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# The Adolescent Childbirth Experience

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# SUMMARY

The phenomenon of adolescent childbirth is worthy of study because increasing numbers of adolescents in Québec are becoming pregnant, and deciding to keep their babies. Although the majority of pregnant adolescents decide on abortion, there is a rise in the numbers of those who continue their pregnancies. Many of these adolescents tend to have a background of social or economic deprivation, and, consciously or unconsciously, seek motherhood as a means of providing them with a role and a status that they are not able to achieve otherwise. Many of these young mothers hold no particular ambition for their lives, and have not completed high school or CEGEP when their child is born.

Childbirth is acknowledged to be an event of great significance in the life of any mother. It exposes the woman to a range of emotional, and physical sensations hitherto unknown, and tests her confidence and endurance. The first childbirth experience is particularly important because it is the one that marks the transformation to motherhood. The experience of childbirth may affect the woman's relationship with her child, her partner, and the quality of her parenting. Adolescents do not necessarily come to the experience of childbirth with the same expectations or life experience as adults. Their experience deserves closer examination than it has yet been granted.

The goal of this present study has been to describe from the point of view of the adolescent what it is like to give birth. The study used a descriptive phenomenological approach, with the analysis guided by Giorgi (1997).

Eight English-speaking adolescents participated in the research study, aged between 16 and 18 years. The participants were chosen according to a convenience sample. Of the eight participants, six gave birth in one of three different teaching hospitals in the Montréal region, one gave birth at a birthing centre, and one gave birth at home. The following five themes emerged from the analysis of their descriptions: a) a need for presence and support, b) pain and its meaning, c) a need for a sense of control, d) childbirth as an accomplishment, and e) childbirth as a maturing process. The essential meaning of the

phenomenon was desdribed as: *Childbirth can be an empowering experience for the adolescent which precipitates the attainment of adulthood.*

This study allowed a deeper understanding of the meaning of the experience of childbirth for adolescents from their perspective. The findings of the study highlights the need by adolescents for accompaniment and support during labour and delivery from their family, partner, and caregiver. Knowing the caregiver prior to the birth can help the adolescent develop confidence and trust, and feel a greater sense of control. With the birth of their child, the interests and preoccupations of the typical teenager give way to concerns for the care and wellbeing of the baby. Childbirth brings the adolescent over the threshold into adulthood. Particularly for previously disenfranchised adolescents, childbirth can be a great accomplishment, in contrast to the rest of their life where they have had few previous successes. Childbirth can bring the adolescent new confidence, a sense of pride in themselves and their child, and a new orientation for their lives.

Study findings give rise to a number of nursing implications. Adolescents in childbirth need caregivers to be sensitive to their needs for help and comfort even in the presence of their partner or family members. Consideration should be given to adolescents' choices regarding support persons, management of labour and birth, and birth place, as well as alternatives to pharmaological pain relief. In accordance with WHO recommendations, help should be given in establishing and continuing with breastfeeding. Changes are also needed in social attitudes and policies, recognising the endeavours of teenage mothers, and smoothing the way for them to succeed.

Research recommendations include the following: that a similar study be made with French-speaking adolescents, that there be an exploration of the adolescent father's perspective in childbirth, that there be a study about initiation, cessation and persistance in breastfeeding, and that a study made with a younger adolescent age group, as was the original intention of this study.

# RÉSUMÉ


## La problématique

L'accouchement est un événement majeur dans la vie d'une femme (Oakley, 1993). Des recherches sur la femme adulte ont montré que l'expérience de l'accouchement peut transformer la perception et l'estime de soi ainsi que la relation avec le nouveau bébé et avec le partenaire (Butani et Hodnett, 1993). C'est un jalon qui inspire la femme pendant de nombreuses années.

Les grossesses d'adolescentes ont augmenté au Canada ces dernières années (Miller et Wadhera, 1998). La tendance est analogue au Québec, en particulier dans le groupe des 14-17 ans, où le taux de grossesse est passé de 12,6 pour 1000 en 1980 à 20,1 pour 1000 en 1993 (Secrétariat de la condition féminine, 1997). La plupart de ces jeunes femmes décident d'avorter. Certaines choisissent cependant de mener leur grossesse à terme. Au Québec, le nombre de ces naissances a peu varié pendant la dernière décennie. L'adolescente qui accouche et qui garde son bébé est en général issue d'un milieu démuni. Elle voit dans l'enfant une solution à ses problèmes, croyant qu'il lui apportera l'amour, l'attention et le statut social auxquels elle aspire ardemment (Adler & Tchann, 1993; MSSS, 1993).

La grossesse et l'accouchement de l'adolescente ont été abondamment étudiés, mais rarement du point de vue subjectif de l'adolescente. L'essentiel de la recherche est d'ordre psychologique ou sociologique, avec peu d'apport des sciences infirmières. La recension des écrits identifie les thèmes suivants: l'accouchement de l'adolescente, y compris les étapes du développement de celle-ci, la grossesse de l'adolescente, les conséquences de l'accouchement et l'importance de l'expérience de l'accouchement pour la femme. Cette recension décrit en outre la théorie humaniste des sciences infirmières qui sert de cadre de référence à cette recherche.

Il est fréquemment écrit que l'adolescente accouche simplement (Charbonneau et al., 1989). Sa perception de l'accouchement a cependant été peu étudiée. Pour appuyer sa pratique, l'infirmière dispose donc, de peu de règles issues de la recherche sur l'adolescente. Mieux comprendre l'accouchement de l'adolescente permettrait d'améliorer l'échange entre celle-ci et l'infirmière pendant cet événement marquant.

L'objectif de cette recherche est de décrire et de comprendre, selon son point de vue, l'expérience de la mère adolescente qui donne naissance à son premier enfant. La question à laquelle la recherche tente de répondre est celle-ci:

Quelle est l'expérience vécue par la mère adolescente pendant son accouchement ?

## Méthode

Il s'agit ici d'une recherche phénoménologique descriptive, par opposition à la tradition herméneutique, qui est interprétative. La phénoménologie husserlienne, utilisée comme méthode de recherche, veut décrire l'expérience ordinaire des gens. C'est une méthode axée sur la découverte plutôt que sur la vérification d'une hypothèse (Davis, 1978; Omery, 1983).

La recherche a suivi toutes les étapes requises par la méthodologie chosie, à partir de la réduction phénoménologique. Le chercheur doit «mettre entre parenthèses» sa connaissance et sa compréhension du phénomène étudié (Munhall, 1994; Psathas, 1973; McCormack Steinmetz, 1991). Il peut ainsi entreprendre ses entrevues avec un esprit ouvert et décrire l'expérience des participants sans préjudice.

Chaque participante fut interviewée chez elle ou dans une pièce privée de l'école où résidaient deux d'entre elles. Les entrevues furent menées à l'aide d'un

guide d'interview. Chaque entrevue fut enregistrée sur bande magnétique avec la permission de la participante et fut ensuite transcrite. Une seconde entrevue fut menée pour compléter la première.

Huit adolescentes anglophones, agées de 16 à 18 ans, ont participé à cette recherche. Chacune y a décrit son premier accouchement. Les participantes ont accouché dans diverses institutions de Montréal, ce qui reflète l'éventail des choix offerts aux futurs parents. Six participantes ont accouché dans un des trois hôpitaux universitaires, une a accouché dans un centre de naissances et la dernière a accouché à la maison avec l'aide d'une sage-femme.

L'analyse a été faite selon la méthode de Giorgi (1997). Tel qu'il le recommande, l'intuition a été mise à profit pour étudier les données, pour donner un sens aux unités de signification aux thèmes et pour découvrir la structure essentielle de l'expérience vécue.

## Critères de rigeur

Les critères de rigeur employés pour cette recherche sont ceux de Lincoln et Guba (1989). Bien qu'ils ne soient pas phénoménologues, leurs critères d'évaluation sont appropriés et ont été utilisés avec succès lors de recherches phénoménologiques antérieures (Pépin, 1997).

Lincoln et Guba (1989) appliquent entre autres le critère de la crédibilité, qui est obtenue lorsque la participante à la recherche approuve la description et l'analyse de l'entrevue rédigées par le chercheur. La description et l'interprétation initiales ont été soumises à l'approbation des participantes. La «transférabilité» est le deuxième critère identifié par Lincoln et Guba, qui le disent relatif. Il faut une description soignée des données pour transférer à une population similaire les jugements portés sur le groupe étudié.

Le troisième critère de Lincoln et Gruba est la consistance des résultats. Cette recherche a été vérifiée et critiquée par des experts. Le dernier critère est la neutralité, reconnue dans la recherche conventionnelle. La «mise entre parenthèses» aide le chercheur à approcher le sujet d'étude sans préjugé. La logique des thèmes de recherche a été formulée de façon explicite pour s'assurer que la voix des participantes soit entendue sans parti-pris.

## Limites de l'étude

Il n'est pas certain que les résultats d'une étude qualitative puissent être généralisés, mais ils peuvent aider à comprendre des populations semblables. Les participantes à cette recherche étaient anglophones, donc minoritaires dans une ville majoritairement de langue française comme Montréal.

## Considérations Éthiques

Afin de protéger les droits des participantes à cette recherche, des principes éthiques ont été respectés. Chaque participante a reçu une explication, verbale ou écrite, sur la nature, la durée et le déroulement de la recherche et sur son droit de s'en retirer en tout temps. Chacune fut assurée de la confidentialité de la recherche et de la destruction des bandes magnétiques à la fin. Des noms fictifs ont été donnés aux participantes et le nom de leur institution n'a pas été révélé.

## Résultats

L'analyse a révélé cinq thèmes qui reflètent l'expérience d'accouchement des mères adolescentes: 1) le besoin de soutien et de présence, 2) la douleur et le sens qui lui est attribué, 3) le besoin de se sentir maître de la situation, 4) l'accouchement en tant qu'épanouissement et 5) l'accouchement comme entrée dans le monde adulte.

La structure essentielle de l'expérience vécue est décrite ainsi:

L'accouchement peut être une expérience émancipatrice pour l'adolescente, précipitant ainsi le passage à l'âge adulte.

## Discussion

Les résultats de cette recherche montrent que l'adolescente partage plusieurs des attentes et des désirs de la femme adulte au sujet de son accouchement. Bien qu'elles dépendent surtout de leur famille ou de leur conjoint pour le réconfort, les adolescentes se sont montrées très sensibles aux attitudes du personnel soignant et à l'affût de toute discrimination sur la base de leur âge.

La plupart des participantes ont accouché à l'hôpital et ont reçu une épidurale. Deux participantes ont accouché hors de l'hôpital et n'ont pas eu accès aux analgésiques pharmaceutiques usuels. Elles ont trouvé des solutions de rechange pour affronter la douleur, comme le massage, la marche ou la distraction et elles s'en sont trouvées fières et fortes.

Les participantes ont senti le besoin de maîtriser la situation et de prendre les décisions relatives à leur accouchement. Les concepts de maîtrise et de douleur semblent entrelacés. Supporter la douleur leur a donné une plus grande impression de maîtrise et vice versa.

Toutes les participantes ont trouvé dans l'accouchement un grand épanouissement. Ce sentiment semble d'autant plus fort qu'elles avaient jusque là peu de réalisations à leur compte.

Chaque adolescente est déterminée à être une bonne mère pour son enfant, même si chacune a sa propre définition. Plusieurs ont revu leurs règles

de vie, plaçant les intérêts du bébé en tête de liste et trouvaient qu'il leur reste peu en commun avec leurs anciens amis.

Alors que la plupart des études traçent un sombre portrait de la grossesse et de la maternité des adolescentes, cette recherche renforce les vues de Smithbattle et Leonard (1998), selon qui la maternité à l'adolescence apporte souvent plus de gains que de pertes, spécialement pour les adolescentes qui se sentent déjà exclues. Bien que cette recherche ne couvre que le début de la maternité, toutes les adolescentes avaient trouvé à la fois un nouveau sens à leur vie et une nouvelle détermination.

## Recommandations

Le personnel soignant doit être sensible au besoin d'aide et de réconfort de l'adolescente, même en présence du conjoint ou des membres de la famille de celle-ci. Le personnel devrait chercher à accroître le soutien émotif, par opposition au soutien technique et à développer d'autres formes de soulagement pendant le travail et l'accouchement, tels que le massage, le bain tourbillon ou des types d'épidurales qui permettent de se mouvoir. L'adolescente qui le désire devrait être encouragée à allaiter et ne pas se voir imposer d'obstacles par le personnel hospitalier.

Une recherche semblable menée auprès d'adolescentes francophones pourrait cerner d'autres facettes du phénomène, puisque les établissements de santé et les organisations de soutien de la population francophone sont distincts. Il est aussi recommandé que trois dernières recherches soient réalisées, la première auprès des pères adolescents, la seconde sur ce qui motive la mère adolescente à commencer l'allaitement et à le continuer, la dernière sur les très jeunes adolescentes, soient celles de moins de 16 ans. La présente recherche n'a pas couvert ce groupe d'âge.

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# INTRODUCTION

Adolescence is a time of exploration of oneself and the world around one, a time of uncertainty, of physical and emotional change. It is a testing of one's limits and one's beliefs, and a time when choices are made about the future. For an increasing number of adolescents, sexual exploration results in pregnancy, and the necessity to choose whether to terminate or continue the pregnancy. Most choose the first option, but many also decide to continue the pregnancy, and keep their child. Those who decide to keep their babies, often do so out of the belief that they will find the affection and status that they are not able to achieve otherwise, and a solution to their problems.

Research into the experience of childbirth has demonstrated it's significance as a event that brings into being both a new life and a mother. It is an experience that may have long-lasting physical, emotional and spiritual affects. The literature on the experience of childbirth is extensive, but has largely neglected the subjective experience of adolescent childbirth. This phenomenological study describes the first childbirth experience of eight adolescents in the Montréal region.

This memoire is composed of five chapters. The first describes the research focus, the purpose of the study and the research question. The second chapter reviews the literature pertinant to the study, adolescent development, adolescent pregnancy and motherhood, childbirth, health consequences for the adolescent mother, as well as outlining the theory of humanistic nursing by Paterson and Zderad (1988) which serves as the nursing theory on which the study is based. An explanation of the origins and use of phenomenology as a research method is presented in chapter three, with specific examples of the research process used in this study. The fourth chapter presents the findings of the study, and is composed of the five themes that emerged, illustrated by extracts of participant interviews. A discussion of these findings makes up the bulk of the fifth chapter, along with implications for nursing practice, and recommendations for further research.

Findings from the study demonstrated that adolescents shared many of the same needs and aspirations for their childbirth experience as adult women. They felt a need for the active presence of their partner and family members as well as a caregiver they knew and trusted. Childbirth brought an overwhelming sense of accomplishment to the adolescents in this study. The birth of a baby brought a new sense of purpose to their lives, in tending to their child or in continuing their schooling. What the future holds for them will be determined by not only their own efforts, but also by the social policies that will support these efforts.

It will be noted that this thesis is written in the first person. This is congruent with a number of other phenomenological works, where it is considered that use of the first person helps bring the reader closer to the research process (Ely, Anzul, Friedman, Garner & McCormack Steinmetz (1991); Loftus, 1998).

# RESEARCH FOCUS

Childbirth is not only significant as an experience in itself, but also as the threshold through which one passes into mother/parenthood. It marks the end of one period of life, and the beginning of another, with all the responsibilities, worries, frustrations, and of course, joy, that children can bring. As a mother, amongst other mothers who remember their childbirth experiences with pleasure, or sadness, I have found that women continue to dwell on their experience for many years after the event. Being a nurse and having shared some womens' experience of pregnancy and childbirth, it has become clear to me that the objective impression of a satisfactory labour and delivery with a healthy baby at the end, does not always reflect the subjective experience of the individual woman despite recent attempts to humanise the process. This has been reflected in, for example, the recent moves to legalise midwifery care in a number of provinces, including most recently Québec, because of a grassroots women's movement seeking alternatives in perinatal care (Fouillard, 1993). Although it is often proposed that the adolescent experience is usually straightforward and unproblematic (Charbonneau et al., 1989) there is little in the research to show subjectively whether or not this is necessarily the case, or exactly how the teenager experiences this process.

There has been much research and reflection about adolescent pregnancy, and a copious amount of literature about many aspects of both adolescent pregnancy and childbirth. This includes discussion of ethnicity and race (Hofferth, 1987; Lawson & Rhode, 1993), risk factors (Morris, Warren & Aral, 1993; Charbonneau et al., 1989; Combs-Orme, 1993; Ferguson, 1987; Hofferth, 1987), motherhood (Bergum, 1997; Serey, 1992; Williams, 1991), decision-making (Cervera, 1993; Cloutier, 1988), the motivation behind pregnancy (Adler & Tschann, 1993; Courtecuisse, 1994), the role of the partner (Miller & Wadhera, 1997; Nichols, 1993; Resnick, Chambliss & Blinn, 1993), and pregnancy prevention programs, (Christopher, 1995; Males, 1993; Bayne Smith, 1994), but virtually no research literature specifically concerned with the adolescent's perceived experience of childbirth, and only limited amounts on her

experience during pregnancy (Bergum, 1997; Sternberg & Blinn, 1993).

Not all adolescents may consciously reflect on the experience of childbirth, but authors such as Kitzinger (1962), Levesque-Lopman (1980), and Bergum (1997) have helped to highlight its importance as a transformative experience in the life of a woman, a "rite of passage" (Oakley, 1993). It is known from studies with adults, that the experience of birth can affect not only the woman's self-concept and self-esteem, but also her relationship with and attitudes towards her newborn baby and partner (Butani & Hodnett, 1980; Kenner & MacLean, 1993). Both Sheila Kitzinger (1984) and Penny Simkin (1991, 1992) point out that the experience of birth is central to a woman's life, and that years later many women can recount the details of their childbirth. The memory they hold of their experience may affect the attitude held by those around them of childbirth as something to dread or to celebrate.

