unmarried mothers and 6% of those mothers who married during their pregnancy. 4,6% of the total sample (N=194) were scholars at the onset of their pregnancy, none of whom were married. This is clearly represented in Figure 4.

Figure 4

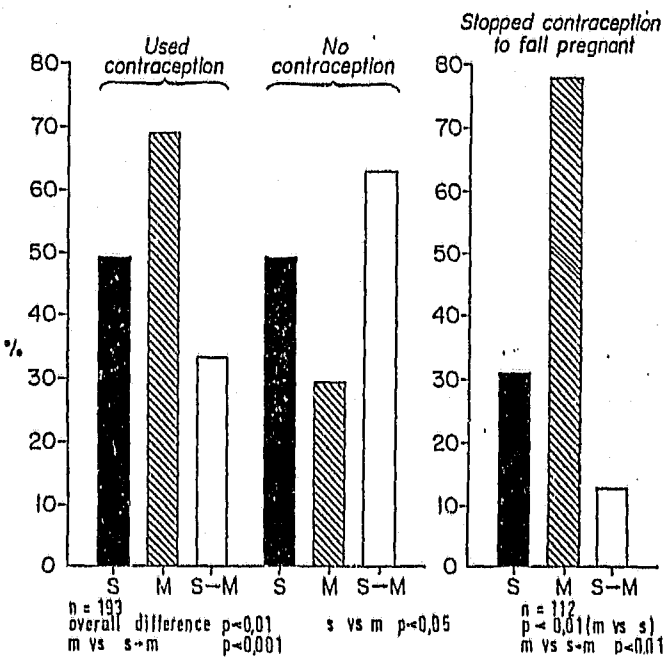


3.2. Prevention and Pregnancy

Contraceptive usage was explored: 50% of the unmarried mothers had never used contraception and 30% used it regularly and stopped in order to fall pregnant. Sixty seven percent of s→m mothers had never used contraception and only 13% used it regularly and stopped in order to fall pregnant, whereas 69% of m mothers used contraceptives and 78% stopped in order to fall pregnant. This is evident in Figure 5.

Figure 5

Contraceptive Usage



There was a significant difference among the groups in terms of contraceptive usage. ($\chi^2_{2;0,05}$ = 13,499, p<0,01). (See Table 2, Appendix J). There was a significant difference between the unmarried and married mothers (p<0,05) and between the married mothers and those mothers who married during their pregnancy (p<0,001). However there was no difference between the unmarried mothers and those who married during their pregnancy. A significant difference was found between the groups with regard to stopping contraception to fall pregnant. ($\chi^2_{2;0,05}$= 31,736; p<0,01). There was a significant difference between the married and unmarried mothers (p < 0,01) and between the married mothers and those who married during their pregnancy (p < 0,01). However, there was no significant difference between the unmarried mothers and those who married during their pregnancy.

Sixty seven percent of married mothers planned their pregnancies and 17,7% of both the unmarried mothers and those who married during their pregnancy, planned their pregnancy ($\chi^2_{2;0,05}$= 47,095, p <0,01). There was a significant difference between the unmarried and married mothers (p<0,01) and between the married mothers and those mothers who married during their pregnancy (p<0,01). No significant difference was found between the unmarried mothers and those who married during their pregnancy. (See Table 2,Appendix J). Seventy three percent of all the mothers' reaction to their pregnancies was one of happiness. However there was a significant difference between the three groups ($\chi^2_{4;0,05}$= 18,534; p<0,001). In

particular more married mothers were happy about their pregnancies than unmarried mothers ($p < 0,01$). There was also a difference between the married mothers and those who married during their pregnancy ($p < 0,05$). However there was no difference between the unmarried mothers and those who married during their pregnancy (See Table 2, Appendix J).

The results reveal that the unmarried mothers and those who married during their pregnancy have similar profiles on all the variables mentioned thus far.

3.3. Level of Depression and Coping Ability

Mothers' level of depression during the post natal period six months after the birth of their baby, as measured by the Beck Depression Inventory, revealed no significant difference between the groups (N=104). The results reflected very little depression amongst the mothers: 73% were normal, 20% were mildly depressed, 4% were mild to moderately depressed and 3% were moderately to severely depressed. (See Table 3, Appendix J).

These results were supported by the findings obtained from the self report questionnaire B, where no significant difference between the groups in terms of the mothers' ability to cope during the first six month, post natal period was found. The majority of the mothers were coping well (N=118) (See Table 3, Appendix J). However, there appears to be a difference in terms of the support networks of the mothers; most mothers had adequate support networks (N=116). Unmarried mothers were greatly supported by parents, family and friends, whilst married mothers were supported by maids

and their husbands, when the standardized deviations were considered. There were fewer unmarried mothers who were supported by their boyfriends than was expected; only 8% of unmarried mothers were supported by their boyfriends (N=116) (See Table 3, Appendix J).

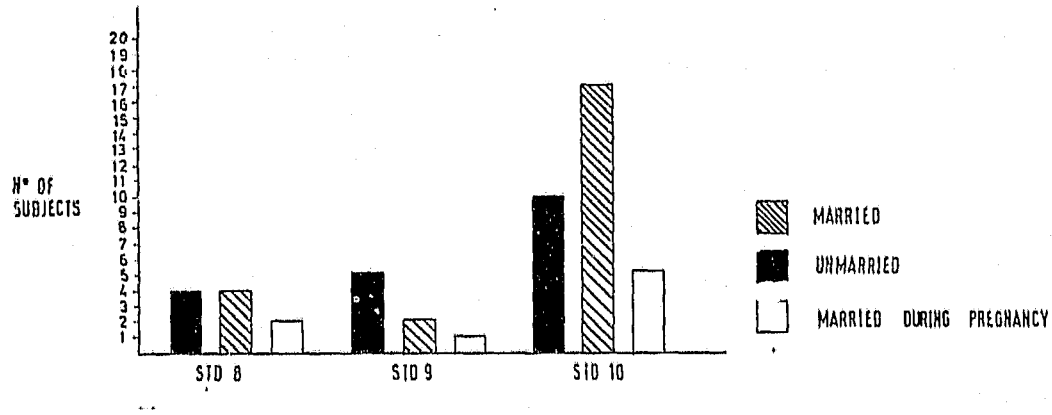
3.4.School Experience

The results below are based on information obtained from the 50 subjects who completed the distributed questionnaire. The mean ages of the subjects were, m=25,739 (N=19); s=22,421 (N=23); s m=21,125 (N=8). A significant difference was found in the age distribution of the three groups as tested by the one way Analysis of Variance ($F=3,92$; $df=2$; $p<0,05$). In particular the difference was between the married mothers and those who married during their pregnancy ($t=3,95$; $p<0,01$).

The histogram below represents the last standard attained at school for the total sample (N=50).

