Preventive Intervention with a Single Pregnant Patient
A Case Report

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ABSTRACT: A twenty-three-year-old single female in early pregnancy was referred to a psychiatrist because she was not willing to permit laboratory tests, nor a pelvic examination, to be done. Supportive and insight-oriented psychotherapy, explicit educational measures and enlisting supportive agencies in her local community were employed in her treatment. The patient was able to go through the gestation and delivery experiences successfully and ultimately to function as an adequate mother for her newborn infant.

Introduction

Although brief interventions with a single mother-to-be in a crisis situation must have been carried out on many occasions, a literature search failed to reveal a great deal of material written on the subject. There is a good deal written about support systems for single mothers as well as different community programs that have been recently developed. However, there is a paucity of material that deals with working directly with a single expectant mother on an individual basis. Numerous studies have shown low level of maternal support to be associated with an increase in post-partum problems and less than optimum outcome of the pregnancy.1,2 This case report demonstrates the actual intervention process and the subsequent favorable outcome.3

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Case Report

My first contact with Ms C. was in January of 1985 when a family medicine resident contacted the Department of Psychiatry for help with a twenty-three-year-old unmarried Caucasian female patient who was in her twentieth week of pregnancy and had refused to have her blood drawn or to allow a pelvic examination to be done for her.

On talking to her family doctor, the young woman showed ambivalent feelings about continuing with her pregnancy and, although she had tentatively agreed to continue with the pregnancy, she was not prepared to comply with the numerous requests made by her family practitioner.

Ms C duly appeared the next morning for a psychiatric session. Her opening remark was to assert that, while she had made this appointment at her doctor's insistence, she really did not think it would be of any use. I gratefully acknowledged her effort in coming to see me and after some introductory comments condoning her skepticism, set about collecting some data.

Ms C., at twenty-three years of age, lived with her grandmother who was also her adoptive mother. Her own mother had had no contact with her for the preceding ten years and Ms C had no idea of her biologic mother's location. She had known her unborn baby's putative father for the last two years and had "gone steady" with him until the time that she found out she was pregnant with his child. He had insisted that she have an abortion and, when she refused, he had stopped seeing her. She had not had any contact with him since that time. Her adoptive mother (maternal grandmother) had also urged, at first, that she should have an abortion, but when Ms C stood her ground firmly, the grandmother had suggested repeatedly that she should have the baby adopted as soon as it was born. The reason for this was that her grandmother felt that Ms C did not have the personal resources to bring up a child on her own.

Ms C smoked incessantly during the first psychiatric interview and otherwise appeared extremely anxious and edgy. She mentioned that she was not interested in discussing adoption or any other issue that involved giving up her baby. I assured her that I did not have any preformed agenda set up for her and her unborn child and that I merely wished to understand her problems as she saw them—and her ways of solving her problems. Ms C was not too sure about coming back; however, she decided to return and made an appointment for the end of the same week.