Research with adults has shown that the mother or parents' experience of childbirth may affect their feelings for their child, as well as the type of parenting they do (Kenner & MacLaren, 1993; Weatherston, 1985). This may have implications for their persistance in breastfeeding, their self-confidence, and their attitude towards themselves and their child (Green, Coupland & Kitzinger, 1990). Oakley(1979), perhaps provocatively to some, states that "the meaning of childbirth is interlocked with a society's attitude towards women"(p.10). The process of labour is determined not only by the woman's wishes or needs, but also by cultural values and believes about birth, women and their bodies, varying widely in today's society (Raphael-Leff, 1991).

The childbirth experience has been shown to have a powerful influence on women's lives (Halldorsdottir & Karlsdottir, 1996; Simkin, 1991), but there is little research to show what is the experience of the teenage mother who is also influenced by her childbirth experience. As either an enhancing experience or one that has increased her sense of powerlessness or inadequacy, it can surely

influence the reality of her life with a dependent baby.

Nurses who work in labour and delivery have apparently little scientifically based knowledge specific to the adolescent on which to base their care. There is a paucity of studies that explore the experience of childbirth specifically from the point of view of the adolescent, and virtually none in the nursing literature. Because knowledge is limited about how the adolescent experiences childbirth, what is important to her, what are her needs and expectations, it is not easy for the nurse to respond appropriately to the adolescent. Nursing care, therefore, is mainly based on knowledge about the adult, since there is no real evidence that demonstrates the similarities or differences in adolescent needs or expectations.

Humanistic nursing practice, as developed by Paterson and Zderad (1988) requires an interaction or sharing with others, and a recognition that each human experience is unique but also shared. Paterson and Zderad's humanistic nursing theory was founded on the tenets of humanistic psychology, an orientation which aims to understand people from the context of their experience of living in the world. A search for a deeper understanding of the adolescent experience of childbirth on the part of the nurse can only enhance that interaction, and allow for a more profound dialogue to be established between nurse and adolescent. Humanistic nursing is concerned with phenomenological experience, or the "exploration of the human senses" (Praeger, 1995, p.302) with its ultimate aim being better able to respond to the 'call' of the other person, and to bring comfort.

The experience of childbirth has been demonstrated to be of great importance to the relationship the adult woman may establish with her baby and her partner, and to her feelings about herself as a person. In the context of today, where little is known about the adolescent experience of childbirth, despite increasing numbers who are giving birth ( Loignon, 1996; Secretariat de la condition féminine, 1997), and that the end result of producing a healthy baby

can cause the woman's experience to be neglected, it seems to the author to be of benefit to seek a greater understanding of the adolescent experience in order to better adapt nursing care and answer the call of this population.

## Purpose of Research Study

This study aimed to describe the experience of the adolescent mother giving birth to her first baby, from the point of view of the teenager herself, as a first step in understanding the experience.

## Research Question

The ways in which adolescents perceive their experience may help nurses to adapt their care, to be more fully engaged with the adolescent and thus develop more appropriate ways and theories of caring, for the ultimate benefit of this population. Therefore this research study has sought to answer the following question as a first step towards understanding:

What is the lived experience of the adolescent mother in childbirth?

This chapter has presented the phenomenon of adolescent childbirth that is the focus of this study. It has also presented some of my own views on the importance of the childbirth experience to women, and the imperative to look further at the adolescent mother's experience of childbirth, when their life circumstances are often already complex. The following chapter presents some issues from the research literature relevant to the study.

# REVIEW OF THE LITERATURE

There is a sizeable amount of literature pertaining to teenage pregnancy and childbirth, but most has been written from an objective rather than a subjective point of view. As well, most of the research to date on the many aspects of the phenomenon has been quantitative, rather than qualitative, and the perception of the teenage girl herself has been largely ignored. There is some literature pertaining to teenage pregnancy and childbirth in the domain of nursing, but the bulk of research occurs in the fields of psychology or sociology. This literature review therefore follows several themes in describing some of the research that has been done in all three fields. It covers a number of aspects including adolescent development, teenage pregnancy, consequences of adolescent childbirth, the importance of the childbirth experience to women, and finally an overview of humanistic nursing theory.

## Adolescent Development

Adolescence is a time of turbulence, of tremendous physical, cognitive, psychological and emotional growth, that is generally associated with the onset of puberty up to adulthood, roughly from age 11 or 12 to 18 or 22 (Harris,1993; Kaplan,1991). Adolescents begin their search for identity, in this stage identified by Erikson (1959) as identity vs. role diffusion (confusion). They seek to forge their own separate identity, while at the same time remaining influenced by their culture, and the attitudes and values of their parents (Kaplan, 1993).

Since the turn of the century in industrialised countries, puberty has been occurring at an increasingly early age, and is generally thought to be due to better nutrition and health. The onset of menarche has been found to occur as early as 10, and already by the age of 14 many young girls have the appearance and 'allure' of a woman (Charbonneau et al., 1989). These early physical changes also signal the earlier onset of desire and sexual tensions in the young girl (Lambert & Paré quoted in Charbonneau et al., 1989), with a more conflictual and distant relationship with their parents (Kaplan, 1991). A Québec government

document, presenting the results of several years of reflection and consultation with researchers and professionals in a number of fields, describes adolescence as a time of self-affirmation, and an increased identification with friends over parents (MSSS, 1993).

In an address to the Prevention of Adolescent Pregnancy Symposium, in Saskatchewan, Hendricks (1982) described adolescence as a time of extremely rapid change, second only to the first two years of life. She claimed that this is both an asset and a liability since adolescents may be more vulnerable if given insufficient support, but also more resilient and able to 'bounce back' when a crisis occurs. As they pass through adolescence, they gradually gain mastery over their environment by undertaking developmental tasks including motor, social, and emotional skills (Hendricks, 1982). Some developmental tasks predominate over others, depending upon their particular stage of adolescence. A large scale report on adolescent pregnancy and birth, by Charbonneau and colleagues (1989) described adolescence as a period of evolution, transformation, and biological, cognitive and psychological change. As they move through adolescence, individuals develop the ability for self-reflection, and to see themselves at a future time. Their moral behaviour evolves from one based on fear or the wish for compensation, to one of conventional judgement based on approval by others and the maintenance of authority and progress, and finally to a morality of principles based on rights and liberties and individual and universal principles (Charbonneau et al, 1989).

Adolescents often feel that they have an imaginary audience (Charbonneau et al, 1989; Harris, 1993) that watches them with a critical eye. They spend much time thinking about themselves and their appearance, and may imagine that a bad haircut or a blemish will be remarked on by everyone around them (Harris, 1993). Egocentrism interferes with their perception, and inhibits teenagers from imagining that they are not the first to feel the way they do, or experience what they are experiencing (Harris, 1993). It may also lead them to feel they have a

great purpose in life, or that they are not subject to the same risks as everybody else (Harris, 1993).

Adolescents like to test their limits and feel a sense of power, caught between the idea of being sexually responsible and having confidence in fate (MSSS, 1993). Approximately half who commence sexual relations use effective contraception, although some avoid it because of family or religious restraints. It is common for teenagers to have a sense of invulnerability, a 'pensée magique', where bad things only happen to others. Peers begin to play an increasingly important role, to compare themselves with, and finding in them what has been rejected in adults (Charbonneau et al, 1989).

## Stages of Adolescence

Generally adolescence is divided into three developmental stages, early, middle and late, beginning around the age of 11 or 12, and ending at approximately 17 or 18 to 22 years (Hendricks, 1982; Kaplan, 1991). It is a time of not only physical and conceptual maturation, but is also a gradual evolution from concrete to formal operations, (the ability to think abstractly), an increased need for peer group membership, and the experimentation with sexual relationships (Hendricks, 1982). Adolescence is a time of turmoil caused by the physical changes occurring, the loss of body control, and hormonal influences on emotions (Miller, 1974).

Early adolescence. Early adolescence refers to the stage between approximately 11 or 12 to 15 years of age (Hendricks, 1982; Kaplan, 1991; Miller, 1974). Early adolescents find that they are suddenly treated as sexual beings, something they are not necessarily ready for, and Miller (1974) believes that adolescents at this stage unconsciously look for control to counteract the restlessness and tension they feel. They may use sex as a way of rebelling against their parents (Trad, 1993). Their sex role identity becomes strengthened

and they may have sexual relations out of curiosity about their bodies, to please their boyfriends (Trad, 1993), or to fit in with what they believe to be the normal behaviour of their peers.

Contraceptives pose difficulties for early adolescents because most have an impact on the body image, and on the person as a sexual being (Hendricks, 1982). It is hard for adolescents to relate to abstract notions of contraception, or to conceptualize the abstract notion of pregnancy (Hendricks, 1982) They may be 12 or 14 before they can actually manifest the ability to think abstractly (Drake, 1995). Young adolescents spend much time talking, thinking and fantasizing about sexual relationships, and there is increasing peer pressure to begin dating or sexual activity (Hendricks, 1982). They may indulge in impulsive behaviours, such as sex because they are unable, or do not think about the consequences which may result, such as sexually transmitted disease, or pregnancy (Trad, 1993). Their sense of invulnerability may lead them to think that it is only others who are at risk from behaviours such as unprotected intercourse (Mercer, 1990).

Middle adolescence. Most of the changes of early adolescence are consolidated during middle adolescence, described as being between the ages of 14 or 15 to 18 years. Middle adolescence is a period of self-identification and self-realisation, when adolescents look to develop their own self-identity, and make choices about what to do with their lives (Miller, 1974). The peer group takes on great importance for identity, support, and the testing out of ideas (Mercer, 1990). Standards for behaviour may be set by role models within the peer group (Mercer, 1990). It is a period of testing family values and struggling with dependence on parents vs. a wish for independence (Stenberg & Blinn, 1993). Mood swings are common, as are changes in self-esteem.

Sexual identity development for boys centers around an interest in the pleasure of sexual activity, while for girls, the focus is more on the development of intense loving relationships with boys (Charbonneau et al., 1989). When family

and significant adults encourage middle adolescents to explore ideas, values, and feelings about relationships and sexual desires, adolescents can further develop their autonomy and identity (Miller, 1974). With their increased capacity for abstract thinking, Mercer (1990) believes that the middle adolescent is capable of feeling concern about the health of a baby.

Late adolescence. The task of autonomy in late adolescence, age 17 or 18 to 22, includes developing skills necessary to independence, and related to an occupation, marriage, or a long-term relationship, a moral code and a socio-political ideology. Becoming independent from one's parents is a process that begins in early adolescence but is particularly important in late adolescence. There is an interest in trying out one's new identity, and learning to cope with the complexity of adulthood (Mercer, 1990). Drug or alcohol use, or pregnancy may be manifestations of this drive (Hendricks, 1982).

The difficulty of finding a meaningful role in contemporary society is believed by many to account in part for an increasing mortality rate in the adolescent population due to suicide, accidents, and homicide (Hendricks, 1982). On the other hand, more formal thought processes allow the teenager to understand abstract concepts and long-terms consequences, and therefore behaviour tends to be more responsible on the whole (Stenberg & Blinn, 1993). By late adolescence egocentricity and idealism has generally diminished, and the adolescent comes to terms with the world as it is (Harris, 1993). From playing with friends they grow to a relationship of solidarity and reciprocity.

## Adolescent Development and Motherhood

Motherhood occurring during adolescence means balancing personal and self-identity needs with those of a child, making extra-ordinary demands on the mother who is also often socially isolated (Charbonneau et al., 1989; Mercer, 1990; MSSS, 1993, Sternberg & Blinn, 1993). Despite their precocious sexuality,

they still have developmental tasks to undertake, and piling adaptation to motherhood on top of this can create added stress (Olds, London & Ladewig, 1996). Reconciling her own developmental needs with the needs of her baby may be very difficult (Stenberg & Blinn, 1993).

The concept of a baby developing inside her may be beyond her capacity for abstraction, and she may therefore not realise the importance of good nutrition or of gaining weight during her pregnancy (Stenberg & Blinn, 1993). The life style of pregnant adolescents is often lacking because of inadequate nutrition, tobacco and alcohol consumption, the absence of physical exercise, and general stress (MSSS, 1993) which can have consequences for her own and the baby's health.

An early adolescent may keep her pregnancy secret, even to her parents, and receive no prenatal care, while the middle adolescent may be more concerned about the effects of her behaviour on her fetus (Mercer, 1990). The middle adolescent may be untrusting and uncooperative with parents and health care providers and often places the blame for her pregnancy on someone else (Mercer, 1990). She is usually stoic and idealistic, but may also boast about her symptoms of pregnancy (Mercer, 1990). By the time she reaches late adolescence however, she has usually mastered abstract thinking and is capable of accomplishing the developmental tasks of pregnancy as an adult. Since her dependency needs are less than in younger adolescents, the late adolescent is capable of motherly, nurturing feelings towards the baby both before and after the birth (Mercer, 1990).

Research into teenage mothers' narratives of self by Smithbattle (1995) challenged the dominant ideology that teenage mothering risks the future. Her hermeneutic-phenomenological study involved interviews with 16 teenagers from diverse backgrounds, ranging in age from 14 to 18 years. In three monthly home-based interviews, participants were asked to describe their experiences of life

before pregnancy, and decisions, emotions and considerations regarding the pregnancy, birth, and the early months of motherhood. Infants were between eight and 10 months old at the time of interviews. Participants fell into three groups, depending on their pre-pregnancy economic and family situations. In each case, mothering was not found in itself to jeopardize their lives or limit their futures. For those adolescents whose impoverished pasts already had granted them a diminished future, motherhood only accorded with the social identity already conferred on them. It did not reduce their life chances, when they already had so little future to hope for. A second group of participants found motherhood to be a world-transforming connection, one that 'granted them a future', which depended however on the availability of nurturing they receive, as well as the availability of resources to assist them. The third group of teenagers came from more stable, secure backgrounds. Their potential for future success seemed to be compromised by early motherhood. However, this group was highly motivated to pursue their education, and received substantial family support and community resources to help them do so. From their perspective, mothering gave them more than they had lost. (Smithbattle, 1995) was careful to point out that for many teenagers, past experience has already foreclosed their future, even before pregnancy. It is supportive policies, family and communities that make the difference in the lives of teenagers, and these must be encouraged in order to provide teenagers with hope for the future (Smithbattle, 1995). It is not the mother's age in itself that results in poor outcomes for herself and her child, as Smithbattle reiterates in a later follow-up study, but what she calls the socially-toxic conditions associated with poverty that endanger mothering and childhood (Smithbattle & Leonard,1998).

## Teenage Pregnancy

The phenomenon of teenage pregnancy has become of increasing concern over recent years not only because of its continued frequent manifestation, but also because of the serious personal and social consequences that often result.

The province of Québec figures amongst the lowest in Canada in terms of numbers of adolescent pregnancies, but it is nonetheless perturbing to note an acute augmentation over the last two decades, particularly in the 14 to 17 year old age group from 12.6 per 1000, in 1980 to 20.1 in 1993 (Secrétariat de la condition féminine, 1997). Recent statistics published by the government of Québec reported the 1995 rate of adolescent pregnancy to be 18.4 per 1000 between the ages of 14 to 17 years (MSSS, 1999). The extent of this phenomenon, the report states, justifies the maintenance or intensification of pregnancy prevention programmes and improved contraceptive measures. A 20-year examination of adolescent pregnancies recently published reported that the rate of teen pregnancy across Canada is reaching levels not seen since the 1970's, and that an apparent decline in 1995, did not reflect the overall trend (Miller & Wadhera, 1998).

## Context and Motivation

It may seem paradoxical that an increasing numbers of young girls are becoming pregnant in an age when information about sexuality and contraception is apparently widely available. It has been found however, that adolescents are generally ill-informed about contraceptive choice and are subject to a variety of myths about both sexual intercourse and contraception (Charbonneau et al., 1989; Loignon, 1996). According to Brown, Saunders, & Dick, (1998), young adolescents plan only for the present without any consideration of long-range consequences, so pregnancy may occur unexpectedly. It could be assumed that pregnancies in unmarried teenagers are accidental, the result of failure in contraception, and that therefore abortion would provide a ready solution to a problem. The adolescent would thus supposedly be enabled to continue her life and her studies unhampered by a child. Adler & Tschann (1993) question those who study the phenomenon of adolescent pregnancy with the assumption that it is unwanted, since they have found that there are also reasons to believe that there may also be both subconscious and conscious motivation for pregnancy.

Preliminary results from their research on adolescent pregnancy motivation showed that preconscious motivation may predominate, where the girl desires but does not actively seek pregnancy (Adler & Tschann, 1993).