Figure 6

Last Standard Attained at School



From Figure 6 it appears that more married mothers obtained their matriculation. Fifty three percent of married mothers obtained their matric as opposed to 31% of unmarried mothers and 16% of those mothers who married during their pregnancy. There was however no statistically significant difference between the groups on last standard attained at school. Ten percent of the subjects in the sample had to leave school as they were pregnant.

Unmarried mothers were found to experience difficulty in early adolescence in relating to the opposite sex. When married mothers were compared to a combined group of u[illegible]d mothers and mothers who married during their pregnancy (as these two groups were very similar in their profiles) a significant difference was found in the difficulty they experienced in early adolescence in relating to the opposite sex, as measured by the information obtained from the distributed questionnaire. ($\chi^2_{3;0,05}$=10,411; p<0,01). (See Table 4, Appendix J).

The table below portrays the guidance teachers' availability to discuss relevant issues with their students at school.

Table 1

Approachability of Guidance Teacher

Area of Concern	Number of Subjects Using Guidance Teacher			
	m	s	s→m	Total
Personal	5	6	5	16
Family	5	8	5	18
Friendship	5	9	5	19
Sex	3	4	4	11
Pregnancy	3	3	5	11
Scholastic	8	11	5	24
Careers	9	12	6	27

No significant difference was found between these groups with regard to the guidance teachers' approachability concerning the various topics. The Chi Square statistical test confirms this finding. However issues related to sex and pregnancy seem to be the most neglected for all groups. Seventy percent of the subjects at the schools represented in this sample had guidance teachers (Appendix K). Only 28% of the total sample received sex education at school. Seventy two percent did not have the opportunity of sex education classes at school; of the subjects who did not receive sex education, 83% would have appreciated such classes and a further 17% were not interested in these classes. A further breakdown of the 83% of subjects who wanted sex education at school were; 95% of m mothers, 64% of s mothers and 100% of s m mothers.

The table below demonstrates the subjects' sources of information obtained concerning sex and sexuality before they were 15 years of age.

Table II

Sources of Information Pertaining to Sex.

Source	Number of Subjects Using This Source			
	m	s	s→m	Total
Mother	10	7	5	22
Father	0	0	1	1
Siblings	4	3	1	8
Friends	9	9	3	21
School	0	4	1	5
Reading	14	15	0	29
Other	1	1	0	2
None	3	0	1	4

The frequency table indicates reading as the most frequent source of information for female adolescents. The mother, too, is seen as an important figure in terms of educating her daughter on sexual matters. In addition the influence peers have on the adolescent is noted. Furthermore, the insignificant role the school plays in imparting knowledge on sexual matters is apparent.

The table below highlights the parents' reluctance and/or inability to discuss the majority of sex related topics with their adolescent girls.

Table III

Sex Education Received from Parents During Adolescence.

Sex-Related Topic	No. of Subjects Whose Parents Discussed Topics			
	m	s	s-m	Total
Menstruation	18	16	6	40
Nocturnal Emissions	1	1	1	3
Reproduction	10	10	4	24
Orgasn	0	2	1	3
Masturbation	0	2	1	3
Sex Deviations	1	2	1	4
Coitus	0	1	1	2
Veneral Diseases	3	5	1	9
Contraception	3	5	3	11
Pleasure of Sex	0	1	0	1
Controlling sexual emotions	1	4	3	8
All	2	0	1	3
None	3	3	1	7

The above frequency table indicates that 14% of the total sample received no sex education at all from their parents. Furthermore parents (mainly mothers) tended to discuss menstruation with their daughters and seemed reluctant to discuss other relevant issues such as coitus, orgasm, masturbation, pleasure of sex and

contraception. However the findings from this study revealed that 82% of the subjects were aware of contraception when they were at school.

The reader is referred to the Appendix for the specific tables pertaining to the results of this study.

4. DISCUSSION

4.1. Introduction

The objective of this study was to obtain a psychoeducational profile of the unmarried mother. The discussion concerns the results that validate or refute the hypotheses of the study. Other results that may have a bearing on explaining the present findings related to the listed hypotheses will be discussed briefly.

4.2. Hypothesis 1 : There is a difference between unmarried and married mothers in terms of sociodemographic factors such as age, sociofamilial background, educational and occupational status.

The results support this hypothesis and indicate that there is a significant difference between the unmarried and married mothers in terms of all the above sociodemographic factors.

If the age distribution of the total sample is examined it can be seen that there was a significant difference in the ages of the three groups of mothers. The married mothers were significantly older than both the unmarried mothers ($t = -3,33$; $p < 0,01$) and those who married during their pregnancy ($t = 5,37$; ($p < 0,01$). Girls are becoming mothers before becoming adults and thus there is the need for early intervention programmes in the schools.

The family backgrounds of the subjects were investigated to ascertain the incidence of discordant (divorce, separation or

death of parents) family circumstances. The findings suggest a significant difference between the groups on this variable. Unmarried mothers and those who married during their pregnancy came from more discordant families (broken homes - divorce, separation) than their married counterparts. This confirms previous research and theory documented by different authors emphasizing the prevalence of discordant family circumstances in the backgrounds of unmarried mothers (Van Andel, 1948, Loots, 1951, Cronje, 1957 and Schreier, 1960).

There was a significant difference in the educational status of the three groups studied. The married mothers attained a higher educational level compared to the unmarried mothers ($p < 0,01$) and those who married during their pregnancy ($p < 0,01$). School pregnancies occurred in 4,6% of the total sample (N = 196), all of whom were unmarried at the time. This finding is similar to those results obtained by Gunston (1986) and his colleagues in the Cape Peninsula. The findings in the present study support McAnarney and Thiede's (1981) statement that "women who are pursuing formal education beyond high school are more likely to delay childbearing until their adult years than women who do not continue their education. They delay sexual activity until they finish their education or if they are sexually active, use contraception or choose an abortion if they become pregnant".

When the three groups were compared on occupational status, it was found that more married women had professional qualifications than the other two groups. This finding can be explained on the basis that higher educational status often leads to higher occupational status. Considering that a high percentage of the unmarried mothers' school careers were interrupted this explains their lower educational and occupational status.

Those mothers who married during their pregnancy approximate the unmarried mothers' situation more than the married group, in terms of sociodemographic factors, contraceptive usage, planning of pregnancy and reactions to their pregnancies. Therefore their situation tends to follow a similar pattern to that of the unmarried mother and consequently their profiles are similar.

4.3. Hypothesis 2 : There is a difference between unmarried and married mothers on their levels of depression as tested by the Beck Depression Inventory (BDI) six months after the birth of their babies.

The results of the BDI refute this hypothesis as no significant difference between the three groups on their level of depression, was found. Whereas 73% of the total population were not depressed, 20% were mildly depressed, 4% were mildly to moderately depressed and 3% moderately to severely depressed. This can be attributed to the good social support received by most mothers irrespective of their status, as well as the absence of any 'at risk' infants in

the sample population, thus allowing for a positive psychological adaptation during the post partum period.

Furthermore no significant difference was found when the three groups of mothers were compared on their coping ability six months after the birth of their baby. The perceptions of the majority of the mothers, (N = 118) indicated that they were coping well, six months after the birth. A possible explanation for the unmarried mothers' effective coping ability could be that these subjects felt it necessary to say that they were coping well because they were unmarried, thereby creating a better impression. Alternatively, many of them lived with their parents, who took over the responsibility of the baby. It may also be related to having no husband making demands on them and just requiring of them that they care for the baby. For 17,8% of unmarried mothers their pregnancies were planned, which had implications for their preparedness to be single parents.

Previous research has indicated that an important factor influencing mothers' ability to cope is their support networks (emotional, financial and social). Although there was a difference in the nature of support networks of the three groups of mothers, the majority of the subjects, irrespective of status, had good support systems. However many more unmarried mothers were supported by their parents and friends. Although husbands participated quite considerably in child rearing, unmarried mothers on the whole still carry the burden of childrearing without the putative fathers' participation.

It must be noted that 78 mothers could not be traced for the follow-up interview, six months after the birth of their baby. It is therefore assumed that these mothers were the less established group in terms of their abode and support networks and more at risk for being depressed.

4.4. Hypothesis 3 : There is a difference between the past school experience of unmarried and married mothers.

This hypothesis was not supported as there was no statistical difference between the groups in terms of the mothers' past school experiences. However, on examining the data qualitatively it is evident that a higher percentage of married mothers matriculated. School pregnancies occurred in 10% of the total sample (N=50) and consisted of unmarried mothers only. Pregnant teenagers should thus be catered for within the school system as is done in the USA. The majority of the subjects obtained school averages of 60%. Because of the nature of the questionnaire and its distribution there was an inherent element of choice by the subjects. Consequently those subjects who had performed poorly at school could have elected not to return the questionnaire and similarly the scores of those returned could have been exaggerated in order to create a better impression.

A significant difference was found between the groups in relating to the opposite sex during adolescence. More unmarried mothers experienced difficulty in adolescence in relationships with the

opposite sex, which can be explained in the followi ways. This includes their need to maintain a long term relationship by falling pregnant as a way of inducing marriage. This is suggested here in this study in terms of the large number of subjects (N = 35) who married during their pregnancy. Consideration should be given to the fact that 18% of both unmarried mothers and those who married during their pregnancy had planned their pregnancies. These subjects are often afraid to jeopardize their tenuous relationships by refusing intercourse. Latimer, et al (1965 cited in King, 1970) observed that the unmarried mothers in his study could not form meaningful relationships with others because their own family relationships had never been constructive. Furthermore 82% of both unmarried mothers and those mothers who married during their pregnancy had not planned their pregnancies. This result supports Young's (1954) theory of the strong, unconscious desires unwed mothers possess to fall pregnant. Fifty eight percent of unmarried mothers and 77% of mothers who married during their pregnany were happy when they discovered they were pregnant. Vincent, (1962, p194) describes those unwed mothers who keep their children as having "to show their desperate need for at least one primary relationship in which they are needed and loved by someone whose dependence on them makes it safe for them to receive and return that love in their own way. When this need is sufficiently strong it tends to insulate against and minimize the stigma concomitant with being an unwed mother."

4.5. Hypothesis 4 : There is a difference between prior exposure to sex information/education of the unmarried and married mothers.

This hypothesis was not supported as there was no significant difference among the three groups in their sex education received during adolescence.

Guidance teachers were present in 70% of the schools represented in this study (see Appendix K). Those issues relating to personal, family, friendship, scholastic and careers were adequately dealt with. However sex education appeared to be somewhat neglected. This was supported by the present retrospective study. Sex education in South Africa is a recent innovation. Such programmes have demonstrated their value and should be available for both adolescents and adults. "Perceptions of sex education as an important part of the guidance curriculum is basic to most education systems in the Western World". (Oakley-Smith, Skuy and Westaway, 1988, p 112).

Research supports the finding that the majority of adolescents during their school years are aware of contraception yet do not make use of it. One reason for this is the inaccessibility of family planning clinics to teenagers. Another reason is the adolescents' "magical thinking" - "it won't happen to me" attitude. However, with the ever present fear of sexually transmitted diseases such as Aids, contraception is being emphasized as a safety precaution, thus the freer availability of contraception.

Early contraceptive usage could have a profound impact on the prevention of premature parenthood.

The findings of this study reveal that the most prevalent source of sexual information is through reading. The next significant source of information is the mother. These results confirm previous research which found the father to play a minimal role in transmitting sexual information to their daughters (Hepburn, 1983). Mothers find it easier to discuss menstruation with their daughters.They are less inclined and feel inadequate to discuss information on sex and reproduction. Parents continue to influence adolescent behaviour greatly. Therefore, parental involvement and communication should be strengthened to help adolescents become more responsible and informed. Programmes are needed to help parents, who are often less informed than their teenagers, become better informed and more comfortable with discussing sexuality and contraception. This will reduce the likelihood of misinformation. Peer groups are yet another important source of information because peers have such an impact on adolescent behaviour, particularly on the initiation of sexual activity. Programmes should assist adolescents to identify and examine peer pressure and explore ways to make individual, deliberate decisions. (Flick, 1986).

4.6 Limitations of the Study

There was a reliance on the integrity of the subjects' responses in this study, thus the results must be viewed accordingly.

Self-report inventories are susceptible to faking, especially the endorsement of socially desirable responses. However the Beck Depression Inventory was completed in the presence of the interviewer which reduced some of the bias.

The retrospective part of the study, which examined fifty subjects' past school experience and prior exposure to sex education involved too small a sample for more comprehensive statistical analysis to be performed. Schools were not contacted to confirm the information given by the subjects on their school results, standard attained or sex education programmes available. This was beyond the scope of the present study.

4.7. Conclusions and Recommendations

The main objective of the present study was to provide a psychoeducational profile of the unmarried mother. The analysis of the data revealed that the profiles of the unmarried mothers and those of the mothers who married during their pregnancy were similar.

The most salient finding in the present study showed that the unmarried mothers and those who married during their pregnancy were younger, had a lower educational status, were less qualified professionally and came from more discordant family backgrounds than their married counterparts. The differences between the unmarried and married mothers were not unexpected. However the

group of mothers who married during their pregnancy appear to be similar to the unmarried mothers. They are mostly disregarded as a separate entity and usually considered as married women by professionals and the community. However, they should be viewed as similar to the unmarried mother.