For some adolescents the pregnancy may indeed be unintentional, due to contraceptive failure, or out of the wish to please their boyfriend, and in such a case, abortion may be a solution. However, this does not eliminate the possibility of future mistakes, or preclude further pregnancies. Recent research has demonstrated that in many instances the adolescent has chosen pregnancy, consciously or unconsciously, as a means to escape from her current life situation, or more poignantly still, in the hope that a baby may fulfill her need for love and affection (Adler & Tschann, 1993; Bélanger & Charbonneau, 1994; Sécretariat à la condition féminine, 1997). Most often those teenagers who have chosen pregnancy are found to have a background of social or economic deprivation, where in their view conscious or subconscious, they have not been sufficiently valorised, or given the family love and support they felt they needed (Charbonneau et al., 1989; Secrétariat à la condition féminine, 1997). With no particular interests or ambitions, the adolescent imagines that a baby will bring her attention and provide her with a status she cannot achieve through other means (Adler & Tschann, 1993; Bélanger & Charbonneau, 1994; Charbonneau et al., 1989; Hayes, 1987; MSSS, 1993). Under the spell of "la pensée magique" she is unable to predict the responsibilities, the isolation, and economic hardship that will almost inevitably result from her project. Smithbattle & Leonard (1998) describe the impoverished teenager as 'drifting' into pregnancy, knowing that delaying it will not make much difference in their already compromised lives. The pregnancy may be unintended, but is welcomed by the time of birth (Smithbattle & Leonard, 1998).

People who work in schools or clinics with young pregnant teenagers attest to the increasingly complex problems which these young women carry with them. A substantial number are already under youth protection services when they

become pregnant (personal communication, Elizabeth House, 1997), or have lived in a variety of group or foster homes. Hayes (1987) amongst others, cites a number of other factors associated with the heightened risk of teenage pregnancy, including those who have grown up in fatherless families, and whose mothers were themselves teenage mothers (Allard et al., 1994; MSSS, 1993). Allard and her colleagues describe emotional considerations as dominating rational ones in these teenagers' acceptance of pregnancy and childbearing, and of a sort of 'cultural determinism' for teenage childbearing that demands great flexibility and hard work on the part of health services in attempting to reach these teenagers.

Part of the current debate in the United States sees teen pregnancy as a symptom of the dynamics of poverty, or what is called the 'underclass phenomenon' (Pearce, 1993). This point of view lumps street crime, drug trade, and teen pregnancy together as underclass behaviours where women are acted upon by men. Both male and female teengers engage in inappropriate adult behaviour, with an ensuing pregnancy seen as morally bad (Pearce, 1993). Women are seen by upholders of this theory according to Pearce as passive objects, with teen mothers relegated to the status of children and the marginalization of the male seen as determining his behavior. Pearce's concern is that underclass theories could guide public policy away from the development of programs for young women, by not considering them important.

Allard and colleagues (1994) of the CLSC Basse-Ville in Québec City, assembled a protocol for interventions with pregnant minors. They found that young people of the 1990's are much more sexually active than those before, and at a much earlier age. They explain this by the earlier onset of menstruation, the liberalisation of norms, adolescents being left much more to themselves, and society's accent on individualism. They also agree with other authors (Charbonneau et al., 1989), that the boy tends to affirm his sexuality at a precocious age, while the girl feels more ambivalent. Pregnancy can for these

girls however, bring them a baby to love and to love them, heralding a new beginning, but with a gamut of consequences that they do not entirely perceive in advance (Allard et al., 1994).

A report by Miller & Wadhera (1997), made an analysis of Canadian vital statistics between 1992 and 1994, which revealed that many of the partners of pregnant adolescents were a number of years older. There was found to be a broader disparity in age between adolescent mothers and their partners than for all mothers and fathers (Miller & Wadhera, 1997). It was not unusual for the child of a 15 year old adolescent to be fathered by a 21 or 22 year old, a fact which these authors recognise may possibly suggest an exploitative relationship, or abuse.

It has been found that the majority of adolescents who decide to keep their babies, do so out of a desire to fill a need for affection or valorisation that they feel unable to gain in other ways. The question of exploitation or abuse of adolescents can also be raised in view of the trend discovered by Miller & Wadhera (1997), that it is often men several years older who father their children. However relegating adolescents to the status of passive children instead of responsible mothers should be avoided, since it may impede the development of effective programs to help them (Pearce, 1993).

## Childbirth

The experience of birth has been of great interest to a large number of researchers who have realised its significance not just as a medical event, but as the beginning of a new life and family formation, with social, spiritual and emotional aspects (Weatherston,1985). Pregnancy and birth are major life events, this author writes, and parents' satisfaction with the birth experience may affect their feelings about the child and the quality of parenting they give.

Weatherston (1985), herself a nurse, urges that those who work in the hospital system can make or break the type of childbirth experience a woman may have.

In her important study about women's transition to motherhood, Oakley described the process of having a baby as both a biological and a cultural act; that a society's definition of reproduction is closely linked with its articulation of women's position within that society (Oakley, 1980). Oakley interviewed 55 adult women at five different stages during 1975 and 1976: during pregnancy and post-partum, and ending at five months after the birth of their first child. The subjects were recruited from a London hospital antenatal clinic, and had an average age of just under 26 years. A part of Oakley's study looked at how mothers felt after the birth, including their experiences of childbirth. She found that it is normal to experience difficulties in the adaptation to motherhood, but that there were childbirth 'victors' and 'victims', dependent upon the degree of vulnerability and the woman's perception of the birth (Oakley, 1980). A model developed from her findings demonstrated interconnections between longer-term depression and postnatal blues, and a technological experience of birth. It was clear to Oakley (1980), however, that the way a woman feels about her labour influences her chances of becoming depressed, to the point of mediating the impact of a medium or high technology birth. Oakley (1980) concluded that not enjoying or experiencing achievement in labour adds a further deprivation, that when combined with a high technology birth and social vulnerability (defined as not being employed, having little or no previous contact with babies, experiencing a segregated role marriage, and housing problems) provides what she called a hazardous start to motherhood (Oakley, 1980, p. 272). In other words, this study showed that more important than the amount of technology used during childbirth, is the woman's feeling about the birth, and her ability to cope.

Mercer, Hackley & Bostrom (1983) studied variables that affect women's perception of her birth experience in a sample of 294 first-time mothers ranging in age from 15 to 42. Their 1983 report was part of a longitudinal study of factors

having an impact on maternal-role attainment in the first year following birth. Subjects in this study were divided into three groups according to age. Group 1 had 66 subjects between the age of 15 to 19 years; Group 2 had 138 subjects ranging from age 20 to 29; and Group 3 had 90 subjects between the age of 30 to 42 years. During postpartum hospitalization, subjects were interviewed, and given a series of questionnaires in the first part of the long-term study's five test periods. Researchers found that in the total sample, women who tended to have a more positive perception of their birth experience shared certain characteristics, regardless of medical events such as length of labour, complications or difficulty of delivery. These characteristics were: earlier contact with the infant; an experience of greater positive life events the year prior to birth; greater network support; greater mate emotional and physical support; a higher total positive self-concept; fewer maternal illnesses and healthier infant at birth; attitudes of choosing family-centered birth; breastfeeding; attending prenatal class; having accurate knowledge of infant competencies; spontaneous labour; Caucasian background, and finally, good feelings about the pregnancy.

The subgroup of 66 teenage mothers aged 15-19 had the least positive perception of the birth experience. Characteristics of those in this group with a more positive experience were: experience of positive life events in the year prior to the birth; greater mate support; greater instrumental and informational support; longer labour; larger baby; higher level of education. The larger baby was speculated by researchers as signifying greater success since prematurity is a common occurrence in this age group (Mercer, Hackley & Bostrom, 1983). The early post-partum perception of the birth was found to have significant positive correlation with the woman's gratification in the maternal role, and with her mothering behaviours for the two younger groups of mothers, including the teenage group. For the group as a whole, it appeared that psychological variables had more effect on the woman's perception of the birth event than medical management. Emotional support of the 'mate', and early interaction with the infant were the two most influential variables in predicting perception of the

birth event, although teenagers were more reluctant to interact with a baby covered with blood and vernix. This study also found that especially for the two younger age groups, the perception of birth experience had significant positive correlation with the woman's gratification in the maternal role, and mothering behaviours at one year post-partum (Mercer et al., 1983).

Simkin (1992) described childbirth as an event involving pain, emotional stress, vulnerability, possible physical injury or death, and a permanent role change that includes responsibility for a dependent helpless human being. The fact that women tend to remember their first birth experiences "vividly, and with deep emotion" is not surprising to her (Simkin, 1992, p.64). Her exploratory study published in two parts (1991, 1992) of 20 women who had attended her natural childbirth classes between 1968 and 1974 involved the completion of questionnaires at two time periods, one shortly after the birth, and one, 20 years later, in 1988 and 1989, as well as an interview after the second questionnaire. All women in her study were Caucasian, and at the time of their first childbirth ranged in age from 19 to 33 years, with the average being 26 years. The two main conclusions Simkin drew from her study were that women had vivid memories or what happened in their childbirth, both what was said or done to them, and how they felt. Secondly, the way the women were treated, and how they conducted themselves were more important than the actual physical and clinical features of the labour. In her part I conclusion, Simkin (1991) advises care-givers that there is the potential for either psychological benefits or damage at every birth, with caregivers having a great influence on how each women remembers her experience. The goal of care, she concludes, should not simply be a good outcome, but also a good memory. Simkin (1992) concluded that the memories women retained of their first childbirth experience were remarkably accurate, despite some inevitable lapses or blurring of specific details. The significance they attached to negative events appeared to gain significance over time, whereas positive events remained positive. Simkin`s (1992) study gave evidence that women's memories of childbirth remain alive on both a cognitive

and psychological level, and continue to exert an influence on women's lives even years later.

Green (1993) looked at the expectations and experiences of pain in labour, in a prospective study of 700 women. A series of three questionnaires were given to women participating in the study, two in the weeks prior to delivery, and a third some weeks after delivery. There was found to be a strong relationship between expectations and experiences which were also associated with higher levels of satisfaction with the birth. High expectations were associated with achieving the desired goal, and with better psychological outcomes. The use of drugs was closely related to the expected level of pain; i.e. the more pain expected, the more likely to use drugs during labour. Most women preferred to keep drug use to a minimum during labour, with better educated women more likely to be those who achieved this. Women on the whole felt more satisfied if they had not used a drug, and if they had not felt under pressure by staff to use it.

Satisfaction with care during labour and delivery are not easy to assess, admit Brown, Lumley, Small, and Astbury (1994). Their two-part survey of women in the Victoria area of Australia sought women's views of their childbearing experiences through pregnancy to postpartum eight months later. The first part of their survey involved a postal questionnaire, of which 790 were returned out of 1107 sent. The second part of the study entailed interviews done in the homes of 90 women, 12 to 18 months after the original survey. Interviews concentrated on the women's experience of motherhood and emotional well-being in the two years after giving birth. Brown and her colleagues found that satisfaction with care was difficult to measure, since women experiencing adverse events in labour may feel positive or negative about their care. A recurring theme from participants in their study however, was the desire to be cared for by people known and trusted by the woman in labour. Knowing the people around them, the researchers concluded, helped to lessen the unfamiliarity and strangeness of the hospital setting (Brown et al, 1994).

Enkin, Keirse, & Chalmers (1989) compiled a widely-respected review of studies concerned with pregnancy and childbirth care in 18 countries. A revised and updated edition added further recommendations for effective care (Enkin, Keirse, Renfrew & Neilson, 1995). According to these authors, there is a diversity of opinion about what objectives of care should be in pregnancy and childbirth, and how these objectives should be achieved. The result is a considerable variation in the type of care provided, across all levels, from the individual caregiver to that of the country itself. The focus of this guide is to examine the effectiveness and safety of many aspects of care related to pregnancy and childbirth. Results of their review resulted in assessments of forms of care which were rated according to their proven benefit or harm, and lists of care that have not yet been proven to be one or the other (Enkin et al., 1995). Beneficial forms of care include such aspects as emotional and psychological support during labour and birth, mobility during labour. They also include the necessity of respecting women's choices concerning birthplace, companions during labour and birth, and position for second stage of labour and birth. Forms of care assessed as unlikely to be beneficial, or harmful, include withholding food and drink from women in labour, routine intravenous infusion in labour, routine directed pushing during second stage of labour, and requiring supine position for second stage of labour (Enkin et al., 1995).

Childbirth was described by Halldorsdottir and Karlsdottir (1996) as a journey; a powerful life experience coloured by the woman's circumstances and expectations, her sense of self during the journey, the journey itself, and the first hours of motherhood. This research project was a phenomenological study of 14 women who had given birth in hospital in various areas of Iceland. Women between the ages of 23 and 42 with one to four children were interviewed about their experience of labour and birth. The study found that women longed for a sense of control of self and circumstances during labour. Women needed explanation, information and assistance, and the presence of a caring midwife and partner. They also needed validation of the normalcy of their experience, with

information and guidance to help them cope. The authors found that midwives (who were the principal caregivers) played an important role in how women perceived their experience. Halldorsdottir and Karlsdottir urged that the midwife/nurse be woman-orientated. She must get to know the woman, and fulfill her needs for control, caring and security during labour and birth by being involved, caring, and competent, and enabling the woman to actively participate in her labour so as to make it a positive life experience.

A Montréal based study examined the amount of time intrapartum unit nurses spent providing supportive care (Gagnon & Waghorn, 1996). The study was made at the tertiary care intrapartum unit of a large university hospital, with 4000 births per year. This was a work sampling study evaluating the effect of one-to-one nurse labour support on several labour and birth outcomes. In evaluating supportive care, observations of nursing activities were made at randomly chosen time periods. The sampling frame consisted of all times of day, and all days of the week over a three week period. Supportive care activites were defined as including physical comfort, emotional support, instruction/information, and advocacy.

Results showed that nurses spent only six percent of time providing supportive care to women in labour, regardless of weekday or weekend shift. The researchers proposed that nurses may not believe their support is needed when a labouring woman is already accompanied by her partner. They also hypothesised that widespread use of technology tends to encourage emphasis on technical expertise over supportive care. In order to rectify this situation, Gagnon and Waghorn recommended that nurses, physicians, midwives, administrators, and educators must believe supportive care to be of equal or greater value than technical care. Secondly, they cited a number of possible changes, such as competency exams for supportive care, documentation structures that prompt supportive care, the requirement for recording of care to occur only in women's rooms, and certain structural changes facilitating the

provision of supportive care. It was stressed that caregivers and hospital administrators should re-examine the philosophy and practice of providing good perinatal care to ensure emotional and physical needs of women are met (Gagnon & Waghorn, 1996).

Bergum (1997) interviewed a small group of teenagers during their last weeks of pregnancy, and in the early weeks after childbirth as part of her larger study of women's experience of becoming mothers. The pain of censorship felt by teenage participants in this phenomenological hermeneutic study was of more concern to them than their pain during labour and birth. This was despite the fact that for some, childbirth was an extremely painful and frightening experience. The eight teenage girls ranged in age from 15 to 18 at the time of interview, and were recruited from a school for single teen mothers and an open adoption agency. Birth for these teenage mothers brought surprises about the start and duration of labour, as well as the intensity of pain. Bergum's (1997) sense however, was that childbirth may have brought a deeper sense of confidence to some women, as for example, the young mother who knew she was in labour despite the nurses who refused to believe her. Some found that they afterwards found certain strengths in themselves when confronted with monumental decisions, and a determination to improve their lives for the sake of their baby (Bergum, 1997).

A Swedish study by Lundgren and Dahlberg (1998) looked at women's experience of pain during childbirth. This was a phenomenological study, with nine participants: four primiparous, and five multiparous women between the ages of 23 to 31, who were interviewed two to four days after normal delivery. Women were cared for by midwives at an Alternative Birth Care Centre in a Swedish university hospital. Some did not use any pain relief, and others used one or more of several methods, including TENS, acupuncture, massage, bath, and nitrous oxide ('entonox'). Analysis of data followed Giorgi's (1989) guidelines. From this, researchers identified four themes: pain is hard to describe and is contradictory; trust in oneself and one's body; trust in the midwife and husband,

and transition to motherhood. The essence of women's experiences of pain in childbirth were expressed as "being in one's body" (Lundgren & Dahlberg, 1998). Pain was found to be in this study as part of labour and delivery, giving strength and power, and moving the woman closer to her baby. The experience of pain was contradictory, as women had both strong negative and positive views of the same experience. It was proposed that the ability to see meaning in suffering may be a key to how women handle their childbirth pain (Lundgren & Dahlberg). In this birthing centre, women were able to know the environment and staff before delivery. Continuity of care is seen as an advantage in enhancing the birth experience. Researchers submitted that the possibility for women to 'be her own body' may be thwarted by the society and the context within which they live. Preparation for childbirth then, they suggested could involve intensive training of the body, including relaxation, breathing exercises, and discussion (Lundgren & Dahlberg, 1998).

The desire to take control of their health and responsibility for their baby's birth led parents in an Australian study to seek a home birth (Morison, Hauck, Percival & McMurray, 1998). This was an exploratory study using a phenomenological approach, with analysis conducted following Colaizzi's method (1978). Ten couples, between the ages of 20 and 40 years, who had experienced a home birth in the Perth metropolitan area within the past two years were interviewed together. Three home birth videos were also viewed. Four couples spoke of their first baby's birth at home, and the other six couples had had at least two babies born at home. Two of these mothers had also previously given birth in hospital. The experience of giving birth at home, was described in four themes: constructing the environment; assuming control; birthing; and resolving expectations. Results of the study were published in two parts, each describing two of the study's four themes, Morison et al., (1998) and Morison et al., (1999). In the first part of the study, home birth was described as a couple actively creating a beneficial environment in which they take on the responsibility of birthing. Participants in the study stressed the importance of creating a physical

and social environment for a positive birth experience. Participants also discussed in positive terms their expectations that pregnancy and birth were to a large extent within their control. The researchers suggested that most birth settings can be adjusted by clients and [caregivers] to meet individual needs and minimise stress, but that the culture of control within health professions means that some health professionals need coaxing into encouraging and facilitating the concept of self-care for parents in childbirth.