The present investigation unexpectedly found that there was no significant difference between the groups of mothers in terms of their levels of depression during the post-natal period six months later. In fact the majority of women in all groups were coping well and not depressed. The main reasons for this were their strong support networks : for the unmarried mothers their family of origin and friends, and for the married mothers their husbands and maids. At present social support is attracting the greatest interest in the area of post partum depression (Brown 1974, Brown, Bhrolchain and Harris, 1975, Brown and Harris, 1978, Brown, Harris and Peto, 1973, cited in Cooke 1985).

The retrospective nature of one aspect of this study namely the mother's past school experience and prior exposure to sex education, could have been distorted due to inaccurate recall or wanting to create a better impression especially with regard to the educational aspect of standard attained and percentage obtained. However more married mothers obtained their matriculation than both the unmarried mothers and those who married during their pregnancy. Ten percent of the sample had to leave school owing to pregnancy and these subjects were all unmarried.

The findings on sex education received during adolescence revealed the paucity of sex education in the school situation as well as the reliance young girls place on information obtained from reading and friends, which often leads to misinformation. Parental involvement was found to be the domain of the mother rather than the father. Her main focus was to teach her daughter about menstruation. Contraception, coitus, and reproduction were not issues as well covered by mothers as they ought to be.

Although the research literature available suggests important aspects for inclusion in intervention programmes, it only hints at a broader issue of prevention. The origins of the problem, and therefore the dimensions of the task of prevention lie in the changes required from the fabric of the adolescents' community - the family, schools, religious institutions and welfare and health systems.

Arising from the present study, several recommendations for future studies on unmarried mothers are made.

Firstly, unmarried teenage mothers could be compared to a group of unmarried teenage girls to investigate prospectively their school experience and educational achievement.

Secondly, programmes on sex education in the school situation should be investigated and the long term effects of such programmes be evaluated.

Thirdly, it is considered essential that future research in this field should encompass the major population groups in South Africa, namely; Black, Indian and Coloured women. This approach will ensure a representative sample and wider generalizability of the findings as the results could be interpreted with more impact.

It is acknowledged that available and accessible contraceptives and abortion services reduce the incidence of premature parenthood. Other factors such as the influence of peers, parental involvement, school sex education programmes and community participation play an integral and vital role in the prevention of early, unplanned and unprepared parenthood.

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APPENDIX A

T.P.H. 49

TRANSVAALSE PROVINSIALE HOSPITALE

TRANSVAAL PROVINCIAL HOSPITALS

Telegrafiese Adres..."HOSPIGE"..... JOHANNESBURG.....HOSPITAAL
Telegraphic Address HOSPITAL

Telefoon No.....643-0111 x 2265..... Private Bag 39
Telephone No.

Dr. R. Drubin .....

IN ANTWOORD VERMELD ASB.
IN REPLY PLEASE QUOTE

No.....1/5/1..... JOHANNESBURG 2000

Alle korrespondensie moet aan die Superintendent gerig word.

All communications to be addressed to the Superintendent.

9th September 1986

Mrs. Debra Danilewitz
Social Worker
Lecturer - Department of Paediatrics and Child Health
Medical School
PARKTOWN

Dear Mrs. Danilewitz,

RESEARCH PROJECT "MOTHERS EXPERIENCE OF CHILDBIRTH AND CHILD BEARING"

Thank you for the copy of your letter referred to Professor Sonnendecker dated 1st of September 1986, with attachments of the revised Questionnaire. I have advised the Chief Matron of this pending study.

Thank you for informing me and wishing you every success.

Yours sincerely,

DR. R. DRUBIN
For CHIEF SUPERINTENDENT

APPENDIX B

TRANSVAALSE PROVINSIALE HOSPITALE

Telegrafiese Adres
Telegraphic Address .....

Telefoon No. 726 5128 X 111
Telephone No. .....

IN ANTWOORD VERMELD ASB.
IN REPLY PLEASE QUOTE
No. 1/5/1

Alle korrespondensie moet aan die Superintendent gerig word.
All communications to be addressed to the Superintendent.

DR A. VAN DER MERWE

T.P.H. 49

TRANSVAAL PROVINCIAL HOSPITALS

J.G. STRIJDOM - HOSPITAAL
..... HOSPITAL

10 JULY 1986

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RESEARCH ON UNMARRIED MOTHERS AT J.G. STRIJDOM HOSPITAL

Permission is granted for mrs Danilewitz and yourself to interview mothers in the wards at J.G. Strijdom hospital and to fill in the questionnaire.

Best of luck with your project!

.....
SUPERINTENDENT
AvdM/cjb
1986/07/10

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Dear

The aim of this research project is to ascertain what sort of experiences you. as a new mother, have had during your pregnancy and in the first few months following the birth. We would appreciate it if you would complete this questionnaire in the course of the interview and would be prepared to have a further interview in your own home in approximately four months' time.

As a result of this survey, we hope to be able to make recommendations regarding the improvement of services to the relevant authorities. All information will be treated as strictly confidential and used for research purposes only. By participating in this research, you may be helping others.

Thank you for your co-operation.

Yours sincerely,

Avis Schreier.

AVIS SCHREIER PhD
DEBRA DANILEWITZ.

MOTHERS EXPERIENCE OF CHILDBIRTH AND CHILD REARING

Questionnaire A Questionnaire No: ☐☐☐

1. Date _____ Hospital _____

Interviewer _____

2. Name _____

3. Present Address _____

_____

4. Telephone No. _____

5. Address in four months time _____

_____

6. Telephone No. _____ Name: _____

7. Alternative telephone number of relative/work Tel: _____

8. Religion _____

9. Marital Status: _____ Date of Marriage _____

10. Date of birth of mother _____

11. Date of birth of baby _____

12. Expected date of birth of baby _____

13. With whom are you living?

Husband ☐

Boyfriend ☐

Child's father ☐

Parents ☐

On your own ☐

Relatives ☐

Friends ☐

Other ☐ _____ Specify

/2.....

14. Do you live in a : flat ☐

house ☐

room ☐

commune ☐

hotel/boarding house ☐

other ☐ _____ Specify

15. What standard of education have you attained?

0 - Std 6 ☐

Std 6 - Std 9 ☐

Matriculation ☐

College(secretarial, computer,etc) ☐

Technikon/Teachers Training College (Diploma) ☐

	Completed	Not completed
University(Degree)	☐	☐

16. Occupation _____

17. At what stage of your pregnancy did you stop working?

☐ 1 - 3 months ☐ 3 - 6 months ☐ 6 - 9 months

/3.....