The second part of this study centered around the themes of 'birthing', and 'resolving expectations'. Within the first theme, participants emphasised their belief in birth as a natural process. They also described the importance of mothers' mobility in labour, control over birthing positions, and having time alone with their new baby. The home birth experience also encouraged collaboration between couples, although the woman was acknowledged as the authority. Parents discussed the sense of rapport established between themselves and the midwife, which included a personal as well as professional relationship, and created a sense of trust and safety. Participants also mentioned the importance of having continuity of caregiver throughout the perinatal period. All the participants' experiences of home birth exceeded their expectations, something the researchers find particularly noteworthy when women had chosen to do without drugs or technological assistance for pain or labour enhancement. Birth was seen as a momentous life experience that gave parents an enormous sense of achievement. The researchers recommended that midwives ensure that their own birth beliefs are congruent with those of the expectant parents (Morison et al, 1999).

Lavender, Walkinshaw & Walton (1999) designed a study in Liverpool, England, to explore aspects of the childbirth experience which women felt to be important. This was part of a larger randomised trial using questionnaires to assess the timing of intervention in prolonged labour. Four hundred and twelve primagravid women responded two days post-natally to an open question asking

them to discuss what they believed to be the most important aspects of their labour. Criteria for inclusion in the study were those women presenting in spontaneous labour with longitudinal lie, cephalic presentation, and a live singleton fetus. Themes emerging from the analysis were support, information, intervention, decision making, control, and pain relief, as well as comments about their participation in a trial. Midwife support was mentioned both positively and negatively, though the majority of comments were favourable. Support from partners in whatever form it took, was always mentioned positively. Many women in the study were glad to contribute to decision-making about their labour management. Women also mentioned the importance of information which they felt they had not always sought or received appropriately. Some women felt abandoned by their midwives in the immediate post-partum period, an issue which researchers stress needs urgent attention. The researchers also found that women saw interventions as positive contributors to their experience when abnormal labour patterns developed. Interested lay groups should not always presume to 'know' what women want, say Lavender and her colleagues (1999). Women in the study welcomed the opportunity to participate in a research study, seeing it as an indication of interest in improving maternity care. Findings from the study suggested that control, pain, information, decision-making, and support all interrelate in women's perception of their childbirth experience. It is concluded that midwives (and presumably nurses in other health-care systems) should assess all these aspects in order to promoted a positive experience for each individual woman (Lavender et al, 1999).

Another study that found a close interrelation between control and pain was conducted by McCrea and Wright (1999) in a teaching hospital in Northern Ireland. This questionnaire-based retrospective study examined the influence of personal control on women's satisfaction with pain relief during labour. One hundred women, both primagravidae and multigravidae who had had a vaginal delivery responded to a questionnaire within forty-eight hours of delivery. It was decided to exclude women who had received epidural analgesia or were

delivered by caesarean section in the belief that these women would not have felt pain, nor been actively involved in decisions concerning pain relief in view of certain medical policies governing epidural and spinal anaesthesia. Women in the study received care from midwives who were unknown to them prior to hospitalisation. The most important finding of the study according to its authors, was the significant relationships between personal control variables and satisfaction with pain relief. For these women, being involved in decision-making on pain relief enhanced their confidence in their own ability to control their pain, and influenced the satisfaction with the pain relief provided. But personal control goes beyond decision-making about pain relief, say McCrea and Wright. It involves making use of personal coping resources to cope with labour pain. They recommended that midwives [and nurses] should encourage personal control during childbirth. Instead of the emphasis on pain medication, there should be greater value put on women's own coping resources. [Caregivers] must work with women to identify these personal coping strategies, and help them use them in the most effective and efficient way. Those in positions of authority must also be involved in encouraging midwives initiatives, and make resources available to them so as to increase women's personal control and satisfaction with their childbirth (McCrea and Wright, 1999).

Overall, it can be concluded from these studies on childbirth, that many women share common needs and aspirations for their childbirth experience. These include the need for support from partners and caregivers, continuity of care through the perinatal period, the need for information, and participation in decision-making. The perception a woman has of her childbirth experience, and the memory she retains, continue to exert an influence on her life even years after the event. However, there is a paucity of research concerned specifically with the adolescent mother's perceived experience of childbirth.

## Health Consequences of Childbirth for the Adolescent

Although the majority of adolescent pregnancies end in abortion, particularly for those from more economically and emotionally stable backgrounds, there are reported to be increasing numbers who decide to pursue their pregnancy (MSSS, 1993). In 1993, 29% of the 3,822 pregnant 14 to 17 year olds in Québec gave birth. (Secrétariat de la condition féminine, 1997). Loignon (1996), in a Montréal based survey, reported that each year 1 in 4 pregnant teenagers in the Montréal region decide to keep their baby. Still caught in the spell of the 'pensée magique' they dream of a happy life, with home, husband, and baby, unable in most cases to foresee the responsibilities involved, or to predict the loneliness, economic instability and stress that is the lot of so many teenage single mothers (Charbonneau et al., 1989; Hechtman, 1989; Lawson & Rhode, 1993; Loignon, 1996; MSSS, 1993).

Most of the research literature agrees that it is not simply the age of the mother that determines the degree of risk, but that young age combined with other factors, such as socio-economic situation, risk behaviours, and prenatal care puts the health and quality of life of both mother and baby at risk (Allard et al., 1994; MSSS, 1993; Olds et al, 1996). Pearce (1993), a sociologist, warns against using the language of "children having children", which only denigrates those adolescents who are seeking to confirm or assert their adultness by having children, and assumes teenage motherhood to be problematic.

The adolescent childbirth experience is usually related as one that is generally without complications, except in the very young adolescent (Charbonneau et al., 1989) who appear to be at risk for high rates of pregnancy and childbirth complications including toxemia, anemia, urinary problems, prolonged labour, and postpartum hemorrhage, as well as low birthweight babies (Charbonneau et al, 1989; Sécretariat de la condition féminine, 1997; Strobino, 1987). Psychologically, very young mothers experience more tension, depression

and suicide attempts, and have a greater tendency to underestimate themselves (MSSS, 1993).

Growing metabolic demands in competition with the demands of pregnancy can affect the adolescent's nutritional well-being both pre- and post-natally (Ferguson, 1982). Her chances of having premature or prolonged labour increase the risks to herself and her baby, and there is overall and inherent biologic risk to pregnancy which medical care cannot compensate for in girls below the age of 15 (Ferguson, 1982).

Pregnancy and childbirth risks for adolescents above the age of 15 appear to be more directly to do with psychosocial and economic factors, than age (Charbonneau et al., 1989). The principle physical complications for adolescents that Charbonneau and colleagues (1989), found in their wide-scale survey of the research, were toxemia in pregnancy, anemia, nutritional deficiency, lack of medical care, and cephalo-pelvic disproportion due to immaturity of the pelvic outlet (Olds et al, 1996). Strobino (1987) concluded, however, that neither toxemia, anemia, or cephalopelvic disproportion were related to the age of the mother alone.

A Greek study comparing teenage pregnancy and childbirth with two groups of older women found that adolescents generally had fewer complications, and a lower caesarian rate (Creatasas et al., 1991).

The provision of adequate prenatal care may have consequences for not only the adolescent's labour and childbirth, but also for both the mother and baby's health. However, it is not always easy to attract adolescents to these services (Allard et al, 1994). Adolescents may deny or fail to recognise the pregnancy, or even become immobilised by depression (Combs-Orme, 1993). All too often, adolescents make poor use of health care services either before or after the birth (Combs-Orme, 1993). Because of a multiplicity of reasons, the

pregnant adolescent has often received late, or inadequate prenatal care, with only a minority having regularly attended prenatal classes, (Hechtman, 1989; Allard et al., 1994). She is usually therefore, ill-prepared for labour (Kenner & MacLaren, 1993). She may not only lack a supportive partner present with her, but by virtue of her age and lack of life experience is in a much more vulnerable position than her more mature counterparts. The adolescent may panic in labour, feeling out of control, and be embarrassed and shy to be examined by a stranger (Kenner & MacLean, 1993).

The initial memory may be one of satisfaction with the childbirth experience, but further reflection over time brings a more critical view and the woman may find that her initial impressions of satisfaction were affected by a sense of euphoria, a 'halo' effect (Erb, Hill & Houston, 1985; Simkin, 1992), that blurred any negative perception at the time. This is important when one realizes that how a woman feels about her pregnancy and birth are integral to a woman's ideas about herself (Kitzinger, 1984; Simkin, 1991, 1992). A potentially rewarding experience can be turned into a terrifying one (with long term effects) for a woman who experiences excessively high levels of anxiety and stress during childbirth (Niven, 1992). This can influence the length and normality of her labour, which may in turn affect the health of both mother and baby (Simpson & Creehan, 1996; Niven, 1996).

There is little specifically known about the effects the childbirth experience may have on adolescent mothers as a group unto themselves, although Kenner & MacLaren (1993) proposed that the adolescent's experience of labour and delivery can directly affect her bonding with the baby. It has been demonstrated that most adolescent mothers who decide to keep their babies come from socio-economically disadvantaged backgrounds, or a have a history of psychosocial difficulties. They therefore generally differ quite substantially from their more mature counterparts, who at least at the time of their baby's birth tend to have a more stable family and emotional life.

Childbirth may be seen by the adolescent girl as the first real challenge particular to her womanhood (Charbonneau et al, 1989). Whether it is an experience she cherishes and feels proud of, or one she would prefer to forget, may depend on the sensitivity of the nursing care she has received. Butani & Hodnett (1980, p.75) found that "sensitivity to the labouring adult woman's needs may have long-term effects on both her self-esteem and her mothering abilities". This could be equally applied to adolescent mothers.

## Humanistic Nursing

In their humanistic nursing theory Paterson and Zderad (1988), testify to the importance of the person's perception to nursing. Each person experiences the world differently and this gives rise to their particular way of seeing the world (O'Connor, 1993). According to O'Connor (1993), for Paterson and Zderad, the expression of the capacity for presence: i.e. being or doing, with another person, that is, the concept of *relatedness,* is essential for human existence. Both persons realise their own uniqueness as beings in the world, and also recognise that they share experiences with others in the world.

Nurses enter into an intersubjective relation with the person they are nursing ('the nursed'), in response to the health needs of that person. There is a 'call and response' between the nurse and the nursed. This process for the nurse is "purposely directed toward nurturing the well-being or more-being of a person...." (Paterson & Zderad, 1988, p.18), while the purpose for the nursed is to be nurtured. The nurse undertakes an "existential engagement directed towards nurturing human potential" (Paterson & Zderad, 1988, p.14). The exercise of choice and this intersubjective relation contribute to human moreness, a fulfillment of the person's potential in their health experience.

Humanistic nursing theory has been described as a blossoming of existential-phenomenological thought, with elements of both philosophies present in the theory (O'Connor, 1995). Paterson and Zderad (1988), cited in O'Connor

(1995) used the term humanistic to refer to an approach which includes an existential concept of person and a phenomenological method of inquiry known as Nursology.

Understanding more about the ways in which adolescents perceive their childbirth experience, and the type of choices they make, may help nurses to more adequately respond and adapt their care so as to be more fully engaged with the adolescent. Nurses may thus develop more appropriate ways and theories of caring, for the ultimate benefit of this unique population during childbirth. This study, therefore, aims to explore the perception of the childbirth experience as lived by individual adolescent mothers, and to describe the essence of that experience. Humanistic nursing theory is used to focus this research inquiry, as suggested by Morse (1994), not to provide a mould for the analysis, but to inspire it and give it boundaries within the domain of nursing.

This chapter has presented a number of issues arising from the research literature relevant to adolescent childbirth, the focus of this study. Most studies do not address the issue of childbirth exclusively, but often intertwine pregnancy and childbirth with one another. Nonetheless, it is evident from these writings that the experience of childbirth is a major life transition, creating a new life, and a mother at the same moment (Oakley, 1980). Adolescents are in increasing numbers seeing their pregnancies through. Even though they have not yet achieved full maturity, and thus merit the study of their childbirth experience in order for nurses to better understand and help them in the process. The next chapter will discuss the strategy that was employed in the study in order to achieve its aim.

# RESEARCH APPROACH

This third chapter discusses the methods that were used for this study, including a discussion of the origins and meaning of phenomenology. It outlines the use of phenomenology in research in general, and specifically in nursing research, and also the steps to be followed in conducting and analyzing phenomenological research. An overview of the criteria used for participation in this study is given, and the process that the study followed is described. Finally, the criteria for evaluation developed by Lincoln and Guba (1989) are presented, concluding with the ethical considerations that guided the whole research process.

## Phenomenology

The importance of the individual human experience may easily be overlooked in the rapid advancements of science and technology. Recent years have seen a cascade of consumer movements reacting against advances applied in the field of obstetrics which they see as having neglected the woman's childbirth experience in the overriding pursuit of producing a live baby (Burtch, 1994; Gasse, 1992). It has been found that the satisfaction of the birth experience does not depend entirely on what type, or what amount of technological intervention is used, but on how and why it is used, and how the woman perceives her experience (Kitzinger, 1984; Oakley, 1980). Providing care for the labouring women's emotional and psychological needs as well as her physical ones, can help her have a joyful and gratifying experience no matter what type of interventions are needed, or what type of objective experience she may seem to have had (Kitzinger, 1984; Niven, 1992; Oakley, 1980). The importance of the human experience is the central idea in phenomenology. As a research methodology in nursing it is gaining increasing popularity (Anderson, 1991; Lauterbach, 1993) because of nursing's concern with the individual experience.

## Origins

Phenomenology is a philosophy, a theory, and a research methodology, all of which are centered on the importance of human experience (Anderson, 1991; Oiler, 1981). Phenomenology as a philosophy is widely attributed to the German mathematician and philosopher Edmund Husserl (1859-1938), although much earlier Hegel (1770-1831) had articulated the ideas about individual consciousness and the world that formed the basis of phenomenological thought (Levesque-Lopman, 1988). Husserl formed his ideas in 1930's Germany, at a time when positivism ruled scientific thought, a belief that all phenomena could be predicted and controlled, and that human experience was being consequently disregarded (Maso & Wester, 1996). Husserl felt that the world of science had become detached from its origins in life experience, to the detriment of ordinary human life (Maso & Wester), and that all philosophy after Descartes took the scientific world view for granted (Fjelland & Gjengedal, 1994).

Phenomenological thought, as developed by Husserl, reduced the hegemony of natural science by forcing the recognition that all scientific technologies, models and theories find their basis and criteria in the world of human experiences (Maso & Wester, 1996). Husserl's method of phenomenological reductionism was to retrace the established opinions, certainties, intellectual insights and positive judgements of the time to find the origins of human experience (Maso & Wester). Phenomenology, according to Husserl, goes beyond positive knowledge, as offered by science, as well as traversing the boundaries between science, art, religion and all forms of practical and theoretical knowledge (Maso & Wester) in its concern with human experience and consciousness. The idea of the researcher as objective, and the existence of social facts which can by described in neutral ways in the realm of natural science (Anderson, 1991) was replaced in phenomenology by the idea that meaning is socially constructed through a dialectical process in people's everyday interactions (Anderson, 1991). In other words, human beings create

meaning through their interactions with one another (Anderson, 1991).

The principle of intentionality is fundamental to phenomenology. For Husserl, intentionality is an essential aspect of the conscience wherein the conscience is always directed towards an object other than the conscience itself (Giorgi, 1997). It describes one's inseparable connection to the world, one's being in the world, where one is always conscious of something (Van Manen, 1990; Streubert & Carpenter, 1995). Ray (1991) describes the principle of intentionality as allowing a way for the philosopher, researcher, or clinician to interpret the nature of consciousness, and the person's involvement in the world, which is not catered for in empirical science.

## Phenomenology and Research

The use of phenomenology as the basis for understanding sociological problems was originated by Alfred Schutz, (1899-1959), a social philosopher, who adapted Husserl's ideas into sociological terms (Levesque-Lopman, 1988). Schutz formulated a method of using phenomenology for studying how ordinary members of society constitute the world of day to day life, and develop meaning out of social interaction (Tesch, 1990). Phenomenological sociology is concerned with descriptions of people living in the world, experiencing themselves and the world in a "pre-reflective state" (Levesque-Lopman, 1988 p.146). Phenomenology as a research methodology aims to understand consciousness and perceptions of the other (Van Manen, 1990), to describe the lived experience (Anderson, 1991; Oiler, 1982) by plumbing the depths of how people live in the world, and what is most essential to being (Van Manen, 1990). Giorgi (1997) describes phenomenology as the systematic study of the structures of consciousness, including a correlation between the actions of consciousness and the object of these actions. The ultimate aim of phenomenological research, as Lauterbach (1993) says, is to facilitate the process of becoming more fully human. It fits well with the holistic and interactive approach of the nursing profession, which is

concerned with quality of life, and the relevance of peoples' experience (Oiler, 1982, Ray, 1991).

## Phenomenology and Nursing Research

Qualitative research in nursing first appeared in the 1960's, and phenomenology a decade later, becoming increasingly common through the 1980's (Anderson, 1991) and 90's. Lauterbach (1993) proposes that phenomenology offers an approach to nursing research that may have a direct impact on practice and education, because it is supplementary to the quantitative methodologies, and is crucial to changing and articulating more informed human care. Paterson and Zderad (1988), who developed their humanistic nursing theory through phenomenological inquiry, understand nursing as an "experience lived between human beings" (p.3) and that understanding the perspective of the other person is vital in nursing effectively. Nurses must simultaneously acknowledge both our own and other people's struggles and needs as part of the process of living (Praeger, 1995). In order to enter into a humanistic nursing practice, one must interact with others, and recognise the human experience that is unique to each of us, but also shared (Praeger). Nursing researchers have found that phenomenology offers a means of conducting research concerned with the human experience of health (Anderson, 1991). It enables the solicitation of memories that were not consciously thought or felt previously (Lauterbach, 1993).

Nursing as a humanistic discipline shares with phenomenology the premis that human phenomena are meaningful (Omery, 1983). Davis (1978) describes the perfect fit between clinical nursing and phenomenology since the former, she says, also emphasises observation, interviewing, interaction and interpersonal relationships in an attempt to understand the perspective of the other person. Phenomenology is a useful alternative to the scientific/quantitative method for nursing research since it can probe deeply into the human health experience

with no pre-conceived hypotheses (Oiler, 1982). Finally, phenomenological research allows the researcher to reflect on the links between their own professional life, their philosophy of life, and that of others, which cannot but help in making changes and improvements in nursing practice on a more humane basis.

## Conducting Phenomenological Research

There is no one way to conduct phenomenological research, because it is an open approach that is still developing. It does not restrict one to a narrow set of methods or perspectives (Psathas, 1973). The type of phenomenological research method developed by Giorgi (1985) is founded upon the Husserlian *descriptive* tradition, as distinct from the hermeneutic or interpretive tradition based on Heidegger, which will not form part of this thesis. In following Giorgi's methods, this study has aimed toward obtaining a description of the experience of childbirth. Giorgi's belief, cited in Omery (1983), is that it is predominantly the data analysis that distinguishes one phenomenological method from another. Common to any phenomenological inquiry however, are a number of processes: bracketing, intuiting, analysing, and describing (Oiler, 1982).

In outlining his methodology, Giorgi (1997) contends that in common with all qualitative research methods, phenomenology entails five major steps: 1) the collection of verbal information 2) the reading of that information 3) the division of information/data into units/themes, 4) the organisation of the data into the language of the particular discipline, and 5) the synthesis of the results in order to present them to the scientific community. Unique to phenomenological research, and commencing prior to the collection of data, is the process known as phenomenological reduction.

## Processes in Phenomenological Research

Phenomenological reduction. Phenomenological reduction is a process conceived by Husserl in order to increase the precision of research results (Giorgi, 1997). Reduction requires the researcher to take nothing for granted in his understanding of the world, to abstain from our natural attitude towards to world, and instead to question what one believes to be the objective reality (Giorgi). Husserl aimed to closely examine the characteristics of a phenomenon prior to saying that it has an existence in human experience (Giorgi, 1997). Reduction entails a number of processes, beginning with an awakening of a sense of wonder at the world, and a questioning of the meaning of experience in the world (Van Manen, 1990). Through this wonder or astonishment, one may delve through the layers of interpretation, knowledge and explanation surrounding a phenomenon, in order to see the phenomenon in a non-distracted manner (Oiler-Boyd, 1995; Van Manen). Bracketing is the technique used to aid phenomenological reduction. Bracketing is the acknowledgement and setting aside, of the researcher's preconceived ideas about the issue to be so as to remain open to the phenomenon. Thus the researcher declares their presuppositions, feelings, and assumptions about the phenomenon in question in order to recognize them, and to enable a clearer view of what they are trying to understand ( Psathas, 1973; McCormack Steinmetz, 1991). Bracketing enables one to see lived experience by identifying and setting aside one's own beliefs (Munhall, 1994). Through bracketing one may concentrate on the phenomenon as if looking at it for the first time (Oiler, 1982; Lauterbach, 1993). It allows the researcher to be completely present in the study of the phenomenon, and to put aside, or render prior knowledge less influential (Giorgi, 1997). One cannot pretend not to possess this knowledge, (Giorgi, 1997) but it is important to minimise it's influence in the interpretation process in order to be open to the participant's views. The final process in phenomenological reduction, known as eidetic reduction requires one to see past or through the particularity of lived experience towards its essence (Van Manen).

In following the exigencies of undertaking a phenomenological inquiry, I, as researcher, bracketed my own personal beliefs and understandings about adolescent childbirth prior to embarking on the research process (appendix A) in order to refrain from judgments and remain open to the participants.

Data Collection. In the phenomenological method, the collection of data comes from either an interview or simple description by the participant, or a combination of the two (Giorgi, 1997). Interview questions are open and large, allowing the person to express their point of view (Giorgi, 1997). The questions seek to stimulate the participant to reflect retrospectively on their experience of the phenomenon being researched, and to describe this experience (Parse, Coyne & Smith, 1985). Posing a question that concerns a specific situation helps to keep the answers relevant to the subject of concern (Giorgi, 1997). When the interview takes the form of a 'conversation' there is greater provision for the possibility of candour and openness (Bergum, 1997), with questions on the part of the researcher serving to guide rather than direct the interview.

Interviews in this study therefore, attempted to assume a conversational form, and avoid a strict question and answer format. All interviews began with a question asking the participants to describe their experience of childbirth. Supplementary questions were based on the interview guide (see Appendix E), and on issues raised in the interviews themselves. Interviews generally proceeded in an informal manner, sometimes over a cup of tea or juice provided by the participant, and often with the baby on his mother's knee, or playing nearby.

Giorgi cautions that the researcher should try to obtain as precise a description as possible, with the least number of generalisations. According to feminist researchers, allowing some reciprocity in the interview relationship, and some sharing of knowledge, reduces the hierarchical relationship between interviewer and interviewee, as well as improving the quality of the interactions

and helping in the sharing of confidences on the part of the participant (Webb, 1983).

In each interview, I presented myself as a nurse, a student, and a mother of three young children. Sometimes participants posed questions about my children, or sought some advice, as in weaning practices for example. I responded naturally, and honestly to each, and found little discomfort or awkwardness in the interview process, on either my part or that of the participant.

In providing an example of his phenomenological technique, Giorgi (1997) asks his participants to describe situations of daily life in which they have experienced learning something. In analysing these descriptions, Giorgi first brackets his knowledge of various learning theories, not letting this knowledge interfere in determining the significance of the learning experience by his subject. Giorgi (1997) recommends tape-recording and transcribing each interview so that no data is lost.

Both these recommendations were followed, with the consent of each participant. Brief field notes were also taken after each interview to record information and impressions not included in the tape-recordings.

Reading of data. After each transcription has been made, the next step is to read the entire description attentively to get a global sense, and without yet attempting to find themes (Giorgi, 1997). This is important according to Giorgi, because it allows one to see how the various parts fit together.

Intuiting, analysing and describing are steps carried out simultaneously in the phenomenological method, as the researcher studies the descriptions given by participants. Even though they are presented here in a linear fashion, they are actually intertwined though the entire research process.

Division of data into meaning units. The researcher re-reads the description and uses intuition and free imaginative variation in identifying elements, or what Giorgi calls 'meaning units', a term he specifies as strictly descriptive, but one that indicates the pertinence of this unit to the research. Intuiting is a process demanding a high degree of concentration and attention to the interpretation of the phenomenon as it emerges in the participants' descriptions (Parse, Coyne & Smith, 1985). Intuiting is a process of thinking through, or reflecting on the data so that a true eidetic comprehension or accurate interpretation of what is meant in a particular description is obtained (Streubert & Carpenter, 1995). Imaginative variation is required in this process, a technique whereby the researcher discovers important relations between elements by carefully studying descriptions obtained, and wondering about the phenomenon being researched in relation to the descriptions. Giorgi (1997) describes free imaginative variation as imagining a modification of elements or aspects of a phenomenon and seeing if it is still recognisable as such. The process allows one to sift out elements which remain unchanged, and which comprise the essence of the phenomenon. The descriptions should be read in a place without distraction, allowing the researcher to reflect upon and weigh the essences of the phenomenon as they become apparent (Parse, Coyne & Smith, 1985). Each time the researcher perceives the appearance of different elements of the subject matter, the place is marked until one obtains a series of meaning units, expressed in the language of the participant. When identifying meaning units, Giorgi (1997), recommends, it is important that they are relevant to the researcher's scientific discipline, and that they result from the attitude and activity of the researcher, even while employing one's intuition.

Organisation of meaning units into the language of the discipline. Once all the meaning units have been identified, and organised, they are examined, explored and rewritten in such a fashion as to render the essence of each clear and relevant to the discipline of the researcher (Giorgi, 1997). One could not content oneself as simply relaying the words of the interviewee, Giorgi (1997)

states, because they were formulated from a perspective of daily life which is neither scientific or theoretic. What was said therefore, must be read, examined and interpreted anew in a more rigorous fashion according to the discipline chosen (Giorgi, 1997).

Once the meaning units are distilled down in accordance with the perspective of the researcher's discipline, they are re-read with the goal of keeping what is essential and eliminating what is redundant. Meaning units are organised into themes which reflect the essential elements of the experience. Using intuition permits the researcher to discover the essential structure of the phenomenon as experienced by participants in the study.

The synthesis of the findings. In this step the themes or essences obtained from intuiting and analysing are integrated into a structure to describe the essence of the lived experience (Omery, 1983). Use of imagination and intuition allows the researcher, from the perspective of their discipline, to describe the essential structure of the lived experience (Giorgi, 1997). The researcher should always try if possible to find one structure or synthesis for all the research participants. The essence represents the commonality between the experience of research participants. There are also variations of the lived experience according to each participant which must also be made sense of, according to Giorgi (1997). The ultimate result of phenomenological analysis should be not only the essence of the phenomenon, but also the various manifestations of the essential identity (Giorgi, 1997).

In sum, phenomenology should be recognised as an important type of qualitative method that may give expression to the human experience within its context. In common with nursing, it lends great importance to the perception and experience of the other person.

## Research Participants and Location of Study

Because of the length of the interview, and the depth of analysis made, phenomenological studies can only include a small number of participants (Omery, 1983). Some authors counsel interviewing as many participants as it takes to reach saturation or redundancy point, where the data begins to repeat itself and the richness and clarity of the text is increased (Benner, 1994; Mucchielli, 1997; Parse, Coyne & Smith, 1985). However, others such as Morse (1991) believe that this is an artificial notion, since each group or person one interviews may have a different perspective on the phenomenon. Redundancy was not really sought in this study due to its nature as a Master's research project, and the difficulties of recruitment. Despite this, there were some commonalities in the experiences of the study participants.

Participants in this study were recruited from a number of different sources after exhaustive telephone contact over six months, with various health clinics and adolescent support organisations across Montréal. Generalisation of results however, is made with caution, since one can only be certain that analysis reflects one interpretation of the phenomenon as experienced by this particular group.

Eight participants were eventually recruited through four of these sources: a residential school for pregnant adolescents, and adolescent mothers, a Montreal CLSC, a community support program for young parents, and a public nutritional advice and support service. One participant was self-referred. The final number of participants in the study arose from its scope as a Master's research project, and difficulties in recruitment, while also attempting to obtain as much data as possible in this context.

In all 10 participants were contacted through these venues. Initial contact with each venue was made by telephone, and in the case of the school, a letter was sent at the request of the director describing the research project, outlining

criteria for potential participants (see Appendix B). The director arranged a meeting between the researcher and three potential participants, at which time the project was explained and an information sheet provided to each person (see Appendix C). Two of the three accepted involvement in the study, and arrangements were made for interviews with them at a later date. Contact with the maternal-child nurse at several Montréal CLSCs was also made by telephone, and the name and telephone number of one young mother who had agreed to participate in the research project was subsequently provided. This person was contacted by telephone to arrange a meeting. Telephone contact with a nutritional advice service for pregnant women, provided the names of four other teenage mothers who were willing to partake in the project. Of these, all agreed to meet for an interview, but one failed to appear at the pre-arranged meeting place, and was not included in the study.

Some months prior to the start of recruitment, I had spent several afternoons at the Adolescent Clinic of the Montréal Children's Hospital to talk with some of the teenagers there who were being followed throughout their pregnancy at the clinic. The object of this exercise was to help in learning how to approach, and talk with teenage mothers, having had little prior experience at doing so. Eight months after the birth of her child, one of these young mothers contacted me, and expressed her agreement to participate in the study. In all eight participants were interviewed, between the ages of 16 and 18. All participants, with the exception of one were first-time mothers, with no previous history of childbirth, and no known history of abortion. One participant had two children close in age, but was interviewed about her first childbirth experience which she easily recalled, and movingly described.

The original intention of the study was to recruit mothers between 14 and 17, but these were impossible to find despite several months of effort. Numerous telephone calls were made to many different organisations working with teenage mothers, but none were able to provide the researcher with recruits younger than 16 years old. Some groups originally mandated to work with young teenage

mothers expressed their dismay that very young mothers were extremely difficult to reach. The difficulty was perhaps compounded by the fact that English speakers are also a minority group in Montréal.

This age bracket was chosen because the years between 14 and 18 include the period of Middle to Late Adolescence (Miller, 1974; Erickson 1968), where adolescents are learning to think and reason abstractly, and do some self-examination. Rochon (1997) estimates that one adolescent in 12, possibly 11, in the province of Quebec becomes pregnant before reaching the age of 18. Due to the nature of this study, as a Master's level research project, and the fact that the researcher's mother tongue is English, it was decided to choose an English speaking population, even though this is considered a minority language in Montréal. Participants therefore were interviewed in English, although a number claimed to be bilingual.

The choice of possible birth place available in a city the size of Montréal was reflected in the experience of the adolescents participating in this study. Amongst the eight participants, six gave birth in three different hospitals in the city, one gave birth at home, and one at a birthing centre established under the auspices of a province-wide pilot project investigating the safety of midwifery care in childbirth.

## Research Process

The participants in the study were recruited on a voluntary basis from the above mentioned organisations across Montréal. The study entailed two interviews with each participant, from approximately half, to one and a half hours duration, the second interview generally being shorter than the first. The intent was to fall within a range of four months to 18 months after their baby's birth, so that the experience was relatively fresh in their minds, but that they were past the euphoria that often surrounds the initial period after birth (Bennet, 1985; Erb, Hill & Houston, 1983; Gordon, 1988). This was in general adhered to, but exceptions were made due to the difficulty of finding participants. One mother, for example,

was first interviewed only two weeks post-partum, with a second interview at two and 1/2 months. Prior to the interviews, I had bracketed any pre-existing perceptions I held about the experience of adolescent childbirth (see Appendix A), and thereafter attempted to approach the interviews with an open and unbiased mind.

Except for the two participants resident at school, with whom an initial meeting was arranged by the school's director, each participant was contacted by telephone to arrange a meeting to explain the study procedure, and obtain their consent (see Appendix D). In the case of the participants from the school, a first meeting served to explain the study procedure to a group of three, of which two accepted. Times for the interview and signing of the consent form was subsequently arranged at the respective convenience of these two participants. Generally participants found it convenient that the interview occur at the first meeting, when the consent form was also signed. Interviews took place in the sitting room of the school, for those participants who were resident there, while interviews with the rest of the participants occurred in their homes.

Contact with participants was initially made by telephone after they had agreed with their contact person to participate in the research. Interviews were tape-recorded, and transcribed thereafter. Brief field notes were also made by the researcher after interviews to record impressions not captured by the tape-recording. Transcriptions of the interviews were first read as a whole, following Giorgi's (1997) recommendations, to obtain a global sense. Second and subsequent readings employing the researcher's intuition permitted the creation of meaning units. With the exception of two participants who were uncontactable, a second meeting was arranged, one to two months after the first interview, to clarify ambiguous points, to show the participant(s) the transcription of the first interview, and to discuss some initial descriptions and analysis of the data, as suggested by some phenomenological authors and researchers (Colaizzi, 1978; Walters, 1995), and in keeping with Lincoln and Guba`s (1989) criteria of

credibility. Study participants read or looked over the transcriptions, and some accepted the offer to be given copies to keep. No participant asked for changes to be made in the transcription, and all agreed with the presentation of my initial conclusions about what directions the description of the phenomenon would take. Next, transcriptions of the second interview were also made and read. The two transcriptions were then re-read, using intuition in identifying the meaning units. These meaning units result from the attitude and activities of the researcher (Giorgi, 1997). Once all the meaning units were identified, they were examined, explored and re-written, so as to clarify their relevance to the phenomenon being studied. The units were then related to one another by their organisation into different themes. These themes were then integrated into a description of the phenomenon which was shown to other researchers for criticism and commentary.

Anderson (1991) advises the researcher, in describing the phenomenon, to present the individual experience within the particular socio/political and historical context, since people are tied to their world and only ultimately comprehensible within this context. The discussion section tries therefore, to take account of these adolescents in the context of the society within which they live.

## Acceptance of the Researcher

As stated above, with the exception of the two participants who resided at school, all participants suggested their home as being the most convenient place for an interview. Each one kept their appointment for the interview, and welcomed me into their homes, often with the offer of refreshment. Some introduced me to friends or family that appeared, as a researcher, or in one case as a friend. In two instances I was able to offer them a lift to a metro station at the end of our interview. For the second meeting, I brought along a small toy or book for the baby, to show my appreciation for their participation, which each mother seemed pleased to accept.

Participants had different reactions to reading the transcripts. One was not pleased with her level of expression, so we discussed the difference between spontaneous spoken language as compared with written statements, being less precise and less attentive to grammatical precision. Another participant was surprised to see how maturely she was able to express her thoughts. Both of these participants accepted my offer to give them a copy of the transcript as did two others.