18. Did you apply for maternity benefits? ☐ Yes ☐ No ☐ N/A

19. When do you intend returning to work?

☐ 0-3 months ☐ 3-6 months ☐ 6-12 months ☐ 12 months + ☐ never

20. When you return to work, who will look after your baby?

Grandmother ☐

Maid ☐

Creche ☐

Child minder ☐

Relatives/friends ☐

Other(explain) ☐ _____

21. Are your parents still married? ☐ Yes ☐ No ☐ Both deceased

22. If not, are they divorced? ☐ Yes ☐ No

Are they separated? ☐ Yes ☐ No

Are they widowed? ☐ Yes ☐ No

23. How old were you when they separated _____

divorced _____

died _____

/4.....

24. With whom did you live during most of your childhood/adolescence?

Mother ☐ Father ☐ Both ☐ Grandparents ☐
Other ☐ Specify _____
Boarding School ☐ Relatives/friends ☐ Childrens Home ☐

25. How long have you known your husband/the father of your child? _____

26. Does his family know about the pregnancy? ☐ Yes ☐ No

27. Are his parents still married? ☐ Yes ☐ No ☐ Deceased

If not, are they: Divorced ☐ Yes ☐ No
Separated ☐ Yes ☐ No
Widowed ☐ Yes ☐ No

28. How old was he when they: Separated _____
Divorced _____
Died _____

29. With whom did he live during most of his childhood/adolescence? _____

_____

30. What occupation does your husband/father of your child pursue? _____

_____

31. What standard of education has your husband/the father of your child?

☐ 0 - Std 6 ☐ Std 6 - 9 ☐ Matric ☐ Tech College ☐ University ☐ Other

32. Is your husband/the father of your child employed at present? ☐ Yes ☐ No

33. Is this your first pregnancy? ☐ Yes ☐ No

If no, did you ever give up a baby for adoption? ☐ Yes ☐ No

/5.....

34. Have you ever had a previous miscarriage? ☐ Yes ☐ No

abortions? ☐ Yes ☐ No

35. Have you ever used any form of contraceptive regularly? ☐ Yes ☐ No

If yes, did you stop so that you could fall pregnant? ☐ Yes ☐ No

36. Did you have any of the following problems during your pregnancy?

Nausea ☐ Yes ☐ No

If yes, how often ———————— ——

High Blood Pressure ☐ Yes ☐ No

If yes, were you hospitalized? ☐ Yes ☐ No

Any other, specify ————————————————————

37. 37. What was your reaction when you discovered that you were pregnant?

Happy / 1 / 2 / 3 / 4 / 5 / Unhappy Proud / 1 / 2 / 3 / 4 / 5 / Ashamed

38. 38. How far into your pregnancy were you when it was confirmed?

☐ 1 - 3 months ☐ 3 - 6 months ☐ 6 - 9 months

39. 39. What were the reactions of the following people when you told them of your pregnancy?

Husband/Boyfriend Happy / 1 / 2 / 3 / 4 / 5 / Unhappy

Parents Happy / 1 / 2 / 3 / 4 / 5 / Unhappy

Friends/relatives Happy / 1 / 2 / 3 / 4 / 5 / Unhappy

/6.....

40. What were your feelings about yourself when you were pregnant?

	Yes	No
Feminine		
Attractive		
Proud		
Afraid		
Ashamed		
Insecure		

41. Was this a planned pregnancy? Yes / No

42. Did you consider:

	Yes	No
Adoption		
Abortion		
Marriage		

N/A

43. Who is providing you with financial support ?

Husband | Boyfriend | Parents | Relatives/Friends

Other ☐ Specify _____

44. Who is providing you with emotional support?

Husband | Boyfriend | Parents | Relatives/Friends

45. Was your husband/father of your child present at the delivery? Yes / No

If no, has he seen the baby? Yes / No

46. Where did you go for ante-natal care?

GP _____

Specialist/Obstetrician _____

Ante-natal clinic _____

Private midwife _____

47. How many times did you go to see the doctor/clinic?

0 - 3 | 4 - 6 | 6 ⟶

48. Did you attend any ante-natal exercise/preparation classes? Yes / No

49. Were you booked in a nursing home/hospital for your delivery? Yes / No

/7.....

50. Did you smoke during pregnancy? [Yes] [No]

51. Did you drink any alcohol during your pregnancy? [Yes] [No]

If yes: Beer _____
Spirits_____
Wine _____

Number of drinks per day week day _____
weekends _____

52. Did you take any drugs not prescribed by the doctor, during your pregnancy?
[Yes] [No]

If yes, specify_____

53. Was your labour: [very difficult] [difficult] [satisfactory] [easy] [very easy]

54. How many hours were you in labour? [0 - 6] [7 -12] [12→]

55. What kind of delivery was it? Normal vaginal _____
Forceps/vacuum _____
Caesarian _____

56. Was an epidural administered? [Yes] [No]

57. Did your baby cry immediately after birth? [Yes] [No]

58. Was anything wrong with your baby at birth?
If yes, what _____

59. How did you feel when you first saw your baby?

[Happy] [Excited] [Indifferent] [Disappointed] [Sad]

60. How are you feeding the baby? Breastfeeding [ ]
Bottle feeding [ ]

61. Have you made any preparation for the baby's homecoming? [Yes] [No]

/8.....

62. How are you feeling about coping with your baby at home?

Frightened	Nervous	Calm	Confident

63. Who is going to help you with the baby?

	Yes	No
Husband/Boyfriend	☐	☐
Parents	☐	☐
Friends/relatives	☐	☐
Maid	☐	☐

64. Do you think you are going to change your routine in any way?

Yes ☐ No ☐ If yes, how _____

65. Have you experienced any changes within tne last year ?

Move house	Loss/change of job	Illnesses	Break up of Marriage or Relationship

Other ☐ Specify _____

66. Has your husband/boyfriend experienced any changes within the last year?

Move house	Loss/change of job	Illnesses	Army call up

Other ☐ Specify _____

67. Has anyone very close to you been very ill or died within the the last year?

Yes ☐ No ☐

68. Anything else you would like to discuss or tell us?

_____

_____

_____

THANK YOU FOR YOUR CO-OPERATION

MOEDERS SE BELAVENIS VAN DIE BEVALLING EN VAN KINDERS GROOTMAAK

Vraely A Vraelys nr:

1. Datum _____ Hospitaal _____

2. Naam _____ Onderhoudvoerder _____

3. Huidige adres _____

_____

4. Telefoon Nr _____

5. Adres oor vier maande _____

_____

6. Telefoon nr _____

7. Alternatiewe telefoon nr van 'n familieid/werk Naam: _____
Tel: _____

8. Kerkverband _____

9. Hywelikstaat: _____ Datum van troue _____

10. Moeder se geboortedatum _____

11. Baba se geboortedatum _____

12. Verwagte datum vir die baba se geboorte _____

13. Saam met wie woon u?

Eggenoot ☐
Kerel ☐
Baba se vader ☐
Ouers ☐
Alleen ☐
Familielede ☐
Vriende ☐
Ander _____
Spesifiseer

/2.....