## Analysis

As mentioned, analysis of data obtained in this research study broadly followed the series of five steps which Giorgi (1985) developed for phenomenological analysis. The steps include: 1) reading over the data obtained from interviews in its entirety to get a sense of the whole, 2) rereading the descriptions with the specific aim of discriminating constituents or "meaning units" 3) identifying these meaning units 4) synthesizing the units into themes pertinent to the subject's experience, and 5) synthesizing the general structural description of the phenomenon, i.e. the description of the lived experience in the language of the researcher's discipline. Once this last step was achieved, transcripts were read over a final time, to ensure than nothing of importance had been ignored in gathering the themes.

### Illustration of the Analysis Process

Reading over the transcriptions. Each interview was carefully transcribed from the tape-recording, and read to get a sense of the whole. Reading over each description also brought memories of the circumstances of each interview.

Re-reading descriptions. The transcript was re-read slowly, and certain passages were marked, as a change in the participant's meaning was observed.

Identifying meaning units. The transcription was re-read, and a series of meaning units were obtained from each participant's description.

To illustrate the above process as followed in this study, the following example is used. Clare describes her moment of birth:

> *...immediately after the water broke I started pushing, and it took about half an hour of pushing. When I started pushing, it was great. "It's finally coming". I was really happy, and I was...in control of when I pushed, and when I didn't; they applied hot compresses, and oil to the perineum, and the hot compresses made it so I didn't really fell any pain, uh, around the opening when the baby's head was coming out, otherwise I think it would have been pretty painful...in between when they were getting other hot compressses, I started to feel burning, but when they put it on, it was hardly, it was nothing...I had no stitches, it went very smoothly, and I was able to push gradually, and then take a break, and when I was ready my body would tell me when it was time to push again, and to do it slowly, so that...both for the baby and me, and when they said, the head was out, and part of the way, and they put my hands to touch, and I was (my husband) said "Oh, you should have seen the expression on your face, you know, just ecstatic". And then, it was after the arms came out, they put my arms so I could catch the baby, and he slithered out, it it was...I'd never seen a baby being born before, and they're a little bit blue when they come out, and I was, and he didn't cry, he just went "Ah", and then starts looking around, he was very aware kind of...and he didn't cry for the longest, he was on my belly, and he was just kind of lifting up his head, and plunking it back down, and I tried to breastfeed, but he wasn't ready, he was getting used to his new surroundings, and he was very calm,...and I was so happy after.*

A number of passages from this description were marked, after second and subsequent reading, as advised by Giorgi (1989). From these passages a number of meaning units emerged, as shown here:

a) Feelings of Control:

*...immediately after the water broke I started pushing. I was in control of when I pushed and when I didn't.*

b) Inner knowledge and trust in body

*I was able to push gradually, and then take a break, and when I was ready my body would tell me when it was time to push again...*

c) Coping with pain:

*...they applied hot compresses and oil to the perineum, and the hot compresses made it so I didn't really feel any pain, around the opening...otherwise I think it would have been pretty painful...in between, when they were getting other hot compresses, I started to feel burning, but when they put it on, it was hardly, it was nothing...*

d) Baby and mother together: developing a relationship

*...my body would tell me when it was time to push again, and to do it slowly...both for the baby and for me, and when they said the head was out,...and they put my hands to touch, and (my husband) said "Oh, you should have seen your face, you were just ecstatic"...And I tried to breastfeed, but he wasn't ready, he was getting used to his new surroundings...*

e) Caregiver support and rapport

> *...and when they said, the head was out, ...and they put my hands to touch. And then, after the arms came out, they put my arms so I could catch the baby, and he slithered out*

Another illustration is shown here, using Tessa's description:

> *My mother, his godmother (were in the room), like my father was in the hallway. When he heard the baby cry he ran in there, and took his grandson (laughs). My mom was the first one to hold him. At first he was on my belly, then my mom took him. My mom cut his cord, she held him, and then my dad came in and held him, and then his godmother did...the (nurse) were watching, they were clapping, they were happy for me...my doctor wasn't there, she couldn't make it, but there was another doctor there, she was great, and there was another one to make sure I didn't tear a lot,...he was great too....(the nurses) told me when I had pressure to count to ten while I was pushing, so I did that, and just a couple of pushes, and he was out...When he came on my belly, I started giving him kisses, and everything (laughs). Telling him how much I love him. I did that too when I was pregnant, telling how much I love him, and he would kick...I thought it would be just like, take him out, hold him, when I did it, it was nothing like anything I've ever experienced in my whole life, I mean nothing like it. My first baby, there'll be nothing like it. I'll always, always remember it...It's amazing, when he came out of me, and I saw him, it's like "Wow, that's mine, it came out of me", and today I can't believe it, cause my belly's so small...I'm so proud of him.*

A number of meaning units emerged from this description as follows:

a) Family support:

*My mother, his godmother (were in the room), like, my father was in the hallway. When he heard the baby cry, he ran in there, and took his grandson (laughs). My mom was the first one to hold him. At first he was on my belly, then my mom took him. My mom cut his cord, she held him, and then my dad came in and held him, and then his godmother held him.*

b) Caregiver support:

*They (nurses) were watching, they were clapping, they were happy for me. My doctor wasn't there, she couldn't make it, but there was another doctor there, she was great, and there was another one to make sure I didn't tear a lot, he was great too*

c) Mother and baby together: developing a relationship:

*When he came on my belly, I started giving him kisses, and everything (laughs). Telling him how much I love him. I did that too when I was pregnant, telling him how much I love him, and he would kick.*

d) Childbirth as a great experience:

*...It was nothing like anything I've ever experienced in my whole life, I mean nothing like it. My first baby, there'll be nothing like it. I'll always, always remember it.*

e) Childbirth as an accomplishment:

> *"Wow, that's mine, it came out of me", and today I can't believe it, cause my belly's so small (laughs), and I can't believe it. I'm so proud of him.*

Once all the meaning units from each description had been noted, they were re-read in order to retain what was essential, and to eliminate any redundancies. Extracts from the transcriptions were grouped according to the meaning unit which had emerged from them, first for each individual description, and then for all participants.

Synthesizing the units into themes pertinent to the subject's experience. Each meaning unit was further reflected upon in a search for its significance to the phenomenon. The meaning units were then transformed into themes relevant to nursing, and to the experience of the participants.

The same process of analysis as described above was followed for each participant. All the meaning units that emerged from each description were grouped together, first for each individual, and then all participants. Each meaning unit, and all the extracts relevant to it were read, re-read, and reflected upon for their significance to the experience of childbirth. Gradually, the meaning units were transformed into five themes illustrating the phenomenon as experienced by the participants.

Synthesizing the general structural description of the phenomenon. Imaginative variation was used to try to arrive at the essential structure of the phenomenon. The themes were integrated into a statement reflecting the essential structure of the lived experience of adolescent childbirth. This essential structure is presented in the fourth chapter, where presentation of the findings is made. (Omery, 1983).

## Evaluation Criteria

In a critique of quantitative research, Giorgi (1997) states that validity and accuracy are very important to empirical research, because facts are either right or wrong, and it is important to report them accurately. In phenomenological research, however, it is not facts as such that are under consideration, but the meaning of experiences, which are subject to interpretation. Reliability in empirical research for example, refers to repeatability, while qualitative research describes unique human experiences which cannot be assumed to be repeatable (Hall & Stevens, 1991). Internal validity, (used in quantitative terms to assess the degree to which the independent variable of a study is responsible for observed effects), and external validity (where findings can be readily generalized) would be quite out of place in qualitative research. Criteria for evaluating empirical research therefore, are not applicable to phenomenological research (Giorgi, 1997). Rather, in qualitative research one must use qualitative criteria that are appropriate to the goals, purposes and philosophical assumptions of the research (Leininger, 1994).

Lincoln and Guba (1989) developed criteria to judge the adequacy of qualitative research that were intended to parallel the criteria used in more traditional quantitative studies, that is, the *truth value, applicability, reliability, and neutrality* which are increasingly accepted as the gold standard for qualitative research evaluation. Giorgi (1997) provides little in the way of evaluation criteria, other than the necessity of reduction, or bracketing one's knowledge, and therefore making it noninfluential; and of providing an accurate description of the essence of the phenomenon as described by the participants. Giorgi does avow that the efforts of the researcher in describing can be evaluated by referring to the raw data, and some researchers have interpreted Giorgi's methods as requiring the consultation of experts for confirmation of findings (Munhall, 1994).

Because of the nature of this study as a Master's thesis and the imperative of its adherence to sound research principles, this study follows Lincoln and Guba's criteria. Although Lincoln and Guba are not phenomenologists, their guidelines for evaluation of a phenomenological study are appropriate, and have been successfully employed in previous phenomenological research (Cara, 1997; Pépin, 1997).

For Lincoln and Guba (1989), truth value, or internal validity, in qualitative terms becomes *credibility.* Credibility is determined by showing study results and interpretations to participants, and having their endorsement of the plausibility of the data (Appleton, 1995). According to Sandelowski (1986), a qualitative study is credible when people who have experienced the phenomenon described immediately recognize as their own, or when other people can recognize the phenomenon from the description. In this present study, therefore, I followed the Lincoln and Guba criteria, and showed the initial version of the description and analysis to the participants for their comments. Although this apparently goes countercurrent to Giorgi's (1988, 1997) belief that only experts should be used for confirmation of findings, it would seem clear that showing an initial version, in which the description retains it's everyday language can only increase its credibility. Moreover, Walters (1995) judges it imperative for researchers using Husserlian phenomenology to consult with participants, since the meanings of the experiences are ultimately known by the actual participants.

Applicability or external validity in judging qualitative research is transformed by Lincoln and Guba (1989) in terms of *transferability*, a criteria which they say is always relative, and depends upon the extent to which similar conditions match or overlap. The main way to meet it, in their view, is to provide as extensive and careful description as possible in order to facilitate transferability judgments on the part of others (Lincoln & Guba); the burden of proof being on the person receiving the information, (e.g. another researcher) rather than the researcher themself. Since qualitative research describes a

particular researcher with a particular participant, it is agreed by most researchers that generalisability is a somewhat illusory concept, and never really completely attained (Lincoln & Guba; Sandelowski, 1986). This study presents the description of the phenomenon of adolescent childbirth, as lived by English-speaking adolescents in Montréal. This may not be presumed to be the same for another group of adolescents in the same city or anywhere else. However, some value may be gained from their descriptions, in advancing towards the eventual understanding of the adolescent experience.

In positivist traditional terms, reliability is a precondition for validity (Lincoln & Guba, 1989) and refers to the *consistency* or *dependability* of a study. In contrast to quantitative research, this can not be tested by repeatability since each individual is recognized as unique. It may be evaluated however, by the ease with which another researcher can track the reasoning used by the researcher within the study, or arrive at the same or comparable conclusion, in other words, auditing the study procedure (Lincoln & Guba 1989; Sandelowski, 1986). This study has undergone auditing by experts for criticism and suggestions.

Finally, the last criteria developed by Lincoln & Guba (1989) is *confirmability*, which parallels objectivity or neutrality in conventional research. In qualitative data this is rooted in the data. The research findings should be determined by the participants and the conditions of the inquiry, and not from the biases, motivations, interests, or perspectives of the researcher (Lincoln & Guba, 1985). The process of reduction/bracketing in this study helped me as researcher to set aside preconceptions about the phenomenon, and an open reading of transcriptions assisted me in articulating themes without superimposing them upon the data. The logic used in the process of identifying and describing themes has been made explicit, so as to enable its confirmation by others, and to ensure the neutrality of giving voice to the participants.

## Ethical Considerations

Initial contact with each organisation was made by telephone, explaining the purpose of the research project, and the criteria for potential participants. All research participants were recruited on a strictly voluntary basis. Potential participants were free to accept or reject the request for participation. They were assured that they could cease their participation during the interview at any time without penalty or prejudice. A Consent form (see Appendix D) clearly outlining the purpose and goals of the research was obtained from every participant before any interviews took place. Each participant was fully informed about the research process. Each was provided with an information sheet (see Appendix C) which included the telephone numbers of both researcher and the researcher's advisor. Participants were told that they could contact either person to express any doubts or uneasiness subsequent to the interview, or to ask any unanswered questions. Initial description of data was shown to participants for their comments. Sensitivity was shown towards the subjects due to the confidential nature of their stories. Before each interview, participants were assured of the anonymity and confidentiality of any data obtained, and that audiotapes would be destroyed at the completion of the research project. Fictive names are used for each participant in the results section of this study, and institutions where they were recruited are not named.

The following chapter presents the findings of the study, with the presentation of themes using extracts from participants descriptions to illustrate each theme.

# FINDINGS

This fourth chapter presents a description of the experience of childbirth as reflected in the testimonies of the eight participants in the study. To begin, participants are briefly introduced using fictive names. Secondly, themes that emerged from the analytic process as described in the previous chapter will be presented, employing extracts from the individual testimonies as illustrations of various facets of each theme. The themes present themselves in a natural order, moving from a more external orientation towards a more internal one; i.e. from participants' reflections about people present, and events related to the birth, towards their thoughts about their own internal changes as a result of the birth of their child.

## Participants

At the time of the interview Karen, 17, had a four month-old baby, and was living in the residential school where she was pursuing her high school studies. She planned to move out shortly afterwards to share an apartment with another friend from this school, and learn to cope more independently, although still under some supervision from staff. Her relationship with her boyfriend appeared to be stable at the time of the interview, but they were not living together. Karen gave birth in a large teaching hospital. Her experience of childbirth was marked by a uterine inversion, to her great shock and pain. This event, she avowed, still continued to afford her pain several months later, and made her fearful about future pregnancies. Despite many efforts made through the school, including sending her a copy of the transcript of our interview, I was unable to arrange a second interview with Karen.

Rebecca, 16, mother of an 11 month old baby, was also living at school at the time of the interview, and continuing her high school studies. She was also planning to move out to the school's independent living program. Little mention was made of her boyfriend, aside from the fact that he had attended the birth. Rebecca described her labour as having been very hard, particularly as she was

found to be toxemic near term, and was rushed to hospital to be induced. From her discussion, it became clear that Rebecca had had a troubled teenage life, including stints in detention. She told me that she was previously very aggressive, even to the point of both physically and verbally beating her father and mother-in-law. Relations have improved with her parents since the birth of her baby, and she said that they will support her financially if she pursues her schooling. She planned to move to another city to complete her high school, because of their daycare program for children, as well as other activities that interest Rebecca. She still wants to enjoy her teenage years and 'have fun'. In fact, she said that she was already having lots more fun than before having her baby. For Rebecca, the baby has given her a reason to try to succeed in life. She is getting better school results than ever before in her life, and has plans to be a school teacher one day. It was also impossible to contact Rebecca for a second interview, since school personnel had lost contact with her.

Clare is a young mother of two small children, eight and 20 months respectively. Although she was 18 at the time of the interview, her first child was born when Clare was 16. She lives with her husband Jim, who is 26 years old. Clare was brought up in a very tight-knit religious community, and schooled at home. It was on staying with family friends as a young teenager that she began to reflect on her life in this community, and decided it was no longer for her. When she first lived with her boyfriend, her parents did not approve, and her father came to try and 'rescue' her, in vain. However, they are now more reconciled, although contact is limited both with her own parents and that of her husband's. Clare would eventually like to attend catering college, and become a chef, but at present they depend on Jim's irregular income, support from social services, and sometimes have to visit the food bank at the end of the month. Clare gave birth to both her children at home under the care of a midwife. During her first pregnancy, she was followed by a doctor, but she was not satisfied with the care, and sought out a midwife who agreed to take her on, even though her pregnancy was well advanced. Despite her chronically poor state, she said that

she felt it was worth paying for a home birth, in order to have type of childbirth experience she wanted.

Melanie, 18, lives at home with her mother, two sisters, and her boyfriend. At the time of the first interview her baby was two weeks old, and two and a half months old at the second interview. Melanie has completed part of a CEGEP education, and plans to resume her studies eventually, but is content to stay at home in the meantime, and care for her baby. She is determined to make her own decisions about her baby, even though she appreciates the help and support she gets from living with her family. Her story was simple and brief, and was infused with the support she received from the CLSC nurse, her midwife, and her family, including her boyfriend. She was very interested to hear from her CLSC nurse about the birthing centre, saying her family was 'into natural things', and phoned them at the first opportunity. She was very happy to be given a place after two weeks on the waiting list and her account of her childbirth was calm and contained, relating a series of events which unfolded smoothly.

Joyce had her baby at a large teaching hospital where she had frequently attended the births of some of her friends. When it was her turn, therefore, she felt that she both knew, and was known by the hospital staff whom she described as 'good people'. At the time of the interview Joyce was 17, with an eight month old baby. She lives in a busy household, with her boyfriend, his parents, her sister-in-law, and her sister-in-law's two small children. She said, however, that she would like to have her own apartment one day. Joyce's mother died when she was a child, and her father lives out of the province. She has little, if any, contact with him, and lived with an aunt until the time that her baby was two months old. She has a year left to complete school, and says she will finish one day, but has no clear strategy for this as yet. Joyce thinks that she would like to help out with young babies one day, perhaps as an auxiliary nurse. At the moment Joyce looks after her baby full-time, something she says is not easy, but that she is managing. Joyce described her birth experience as really great.

Despite all the pain she said she had felt, it was worth it for the 'perfect' baby she had at the end of it. The second interview with Joyce was carried out over the telephone, after two unsuccessful attempts to meet in person.