14. Woon u in 'n:

Woonstel

Huis

Kamer

Kommune

Hotel/losieshuis

Ander _____
Spesifiseer

15. Akademiese kwalifikasier:

0 - st 6

st 6 - st 9

St 10

Kollege (sekretarieel, rekenaars, ens)

Tegnikon/Onderwys kollege (Diploma)

Universiteit (Graad) Voltooid Onvoltooid

16. Beroep _____

17. In watter fase van u swangerskap het u opgehou werk?

1 - 3 maande 3-6 maande 6-9 maande

/3.....

18. Het u aansoek gedoen vir swaneskap voordele?

Ja	Nee	NVT
☐	☐	☐

19. Wanneer beplan u om u werk to hervat?

0-3 maande 3-6 maande 6-12 maande 12 maande - nooit

20. Wie sal na u baba omsien wanneer u weer u werk hervat?

Ouma ☐

Biediende ☐

Kleuterskool ☐

Kinderappasser ☐

Familie/vriende ☐

Ander (verduidelik) ☐

21. Is u ouers steeds getroud?

Ja	Nee	Beide oorlede
☐	☐	☐

22. Indien nie, is hulle: Geskei

Ja	Nee
☐	☐

Woon hulle apart van mekaar?

Ja	Nee
☐	☐

'n Weduwee/wewenaar?

Ja	Nee
☐	☐

23. Hoe oud was u toe hulle: Apart begin woon het _____

Geskei het _____

Oolede is _____

/4.....

24. Saam met wie het u die meeste van die tyd gewoon gedurende u kinderdae/adolessensie?

Moeder ☐ Vader ☐ Beide ☐ Grootouers ☐

Ander ☐ Spesifiseer _____

Koskoot ☐ Familie/vriende ☐ Kinderhuis ☐

25. Hoe lank ken u al u eggenoot/vader van u kind? _____

26. Is sy familie bewys van u swangerskap? ☐ Ja ☐ Nee

27. Is sy ouers steeds getroud? ☐ Ja ☐ Nee ☐ oorlede

Indien nie, is hulle: Geskei ☐ Ja ☐ Nee

woon hulle apart van makaar ☐ Ja ☐ Nee

'n weduwee/wenenaar ☐ Ja ☐ Nee

28. Hoe oud was hy toe hulle: apart begin woon het:

Geskei het _____

Oorlede is _____

29. Saam met wie het by die meeste van die tyd gewoon gedurende sy kinderdae/adolessensie?

_____

30. Wat is u eggenoot/vader van u kind se beroep?

_____

31. Watter akademiese kwalifikasies het u eggenoot/vader van u kind?

0 - st 6 ☐ St 6 - 9 ☐ St 10 ☐ Tegnikon/kollege ☐ Universiteit ☐

Ander ☐

32. Beklee u eggehoot/vader van 'n kind tans n betrekking? ☐ Ja ☐ Nee

33. Is hierdie u eerste swangerskap? ☐ Ja ☐ Nee

Indien nie, het u al ooit voorheen 'n baba vir

34. Het u al voorheen 'n mistraam gehad? ☐ Ja ☐ Nee

35. Het u al ooit enige vorm van voorbehoedmiddels op 'n geereelde basis gebruik? ☐ Ja ☐ Nee

Indien wel, het u dit gestaak om so doende swanger te word? ☐ Ja ☐ Nee

36. Het u enige van die volgende probleme tydens u swangerskap ondervind?

Naarheid ☐ Ja ☐ Nee

Indien wel, hoe geveeld _____

Hoe bloeddriet ☐ Ja ☐ Nee

Indien wel, was u daarvoor gehospitaliseer? ☐ Ja ☐ Nee

Enige ander, spesifiseer _____

37. Wat was u reaksie toe u uitgevind het dat u swanger was?

Gelukkig | 1 | 2 | 3 | 4 | 5 | Ongelukkig

Trots | 1 | 2 | 3 | 4 | 5 | Skaam

38. Hoe lank was u swanger, alvorens dit bevestig was?

☐ 1 - 3 maande ☐ 3-6 maande ☐ 6-9 maande

39. Wat was die volgende persone se reaksie toe u hulle van u swangerskap meergedeel het?

Eggenoot/kerel	Gellukig	1	2	3	4	5	Ongelukkig
Ouers	Gelukkig	1	2	3	4	5	Ongelukkig
Vriende/familie	Gelukkig	1	2	3	4	5	Ongelukkig

/6.....

40. Wat was u gevoelens oor u self toe u swanger was?

	Ja	Nee
Vroulik		
Aantreklik		
Trots		
Bang		
Skaam		
Onseker		

41. Was die n beplande swangerskap? Ja ☐ Nee ☐

42. Het u enige van die volgende oorweeg? Ja ☐ Nee ☐

Aanneming	☐		☐
Aborsie	☐		☐
Trou	☐	☐	N V T

43. Wie voorsien u van finansiele ondersteuning?

Eggenoot ☐ Kerel ☐ Ouers ☐ Familie/vriende ☐

Ander ☐ Spesifiseer _____

44. Wie voorsien u van emosienele ondersteuning?

Eggenoot ☐ Kerel ☐ Ouers ☐ Familie/vriende ☐

45. Was u eggenoot/vader van u kind teenwoordig tydens die bevalling? Ja ☐ Nee ☐

Indien nie, het hy die baba gesien? Ja ☐ Nee ☐

46. Waar het u voorgeboortelike versorging ontvang?

Algemene Praktisn _____

Spesialis/verbskundige _____

Voorgeboorte kliniek _____

Private vroedinou _____

47. Hoeveel keer het u die dokter/kliniek besoek?

0 - 3 ☐ 4 - 6 ☐ 6 ☐

48 Het u enige voorgeboorte oefeninge/voorbereuding klasse bygweoon? Ja ☐ Nee ☐

49. Het u n bespreking vir die bevalling in n kraaminrigting/hospitaal gehad? Ja ☐ Nee ☐

/7.....

50. Het u tydens u swangerskap geroek? Ja Nee

51. Het u enige alkohol tydens u swangerskap gebruik? Ja Nee

Indien wel: Bier _____
Sterk drank _____
Wyn _____

Aantal drankies: woekdae _____
naweke _____

52. Het u enige medikasie, wat nie deur 'n dokter aan u voorgeskryf is nie, gedurende u swangerskap gebruik?
Ja Nee

Indien wel, spesifiseer _____

53. Was u bevalling: Baie moeilik moeilik bevredigend maklik baie maklik

54. Hoeveel ure het u bevalling geduur? 0 - 6 7 - 12 13-

55. Watter tipe bevalling was dit? Normaal vaginaal _____
Tang/Vakuum _____
Kersersnee _____

56. Het u in epiduraal ontvang? Ja Nee

57. Het u baba direk na sy geboorte gehuil? Ja Nee

58. Was daar enige fout met u baba by sy geboorte? Ja Nee

Indien wel, wat was fout? _____

59. Hoe het u gevoel foe u vir die eerste keer u baba gesien het?

Gelukkig opgewonde neutraal teleurgesteld ongelukkig

60. Hoe voed u u baba? Borsvoed ☐
Bottlevoed ☐

61. Het u enige voorbereidings getref vir wanneer die baba huistee sal kom?
Ja Nee

/8.....