During the interviews, Tessa, 18, was living with her boyfriend, her baby of four and a half months, her boyfriend's father, and two other young adult men, one of which was a family member, and one a family friend. Five adults and the baby share a small third floor apartment. Tessa says that she will move out with her boyfriend in the future, but that at the moment her boyfriend's father is happy to have them stay with him. During most of her pregnancy, she was separated from her boyfriend, and he did not attend the birth. However, they were reconciled when the baby was three months old. The birth of her baby was for Tessa an 'amazing' experience, something she says she will always remember. She radiates with joy when speaking about her baby and her plans to marry by next summer. Tessa intends to be at home with her baby for his first year, and although she says that she would do her courses to finish high school in the following year, she also plans to be pregnant with her second baby at that time. Tessa decided that she would like to have her babies while she is young, and said that this baby was planned. Neither Tessa nor her boyfriend have finished school, and they live on social services, sometimes needing to borrow money from her mother or his father. Both of these grandparents seem to have very good relations with the young couple, and provide both practical and financial help. However, Tessa says she sometimes goes without in order to ensure that her baby has what he needs.

Cathy, 18, lives alone with her five month old baby girl in a small apartment, an arrangement which pleases her, although she would like to change apartments when her lease is up. Cathy successfully completed her high school during her pregnancy, and now attends CEGEP, thanks to the support of her family, and her boyfriend's family who look after the baby for her. Cathy said that her mother had continued her schooling until the age of 28, and that with the

birth of her own baby she had come to realise the importance of getting a good education. Her relations with her mother prior to her pregnancy had been troubled, but she said that now she has her own baby, she and her mother have a good relationship, and she frequently asks her mother for advice. She occasionally visits her father who lives outside the country. Although she has good relations with her boyfriend, she prefers to live on her own. Cathy said that her birth was a good experience, not as bad as she had thought it would be, although she still has back pain which she attributes to her epidural.

Until she became pregnant, Anna, 18, lived at home with her parents and sister, and attended first year CEGEP, although she occasionally stayed with her boyfriend at his parents' house. She did not inform her parents until she was five months pregnant, because she was afraid of disappointing them. Her father had difficulty in coming to terms with her pregnancy, but her parents now frequently babysit for her. She currently lives with her boyfriend and their son, who was six months old at the time of the first interview. Her boyfriend has a stable employment, with a comfortable income, but they live in a modest fashion. Anna stays at home with her baby, and would love to have another one in the near future. She is lucky she says, to have had an easy pregnancy, and easy labour and delivery. She feels that being a mother at home with her children is her destiny, and that even though she had been attending CEGEP, she would have eventually have dropped out. Once her children are older she intends to go back to school, but has no particular career in mind.

## Preparation for Childbirth

In preparing for the birth, all the teenage mothers in this study attended at least some prenatal classes, either at a CLSC, the Adolescent Clinic at the Montreal Children's Hospital, the birthing centre, or at school. Not all attended regularly, but found certain aspects of them useful, while others found they were better able to learn on their own, especially if they felt out of place, as when the majority of mothers were clearly older.

## Themes

Five themes emerged from the study, reflecting the childbirth experiences of the participating teenage mothers. The themes all arose from the transcribed interviews, although a number also find echoes in the literature concerned with childbirth, particularly the themes pertaining to questions of pain and control. The themes are as follows:

a) The need for support and presence
b) Pain and its meaning
c) The need for a sense of control
d) Childbirth as an accomplishment
e) Childbirth as a maturing process

There is an interrelation and an overlapping of the themes in representing parts of the adolescent childbirth experience. As Bergum (1997) eloquently describes, each theme reveals the experience from a slightly different perspective, while casting its shadow and reflection on the other themes.

### The need for Presence and Support

Family presence and support. I was struck by the variety of support people that most of the participants brought with them to be present during their childbirth. These included not only the baby's father, or the participant's mother, but also their father, or mother-in-law, or sister or brother, and sometimes one or more friends.

> *[At the birth there were] [baby's] dad, and his two sisters, and well, his cousin, and a friend, but there was, there was, I didn't expect so much people, but they were all there. (P7 204-206)*

*They [sister and babyfather] were trying to make me laugh a little bit. Trying to get my mind off the pain and all of that. (P5 264-266).*

Although she was not able to specify what actions her family took during her labour, Melanie was sustained by their presence, and the love and support they gave her:

*...And my Mom was there, and my boyfriend was the whole time, and then later my sister got there...my boyfriend was holding me, my boyfriend was in back of me, he was holding me, and my Mom was right beside me, and I don't know what they were doing, I didn't take notice I guess, but they were holding my hand, and making me feel better. (P4 145-147,212-216)*

What emerges from the adolescent mothers' accounts is not only the presence, but the active participation of family members in the birth process. Sometimes, for the labouring adolescent, this was almost to the point of excluding hospital personnel completely. Karen, for example, relied on her sister and her boyfriend to encourage and comfort her during labour:

*...And I have my sister you know, holding my hand, and like "It's ok, it's ok, the baby's coming out soon", and you know, telling me all this, "Just push one more time", and you know, it was like my sister who was comforting me, what if I had nobody?...It was my sister, my babyfather [sic] who was comforting me. The nurses didn't do nothing. (P1 922-928)*

Tessa's mother stayed with her continuously through her labour, except for a short break taken while Tessa was sleeping. Tessa's mother was completely involved in sharing the experience with her daughter, guiding her, and providing Tessa with what she needed:

*[Mom, during labour] was holding my hand, and she was telling me to breathe, that was before I got the epidural, she told me to sleep, she would stay there, and then she'd go home and eat and she'd come back. She was really great She was there for me the whole time. (P6 260-264)*

There was often a feeling of joy implicit in the young mothers' descriptions of being surrounded and supported by family and friends:

*My mother, his godmother, [were in the labour room], like, my father was in the hallway. When he heard the baby cry he ran in there, and took his grandson (laughs). My Mom was the first one to hold him. At first he was on my belly, then my Mom took him. My Mom cut his cord, she held him, and then my dad came in and held him, and then his godmother held him. (P6 81-86).*

*There was the midwife there, and her assistant, and my husband, so I think I had a lot of support. And I found that it was a nice experience to be there as a family, to have him there. I found it supportive, when the baby was being born. It was such a happy experience. (P3 21-24, 30-33)*

When family members were not present for some reason or other, as in the case of Karen, whose family were asked to leave for a time, the young mother found it hard:

*I felt bad because there was no-one there that I knew, you know, I had all these nurses around me, holding me and everything, and I would have been more comfortable if it would have been my family. (P1 28-31)*

Partner Support. Except in one instance where the young couple had separated, all the 'babyfathers' were present at the birth, staying near their

partners and fulfilling a multitude of functions: reassuring, consoling, encouraging and providing support and comfort. Most babyfathers accepted the offer to cut the baby's cord after the birth, although one father refused, and at least one had to ask to do so. For one young mother, the babyfather was the only person allowed to remain with her because of her toxaemia. When she needed his help at one point during her labour however, her boyfriend was sleeping so soundly in a chair that she could not rouse him. Nonetheless, once she was in second stage, pushing desperately, and feeling that her son was never going to be born, her boyfriend at last came to the fore, spurring her on to redouble her efforts:

> *I was just like screaming "I cannot do this", I was begging them like, I'm never going to be able to have my son, like he's never going to be born". I thought I'm just going to be pushing for the rest of my life....and they're like [babyfather] kept saying "Yes, you can", like "No, I can't" and he's like "Yes you can"...(P2 361-371)*

In some instances the boyfriend was the only person present aside from the caregiver, because this is what the couple wished for, as in the case of the mother who gave birth at home. Here, her husband played a very integral role in the labour and birth:

> *He kept coming in, and when I started pushing he was holding onto me...uh, I remember he was putting the compresses on the perineum, and he was putting the hot oil. The midwives got him to do that, and it helped a lot....He wanted to catch the baby, but I didn't want...and he was, he stayed cheerful, but he wasn't....nervous, he wasn't anxious because he knew it would be fine. We would be able to deal with it. He wasn't pacing the halls smoking a cigar, whatever. (P3 13-31)*

In another instance the mother found that it was the boyfriend's voice that really inspired her, and helped her concentrate on pushing:

> *... every time I'd hear him say "Push", it would make me want to do it twice as hard, cause I know he knows what's happening, cause my eyes are shut, you know, so he knows what's happening, so I'm going to listen to him, so I just somehow blocked out anything else that was going on except for his voice, just him saying "Push, push!", and that helped a lot. (P8 571-577)*

In brief, the adolescents all felt a strong need for at least one family member, or their partner, to be with them during the birth. Usually they had a number of support people with them. They relied on this person or persons to sustain them through their experience by comforting them, holding their hand, encouraging them, guiding them, inspiring them, and simply being with them, to share in the experience and the joy of a new baby. When family members were not present they tended to be fearful, or feel isolated, especially when personnel did not adequately respond to their requests for help.

Caregiver presence and support. Participants in this study gave birth in a range of facilities, from three teaching hospitals, for the majority of adolescents, to one mother who chose to deliver at home, and one who opted for one of Montreal's birthing centres. Caregivers, therefore could include nurses, doctors or midwives. Each mother was very sensitive to the type of care they received throughout the perinatal period, even if, as in some cases, caregivers assumed very much a secondary importance, in the presence of family or friends during labour and birth. What was clear from all the mothers' accounts was their need for the presence of a person who cared for them, and who expressed this care by spending time with the mother, holding her hand, talking with her, explaining procedures, or responding to her requests. Where family or friends could not

provide all that was necessary, caregivers were looked to, to fulfill needs over and above the role of ensuring a safe delivery:

> *...sometimes you forget, when you're pushing it's kind of hard to breath, so like, between the pushing, they were like, breathing deeply, and they were like very supportive, like I was doing a good job, they made me feel like I was doing the right thing...they were very supportive...they were like using gestures, and stuff, and comforting me...(P8 64-82)*

Joyce, who felt that she had received the kind of care she needed, talked about the notion of comfort. For her, the hospital's *raison d'être* was to help, and make her comfortable, including anything from assuaging pain, to taking time to sit down and explain things:

> *....they help you. If I was in pain they gave me what I needed to make me feel better. I mean, that's what doctors do, but you know, um, they made me feel comfortable. That was the main thing....If you don't have anybody else there with you at the time, or whatever, they make you feel um, like they give you their time. You know what I mean? You want something to drink, you ask, they'll give it to you. You know, sometimes you don't even have to ask, they'll just bring it to you, you know, some of the nurses will just sit in your room and talk to you, and laugh, or, you know what I mean, tell you what you're going to expect and take you through it slowly. It's comfort, and I felt pretty comfortable I think. (P5 300-309, 317-330).*

One mother rather poignantly described the type of care she felt she would have liked, even if she felt it had not been provided for her:

*You know, they didn't come and tell me, like, come warm me up, like "Don't worry, it's going to be ok, you know, we have lots of teenagers", or something like that, you know, something, to like, you know, make me feel like, you know, make me feel more, prepared or something. (P1 587-592)...they should have like, talked to me more about how it's gonna feel, and what can I expect if something can go wrong, or something like that...[I would have liked] them to be more friendly, like, I dunno, to talk more, and to comfort them...that's it...maybe, I had like three nurses or doctors in the room, and they weren't telling me nothing, just like "Push", or "Do this, ok, do this"....Yeah, and they'd be telling me not to yell, not to yell, you know, that's all they're telling me, but they could have just said "It's ok, just a few more minutes", or you know, something like that to comfort me, they were just telling me not to yell, you know, they could have just said something to make me you know, comfort, more comfortable...(P1 587-602, 915-928, 1056-1061)*

In other instances there was a real rapport established, particularly evident in the descriptions of mothers who had given birth attended by midwives. Clare had opted for a birth at home, and was attended by a midwife, and the midwife's assistant. Although she had been followed by a doctor through most of her pregnancy, she was increasingly unsatisfied with what she felt to be a lack of personal interest in her on the part of the doctor. Instead, she found what she was looking for in her midwife's care during the preparation for childbirth. This included discussing beforehand the type of birth experience she would like to have, as well as giving information in a way that satisfied Clare's needs:

*She agreed to take me on, because I wanted to have that kind of experience,...I got what I needed from her...medically and supportively, it was very good...It was much more personal, I would stay for an hour, she made me a cup of tea, she'd ask how I was doing, she'd help in any way she could, any information, and she was*

*a very relaxed...she told me what I needed to know, so for me personally, it was the kind of thing that I needed, it was...very good. (P3 282-286, 330-342, 361-364)*

Melanie had decided to have her baby at one of Montreal's birthing centres after being informed about it by the CLSC nurse, saying that she and her family were 'into natural things'. With prenatal appointments lasting typically one hour she had had plenty of opportunity to get to know her midwife well, and discuss any concerns she had at the time:

*I liked her [the midwife], I looked forward to going every time...it was fun...And my appointments were about an hour at most, and she, we would talk, she would ask me how everything was, how I was feeling, then, um, she would check the baby's heartbeat with the little microphone thing, she would also feel the baby, his position...(P4 63-68)*

During labour Melanie's midwife stayed by her side, talking with her, focussing on her baby, and explaining everything that was going on. Melanie felt that she was given personalised care that she would not have been certain to have received in hospital.

Both of these participants had the advantage of a relationship established with their caregiver prior to the birth. With other participants also, knowing the caregivers beforehand helped to inspire confidence and trust. Joyce had accompanied a number of her friends to the hospital during their childbirth, as well as visiting periodically when she had questions about her own pregnancy. By the time her turn came to give birth, she felt she both knew, and was known by the hospital staff, and was pleased with the care she received. Anna found a confidante in her doctor, with whom she was able to unburden her worries during her pregnancy:

*[My doctor] was great. I liked him a lot. He understood, like if I talked to him about things, he understood, like about my parents. He's always there to listen, and not...to judge me, you know, so he's very good (P8 428-431)*

She was glad when her doctor came to assist with her delivery, and had faith in the benefit of his actions and advice.

Sometimes it was enough just to have their needs provided for at the time, without previously knowing the caregiver, if the caregiver was sensitive to what the teenager needed, even if that meant simply holding their hand, staying with them, or giving directions or explanations:

*Well, the nurses, I don't know their names. The nurses on the side told me "When you have pressure, push".They would count to 10 for me, or "Breathe, and then push again when you have pressure" (P6 118-122)...they [caregivers] were great. If I wanted something, and they gave it to me. (P6 169-173)...she [nurse] was nice, she was there for me, she was holding my hand, and everything...for everything...(P6 421-422)*

But mothers did not always find the support they needed from the caregivers, sometimes finding a lack of sympathy, or a failure in responding to their need for help. One mother even voiced her desire to help others giving birth, since she said the doctors and nurses had not helped or understood her needs, but had instead told her to lower her voice when she was yelling with pain:

*...I wish I was there for people...cause I don't think the doctors and all that really help you out or nothing....like I was yelling, you know, cause I was in pain, and they're telling me, lower my voice, lower my voice, and I'm like, well I'm in pain, you know, and she's like "Oh yeah, well, just lower your voice a little bit". (P1 460-472)*

In some instances, participants felt that the fact of being a teenager engendered certain attitudes towards them. One felt that she received more explanation from the hospital staff because she was so inexperienced, but a number of others mentioned being conscious of a certain censure on the part of those around them particularly when they were learning to care for the newborn baby after the birth. This was not always definable, but more in what the mothers perceived as an attitude on the part of hospital personnel:

> *I think, uh, I guess you could say a lot of discrimination...big time...they talked to me like I was a kid....that's not during the labour, it's not down to me, but just, (sighs), the way they look at me. (P8 373-382, 413-424)*

> *I think they respect like, elderly people more, you know, having babies and everything...they treated me like I wasn't even, like, you know, they didn't even care, I just think they probably treated other people more better. (P1 588-594)*

Two mothers tried to rationalize their experiences of a lack of help from nursing staff by empathising with them: no doubt the nurses were doubtless very busy seeing to other patients, or were tired. Anna arrived at the hospital just in time to deliver her baby, but felt that the nurse was being rude to her, until she realised that Anna was fully dilated "*...it was like five in the morning by that time, so she [was] probably tired...*". Another found that with the callbell out of her reach, and the busyness of the nurses, she did not get the help she needed at the time:

> *I understand it's not really their fault, because they're busy, there's other people, you know, there's other people who are having trouble and pain, and stuff, but I needed help at that moment, I needed, you know, the buzzer was far away from me, and I, I just wish there had been someone, showing me the breathing techniques... (P2 436-442)*

In summary, the adolescents who participated in this study were extremely sensitive to both the actions and attitudes of their caregivers. They were very appreciative of the help given to them, and of any sensitivity shown towards them on the part of the caregiver. Two participants felt that they were shown less respect because of their youth, and that hospital personnel showed little faith in their abilities as mothers, while one felt she received more explanation because it was her first experience of childbirth.

## Pain and its Meaning

Rationalization of pain. The existence of pain was sometimes seen as purposeful, and a natural part of the birth process. Even if perceived as an ordeal at the time, the memory of pain often fades or becomes obliterated afterwards because of the preoccupations and pleasures the baby brings. One mother tried to make sense of her pain thus:

> *....like you're in pain for a good reason you know...cause if you're in pain, like, you've broke your leg like nothing comes out of it, you know, but then I had my son, so I guess I forgot about it. (P2 22-29)*

It was also possible to ignore the pain in the hard work of pushing the baby out. Immersing oneself in this required intense concentration and enabled the participant to experience her pain dispassionately:

> *I didn't mind that it hurt because I was pushing, I could do something about it basically, you know, so I was just pushing...I didn't feel the pain, but I remember I screamed at one point. It was just the final push, but I didn't feel any pain.....(P8 218-223, 265-275)*

Pharmacological pain relief. As this theme emerged, an apparent division became distinguishable between participants, depending on whether they had given birth in or outside hospital, since only negligible pharmacological pain relief for childbirth is currently available to midwives in Quebec outside the hospital system. Therefore, the two participants who chose to give birth outside the hospital were also renouncing the possibility of analgesic medication for their labour, while those who delivered in hospital all expected to receive pain relief in one form or another, usually an epidural.