62. Hoe voel u daaroor om die baba huis te hanteer?

Bang	Senuweeagtig	kalm	vol selfvertroue

63. Wie gaan u help met u baba?

	Ja	Nee
Eggenoot/kerel		
Ouers		
Vriende/familie		
Bediende		

64. Dink u dat u enigsins u u roetine gaan verander?

Ja Nee Indien wel, hoe _____

65. Het u enige veranderinge die afgelope jaar beleef?

Verhuis	Verlier/verandering van werk	Siekte	Verbrakkeling van huuelik of verharding

Ander spesifiseer _____

66. Het u eggenoot/kerel enige veronderinge die afgelope jaar beleef?

Verhuis	Verlies/verandering van werk	Siekte	Weermag oproep

Ander Spesifiseer _____

67. Het enige persoon, wat baie na aan u is, die afgelope jaar baie siek geword of gestref? Ja Nee

68. Enige ander informasie wat u ons wil meedeel of wil bespreek? _____

_____

_____

_____

Baie dankie vir u samewerking.

QUESTIONNAIRE B Questionnaire No. _____

Interviewer: _____

1. Date _____

2. Name _____

_____

3. Telephone No. _____

4. Marital Status - if changed _____

5. How have you been coping since the last interview?

Very well well satisfactorily not well poorly

6. Is caring for your baby different to what you expected?

If yes, specify? _____

_____

7. Who has been most helpful to you? _____

8. How are you feeding the baby now: _____

9. Have you altered the method of feeding your baby since you left hospital? [Yes] [No]

If yes, When _____

and why _____

What did you change from? _____

10. Does your baby wake during the night? [Yes] [No.]
If yes, how many times? _____

11. How would you describe your baby's crying in the first three months:

[frequently] [continually] [occasionally]

If constant, what did you do to pacify him/her? _____

How did this crying make you feel? _____

12. Do you feel your baby is restricting you in any way? [Yes] [No]

If yes, specify _____

13 Are you attending the well baby clinic? [Yes] [No]

If yes, how often do you attend? ___ _____

14. Have you got a road to health card? [Yes] [No]

If yes, can I see it? Growth: Weight _____

Height _____

15. Has the clinic helped you in any way? [Yes] [No]

16. Has your baby received the following immunizations?

B C G _____
First D W T and Polio _____
Second D W T and Polio _____
Third D W T and Polio _____

17. Since the birth has your baby been ill? [Yes] [No]

If yes, state what was wrong _____

_____

18. Whom did you consult? Hospital
General Practitioner
Clinic
Specialist
Paediatrician
Homeopath
Other - Specify

19. How often do you take your baby out of your home?

[Daily] [Three times a week] [Once a week] [less often]

/3.....

20. Are you on any form of contraceptive now? [Yes] [No]

If yes, what? Oral _____
Injection _____
Interuterine Device _____ Other _____

21. Have you returned to work? [Yes] [No]

If yes, [Full time] [Part time]

22. Who cares for the baby whilst you are working?
Mother _____
Child Minder _____
Creche _____
Maid _____
Relatives/friends _____
Other _____

23. How do you feel about this arrangement? _____

_____

24. Has the father of your child/your husband, helped you in any way? [Yes] [No]
If yes, specify _____

_____

25. Are you receiving financial support from: Husband _____
Boyfriend _____
Father of the Child _____
Family _____
The State _____
None _____
Other _____

/4.....

26. Do you see your family/friends?

Daily	Once a week	Fortnightly	Monthly

27. Are you in regular contact with any friend/family who are in a similar situation to you? Yes | No

If yes, specify _____

_____

28. What services in the community have been most helpful to you?

_____

_____

29. What services that are not available would you find helpful?

_____

_____

30. Is there anything about your child that worries you? Yes | No

If yes, who have you consulted? Doctor _____
Social Worker _____
Health Visitor _____
Hospital _____
Minister _____
Family/Friend _____
Other _____
Nobody _____

31. If you are unmarried what do you intend telling your child about his father? _____

_____

/5.....

BECK INVENTORY

Name_____ Date_____

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. **Be sure to read all the statements in each group before making your choice.**

1 0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.

2 0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.

3 0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4 0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5 0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6 0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7 0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8 0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9 0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10 0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11 0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

12 0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

14 0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19 0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.
I am purposely trying to lose weight by eating less. Yes_____ No_____

20 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

Dear _____

This is an extension of the research project you participated in during 1986/7 when you were in the maternity ward of either the Johannesburg Hospital or the J G Strydom Hospital. I am currently an Educational Psychology Masters student at the University of the Witwatersrand and hope to gain some additional information from you with regard to your school experience. The study is being undertaken under the supervision of the Department of Specialized Education of the University of the Witwatersrand.

You are participating in an extensive research project on mother's experience of pregnancy and childbirth. Attached you will find a short questionnaire which can be easily and rapidly completed. It would be appreciated if you would complete this questionnaire by ticking the appropriate response or filling in the necessary answers. On completion of the questionnaire, please return it in the reply-paid envelope by the 30th July 1988.

The data from this questionnaire are very valuable for the success of the project. Thus, by participating in this research project, you may be helping others. All information will be treated as strictly confidential and used for research purposes only.

Your privacy is guaranteed.

Thanking you for your courteous co-operation.

D A Danilewitz

I agree to co-operate:
(Signed) _____
Date _____

QUESTIONNAIRE ON SCHOOL EXPERIENCE

Please fill in your responses to the questions in the space provided. Where there are alternatives, please tick your response.

Name: _____ _____

Address: _____

_____

_____

1. Which school did you attend?

   _____

2. Was it a co-educational school?

   Yes No

3. (a) Which standard did you complete at school?

   Below Std 4, Std 5, Std 6, Std 7, Std 8, Std 9, Std 10

   (b) Which standard did your Mother complete at school?

   _____

   (c) Which standard did your father complete at school?

   _____

4. What was your general experience of school?

   Like 1 _ _ _ 2 _ _ _ 3 _ _ _ 4 _ _ _ 5 _ _ _ Dislike

5. What was your best subject at school?

   _____

6. Which subjects were problematic for you?

   _____

7. What overall percentage did you attain in your last year at school (to the nearest percentage)?

   Average - A(80%) B(70%) C(60%) D(50%) E(40%) F(30%)

8. What were your extra-mural school activities?

   _____

   _____

   _____

9. Did you experience any difficulties during your school years?

	Primary School	High School
- with schoolwork	_____	_____
- with teachers	_____	_____
- with discipline	_____	_____
- with friends	_____	_____
- with your own family	_____	_____

10. (a) How many friends did you have at school?

_____

(b) How intense were your friendships?

Close 1 _ _ 2 _ _ 3 _ _ 4 _ _ 5 Superficial

11. How much difficulty did you have in early adolescence, in making friends with the opposite sex?

Very little Little Average Great Very great

12. Did you ever have a steady boyfriend at school?

Yes No

If Yes, how old were you? _____

13. Did you go on dates with boys at school?

Yes No

If Yes, how often?

Seldom Frequently Regularly

14. Did you have a guidance teacher/social worker at your school?

Yes No

If Yes, was he/she approachable on issues related to:

Personal	Yes	No			
Family	Yes	No			
Friendship	Yes	No			
Sex	Yes	No			
Pregnancy	Yes	No			
Scholastic	Yes	No	Careers	Yes	No

If No, would you have wanted a guidance teacher to have been available to discuss such issues ?

Yes No

Which of the above areas would have you wanted your guidance teacher to cover? Specify _____

_____

15. Did you have any classes on sex education, relationship issues or contraception at school?

Yes No

If Yes, please specify _____

If No, would you have wanted such classes?

Yes No

16. Were you aware of forms of contraception when you were at school?
Yes No

17. From where did you get most of your information about sex before you were 15 years? (Please tick)

- Mother ☐
- Father ☐
- Brother/Sister ☐
- Other children ☐
- School classes ☐
- Reading ☐
- Parent of a friend ☐
- Had no information ☐
- Other (Please specify) _____

18. What information about sex and reproduction did your parents give you? (Please tick)

Menstruation	☐	Coitus	☐
Nocturnal emissions	☐	Venereal diseases	☐
Where babies come from	☐	Contraception	☐
Orgasm	☐	Pleasure of sexual relations	☐
Masturbation	☐	Difficulty of controlling	☐
Sex deviations	☐	sexual emotions	

19. Did you have to leave school as you were pregnant?
Yes No

20. If Yes, would you have wanted to complete your schooling at a special school for pregnant school girls?
Yes No

APPENDIX J

Table 1 Sociodemographic Variables

Variable	*s	m	s→m	Total	Chi Square	**Significanc Level
Age						
15-19yrs	22	7	12	41	32,733	
20-24yrs	43	29	20	92		p<0,01
25-29yrs	13	21	2	36		
30-34yrs	4	14	0	18		
35-40yrs	6	2	1	9		
	88	73	35	196		
Education						
0-Std 9	45	19	14	78	17,841	
Std 10	28	26	17	71		p<0,001
Post Matric	14	27	3	44		
	87	72	34	193		
Occupation						
Professional)	3	21	2	26		
Managerial)	1	1	0	2		
Secretarial	39	27	19	85		
Skilled)	11	4	2	17		
Semi Skilled)	11	5	2	18		
Housewife	7	15	8	30		
Scholar	7	0	2	9		
Unknown	7	0	0	7		
	86	73	35	194		
Family Background						
Parents Married	42	48	16	106	14,118	p<0,01
Parents Divorced	28	8	14	50		
Parents Died	15	14	4	33		
	85	70	34	189		

*s = Unmarried mothers
m = Married mothers
s→m = Mothers who married during pregnancy

** The significance level was set at 5% throughout the study.

Table 2 Prevention and Pregnancy

Variable	s	m	s↛m	Total	Chi Square	Significance Level
Contraception Usage						
Yes	42	52	11	105	13,4999	p<0,01
No	43	23	22	88		
	85	75	33	193		
Contraception Stopped to fall pregnant						
Yes	13	42	2	57	31,736	p<0,01
No	29	12	14	55		
	42	54	16	112		
Planned Pregnancy						
Yes	15	50	6	71	47,095	p<0,01
No	69	25	28	122		
	84	75	34	193		
Reactions to pregnancy						
Happy	47	67	24	138		
Indifferent	23	7	2	32		
Unhappy	11	1	5	17		
	81	75	31	187	24,425	p<0,001

Table 3 Emotional Sequalae and Support Networks

	s	m	s→m	Total	Chi Square	Significance Level
Normal	32	33	11	76	5,135	
Mild	4	12	5	21		p = ,5266
Mild-moderate	2	1	1	4		
Moderate-severe	1	1	1	3		
	39	47	18	104		

Using the t-test no significant difference was found between the three groups.

Support Networks						
Husband/Boyfriend	4	29	14	47		
Parents	27	12	7	46		
Maid	0	6	0	6		
Family/Friend	14	3	0	17		
	45	50	21	116		

Coping During Post-Natal Period (6 months)						
Well	44	44	17	105	3,850	
Satisfactory	2	7	4	13		p = ,1459
	46	51	21	118		

Table 4 Difficulty with Male Relationships during Adolescence

	Married	Unmarried (s+ s→m)	Chi Square	Significance Level
Very little	4	8	10,411	$p < 0,05$
Little	8	4		
Average	11	7		
Great	0	7		
	23	26		

APPENDIX K

LIST OF SCHOOLS

PRETORIA, WITWATERSRAND, VERENIGING
Alberton Hoerskool
Athlone Girls High School
Bedford High School
Blairgowrie High School
Bracken High School
Commercial High School
Damelin College
Discovery Commercial High School
Drie Riviere Hoerskool
Edenvale High School
Elsberg High School
Fakkel
Germiston High School
Greenside High School
Holy Rosary Convent
Hyde Park High School
J G Strydom School
John Jurgens High School
Kensington High School
Malvern High School
Mondeor High School
Nigel High School
Northcliff High School
Potchefstroom Girls High School
Pretoria Girls High School
Pretoria School for Art, Music and Ballet
Queens High School
Randburg High School
Roosevelt High School
Sandown High School
St Marys High School
Volksrust High School
Vorentoe High School
Waverly Girls High School
Westonaria Hoerskool
Witbank Convent

ORANGE FREE STATE
Bloemfontein : Redner High School

NATAL
Girls Colligiate School
Howick High School
Kloof High School
Northlands High School

CAPE PROVINCE
Tygerberg Commercial High

SWA/NAMIBIA
Windhoek : Hoerskool Akademia
ZIMBABWE
Harare : Arandul High School
MAURITIUS - Loretta Convent
BRITAIN - Cottesmore St Mary's Sussex

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Elsberg High School
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Greenside High School
Holy Rosary Convent
Hyde Park High School
J G Strydom School
John Jurgens High School
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Malvern High School
Mondeor High School
Nigel High School
Northcliff High School
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Pretoria Girls High School
Pretoria School for Art, Music and Ballet
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