Of the six mothers who gave birth in hospital, five were augmented or induced, with one arriving just in time to deliver her baby. Three of these mothers presented themselves at hospital after partial or complete rupture of membranes, and subsequently had their labour augmented. One adolescent was found to have toxaemia during a regular prenatal check-up at 37 weeks, and rushed to hospital where she had an induction with artificial rupture of her membranes. One mother requested, and was given an induction four days after her due date *"because I was getting on the doctor's nerves"*. These five mothers all received epidurals for pain relief during labour. Anna, who arrived at the hospital already fully dilated, requested an epidural to help her sleep, but was refused because labour was too advanced. Cathy tried to resist having an epidural, despite being induced, after her membranes had ruptured at home. She had been told by friends about possible back pain that could result from the epidural, and she wanted to try to have her baby 'naturally'. Both Cathy and her boyfriend were also worried about the effect an epidural could have on the baby, and so she endured several hours of oxytocin-induced contractions. The intramuscular injections she was given were ineffective in relieving her pain, and so, worn out, and in great pain, she asked for, and received an epidural. The effect was a great relief at the time, but five months later, at the time of the interview, she was still plagued with lower back pain. She attributed this to the epidural, which she now regrets having taken:

*I...I really tried to like, not take the epidural like,...I completely refused it,...but the pain was really harsh...it was a relief, sort of, but...I wouldn't recommend it to anyone...because of the pain that I'm having now in my back...I was just relaxed, the contractions were coming, but I wasn't feeling it, and it was good at that moment. The aftereffects, it's not something pleasant for me. (P7 252-254, 515-547)*

One mother related a sequence of events in which her membranes were artificially ruptured at the hospital, after having partially ruptured at home. With the onset of painful contractions, she requested and was given an epidural. Although insertion of the epidural hurt, and "*was the only thing I didn't like*", it was successful in taking away her pain. When contractions subsequently decreased she was told that she needed an augmentation with oxytocin. Once this was underway she slept until the next morning, when she was informed that it was time to push. Unable to feel anything more than pressure, and informed by the nurses when to push, she was happy to observe events in the ceiling mirror. "*It was amazing, I loved it; it didn't hurt so I got to see everything" (P6 29-35).*

The type of epidural adolescents apparently received, took away the pain of contractions, but made the mother dependent on nurses or doctors to tell them when to push, since sensation was reduced or absent. Participants did not seem to have any objection to this, seeming for the most part to take this in their stride, taking their cues about when and how long to push for, and sometimes how to push." *And I was getting contractions, but I wasn't feeling them...and finally I got to 10 (cm), and they told me I could push...and they told me how to push." (P1 107,159, 198)*

For one mother, insertion of the epidural was both a painful and frightening experience. In her account, when she was held for insertion of the epidural, her family was asked to leave because they were thought to be making her more nervous:

*Well, like, when I was eight months, I was like...I couldn't wait until I had my baby, and then like, when the time came I wish I would have waited cause it was so painful...the epidural really hurt and everything...and I was just yelling, and my babyfather was just crying. (P1 18-25)*

In Rebecca's case, labour was slow, and doctors debated the possibility of a caesarian because of her toxaemia, and the merits of epidural anaesthesia over intramuscular injections for pain control. She was eventually given an epidural, "and from then on it was heaven...I was so happy". Some hours later, pending an emergency caesarian because of a drop in the fetal heart rate, she was given a more profound epidural anaesthesia "*from the neck down*", as she described it. But with stabilisation of the fetal heart rate, the caesarian was postponed. In Rebecca's case, both of the epidurals relieved her pain during contractions, but had "*worn off*" by the time it came to push. *"I knew I was 10 centimetres because his head was pushing so hard...and I was in so much pain...the epidural was just not working anymore." (P2 243-245)*

Alternative pain relief. A variety of means, singly or in combination, were used to help ease the labour pains of the two mothers attended by midwives. These included walking about during labour, taking hot showers or sitting in a jacuzzi, as well as back massage, pressure to the lower back, perineal massage and the application of hot compresses. They both acknowledged that labour had been an extremely painful process, but that techniques such as vigorous lower back pressure for 'back labour', or slow protracted breathing had helped them to manage. One participant found that tensing up with her contractions only made them more acute. When her midwife taught her how to breathe and to relax, her pain was consequently diminished. Nonetheless the pain was considerable, and she felt that if she had been in a hospital she might have succumbed to an epidural despite her intention not to do so. She was pleased with herself for having managed without:"...*at the time I thought it was*

*the most painful thing in the world, but now I'm happy, I'm proud...I didn't want to take anything before, so I'm happy that I didn't." (P4 439-470)*

Clare found that she was really helped by taking hot showers over the course of her labour, combined with back massage and pressure. During second stage, her husband applied hot oil compresses to the perineum in between contractions, with guidance from the midwives. She is convinced of the efficacy of these nonconventional means in assuaging her pain:

> *...they applied hot compresses, and oil to the perineum, and the hot compresses made it so I didn't really feel any pain,...around the opening when the baby's head was coming out, otherwise I think it would have been pretty painful...I think that the warm oil really helped, I didn't tear or anything, and it seemed to made a good difference (P8 96-102, 123-128)*

Reflections on the experience of pain. Both Clare and Melanie expressed satisfaction in their respective labour experiences, and both mentioned that they had had a better, or easier labour compared to many of their friends. Both took pride in their ability to have felt, and dealt with their labour pain. Clare said that going through the pain of childbirth gave one an emotional strength that would help in dealing with other problems in life, by making them seem comparatively not as hard:

> *It is an ordeal, a lot of it, it's a lot of pain, it's a very emotional kind of thing. I think it can make you stronger for one thing. If you can go through that, I mean you can do almost anything.(P3 418-422)*

Responses to pain from the participants who gave birth in hospital were more mixed, and as Joyce said, "*everybody's pain is different*". Almost all were glad to receive the epidural at the time they did, and some felt they were able to

enjoy the experience because the epidural stopped them feeling any pain. Another mother however, as mentioned, regretted giving in to herself and asking for the epidural that was a great relief at the time, but that she feels has since given her near constant back pain.

In sum, the attitudes towards, and experience of pain were very much an individual matter. Some of the adolescents tried to make sense of their pain as a natural part of the birthing process, others concentrated on the work at hand, and ignored the pain. Epidurals were mostly received with gratitude for hospitalised adolescents, although insertion of the epidural was painful for one adolescent, and another attributes it with causing her continuing back pain. Adolescents birthing outside the hospital used alternative means of pain relief to cope with rather than remove the pain. They found pain to have been a sort of 'rite-of-passage' which had made them stronger, more prepared to cope with other problems in life.

## The Need for a Sense of Control

Being informed. The receipt of information about the pregnancy itself and what was to be expected in labour helped give the adolescents the tools for assuming a sense of control and diminishing the fears they might have. The two participants planning their births outside the hospital discussed in advance their wishes for the type of birth they wanted. As well, Clare discussed not only the normal process of birth with her midwife, but also possible complications that could arise, and what steps would be taken, contributing she felt, to her sense of responsibility for the choice which she had made, particularly at a time when home-birth is not officially recognised in Quebec:

> *She made me prepared for anything, if there was something that does go wrong, that I'd be prepared for it...you can never be 100% sure your baby's going to come out alright...to hope for the best, and*

*prepare for the worst...I was prepared...I think if you're prepared ...you're just ready to grit your teeth and be able to do it .(P3 286-335)*

Trust in the caregiver. Feelings of control were not affected necessarily by whether or not interventions were made during labour or birth. Rather, it seemed that it was the way in which interventions were carried out that influenced the mothers' feeling of keeping or losing control. In some instances the mother asked for the intervention, an augmentation, or epidural, (or had her membranes ruptured). Trust in her caregiver and her caregiver's rationality for carrying out certain procedures, or recommending certain actions, was an important factor in both retaining and ceding control to the other when they felt the need to do so, as illustrated below:

*So they gave me the epidural, and it was like my choice. They didn't like, decide for me, that was what I liked about the hospital...they told me I needed [an induction]...they said I had to have it, cause the baby stopped moving and my waters already broke. (P6 376-379)*

*I mean she [midwife] helped me and everything, and she explained to me everything that was going on, but I was the one doing it, and nothing or nobody was interfering. And even if I'm young, I'm glad I got to do it...I did feel I had control. (P4 614-618)*

An element of control could be as simple as the ability to contact the caregiver when needed. Melanie was provided with her midwife's pager number, in anticipation of her labour, and said she was not scared because she knew she could use it when she needed to.

Self-knowledge. Trust in one's body was also another aspect in the possession of confidence and control, particularly marked in the two mothers

who had their babies outside the hospital. They were able to listen to their bodies, and use their innate knowledge to guide them in their actions during birth:

> *I was in control of when I pushed and when I didn't...It went very smoothly, and...I was able to push gradually, and then take a break, and when I was ready...my body would tell me when it was time to push again and to do it slowly...both for the baby and me. (P3 94-114)*
> *I'm the one who knows better than anyone else, because I'm the one doing it, and I think it's better like that. (P4 704-715)*

Knowing one's own body however did not help the mother to retain a sense of control if this was not given credence by the caregiver. If this was aggravated by a physical impediment such as an incapacity to call for help, as in the case of the young mother below, then it could turn into a scenario such as the one she described:

> *....the bell was too far for me to reach it, I couldn't get it, and because I was all frozen I couldn't move, to like lean over...so I was trying to wake up my babyfather...and I call "Nurse, I'm ready to push, I know I am". I could feel it, and he's just sleeping, and I was calling the nurse...and nobody came for like 2 hours, the same feeling, and then a nurse finally came...and she said "No, you can't possibly be 10 cm"...she goes, "Well anyways, we don't have any doctors available to check you".(P1 256-267)*

In some instances the young mother bowed to directions from caregivers without protest, even if she was not very happy with this. She obeyed orders or recommendations out of an apparent timidity, or with the assumption that the caregiver knew best:

*...they told me I had to lie on the bed. They said [getting up] could harm the baby, or I could be harming myself by walking around, but they completely refused for me to get up...and I was just basically lying on the bed until...I had her. (P7 499-513)*

*When I wanted to go up like, sitting up...they're like "No, no, no, you have to lay down", and pushed me back down. (P1 829-832)*

Fear. Some feelings of apprehension about the whole process of giving birth were evident in the testimonies of more than one participant despite their efforts to be brave and to maintain their sense of control. Not knowing exactly what to expect or even a fear of what the baby would be like contributed to this. One participant was so nervous through her pregnancy that she went to the hospital for reassurance nearly every week, whenever she felt a pain, or a kick. This nervousness continued into her labour :

*...for me, I was pretty nervous, but uh, when it came down to, to actual earth, I was nervous like, but I was ready, like "Get him out". I thought it was a species...I was scared, I didn't know what to expect,...but then time went by, and he came out. (P5 67-74)*

In the end, however, this mother was comforted by her familiarity with the hospital staff after so many previous visits. Because she said the 'whole floor' knew her, she was convinced that they were all equally anxious to see her baby. She felt that they had responded to her needs, even without prompting; bringing her drinks, or sitting and talking with her, giving her their time. The perception that caregivers were acting in her own interests, helped this mother feel a sense of collaboration with them, enabling her to have a good experience as well as a healthy baby.

In brief, the adolescents felt the need for a sense of control, and a participation in decision-making even if their individual perception of control differed. Some participants, such as the two who delivered outside the hospital actively sought control, by planning in advance the type of birth experience they wanted. Others were happy to hand over control of events to the caregivers when they felt they had been consulted. Dissonance occurred when participants felt forced to comply with actions or interventions that they were not comfortable with, but felt unable to refuse for one reason or another

## Childbirth as an Accomplishment

Again and again the teenage mothers spoke in terms that demonstrated their pride and sense of accomplishment. This was as much to do with having created and produced the baby as it was in having gone through the experience of childbirth. It was not possible in most instances to detach the feelings aroused by the childbirth itself from those that came with having brought forth their baby. Rather these were melded into a mixture of incredulity that the baby had come from them, pleasure in their achievement, and pride that they had come through the trial of childbirth.

Pride in the baby and disbelief. Joyce could not wait to see her baby, so much so that she had asked for an induction when she was four days past her official due date. She was very pleased, then, to see how much he resembled her, *"like my twin"*, and after counting his fingers and toes, and checking all his features, she was reassured to see that all was there as it should be. Joyce was proud of the size and perfection of her baby, and joked about her family's disbelief that this eight pound plus baby could really be hers: *"Wow...I did this?" It's like, I'm so proud of myself. "No, I'm proud of you [baby]"* (P5 151).

A sense of unreality and incredulity that they could actually have produced the baby was a common reaction described by the teen mothers, despite having

gone through what was often a long and trying labour: This Incredulity did not diminish the real sense of achievement evident in their testimonies. This was true not only at the time of the birth, but also afterwards at the time of the interview, as illustrated by Tessa and Cathy's words:

> *Giving birth...It's amazing, when he came out of me, and I saw him, it's like "Wow, that's mine, it came out of me", and today I can't believe it cause my belly's so small...and I can't believe it [today] to see how big he is...O my god...Everytime others are asking "So how was your labour?", I tell them the whole thing. I'm so proud of him. (P6 147-160)*

> *I was so happy. I couldn't believe like she was mine, like she came out of me. It was a real miracle for me, having a kid .(P7 591-592)*

Meeting the baby. The young mothers had not anticipated the emotional reaction that the birth of their child would arouse within them. Many had anticipated the pain they would feel, or had rehearsed in their minds the steps that labour would take, but when it actually happened to them, and they held their baby for the first time they were transfigured. Tessa describes her reaction to first meeting her baby:

> *I thought it would be just like, take him out, hold him....when I did it, it was nothing like anything I've ever experienced in my whole life, I mean nothing like it. My first baby, there'll be nothing like it. I'll always always remember it. (P6 139-143)*

Pride in the birth. There was also pride evident in the mother's reflections on the birth itself. Melanie had previously had childbirth described to her by many people as a "horrible experience", but was pleased with her own short and uncomplicated labour, managed without anaesthetic. Even though at the time she had felt it was extremely painful, she was afterwards proud and happy.

Clare also described her satisfaction with her experience as compared with many of her acquaintances:

> *I find that out of all the people I've talked to, I seem to have had one of the better experiences...where it went so well, and I was so satisfied with the way it went. I wouldn't have changed anything....It's an accomplishment. It's something you did. It's a very happy memory. (P3 463-478)*

A great experience. Almost without exception the adolescent mothers spoke of their childbirth as a great experience, regardless of the type or number of interventions they had received during labour. It had all been worth it because of what they had received in the end: their baby:

> *I thought I was going to die for the first part, and then after the whole thing was over I was just, I was ecstatic...I think a lot of women after their baby is born they feel a surge of energy...I think it was a wonderful experience. (P3 165-169)*

> *It was a great experience. I'm not saying I'd do it again. But in a couple of years, I'd say I would...I might. (P5 460-462)*

They were happy to talk about their childbirth, and remember what had happened, and often found it to be a subject of conversation with friends:

> *I'm always talking about my birth experience. It's something that I think a lot of women who have babies like to talk about, how it went, and what things happen. (P3 463-471)*

A worthwhile experience. Even the less pleasant parts of labour were tolerated, when the overall goal of giving birth to the baby was achieved. Karen

suffered an unfortunate complication during labour which caused her much pain and fear. Nonetheless she expressed herself as willing to repeat the experience, but without enduring the same complication or having an epidural, the two events which caused her the most distress. She spoke fondly of the happiness she felt when the baby's head was first visualised, and then the moment when her baby was placed in her arms "*so nice and warm*". Rebecca declared that even if it was "*bad, really bad*" in labour, she could ignore this in retrospect. Tribulations had been worthwhile enduring because of the reward of a baby at the end. Even if the labour itself had been difficult, once the baby was in their arms these difficulties were forgotten, and the mother rejoiced in her new baby:

> *...in a way it was good, and in others it was bad, you know, the one part I really like was, ...just having my baby in my arms. I like when I was pushing, and like everyone's like "Oh look, there's his head...Oh he has lots of hair!" (P1 1081-1084 )*

> *...it's bad, like it's really bad while you're in labour, and like you just want it to be over with, but then, like you forget about it, you know... cause I had a hard hard labour, but after I gave birth it's like, when people ask me if I had a bad labour I was like "No, it was ok", (P2 17-23)*

This feeling that it had all been worthwhile was echoed in the words of many participants:

> *I enjoyed the whole experience...it was worth it...it's always worth it, once you see what you made...what you get to have at the end, what you get to keep at the end. (P5 360-373).*

> *I think it was good....I always expected the worst...but mine wasn't as bad as I thought it would be...it was worth it in the end. (P7 112-115)*

Clare and Anna each felt that they had been lucky their experiences had gone so well:

> *...I can't think of anything that really didn't go well...it was like...just seemed like a normal part of life happening, and there weren't any complications...I'm so lucky I had such a good birth experience....(P3 165-180)*

> *It just went smoothly, perfectly, but I was very lucky for that. (P8, 498-500)*

Sometimes the experience was marred by a wariness of people in authority. One mother had been warned by her boyfriend that if she yelled too much in labour her baby might be taken away from her, although she herself professed not to believe this. Two mothers were disturbed by visits from a social worker who had come to the hospital to see how they, as teenagers, were coping with a new baby. Tessa sent this person away, saying that she had no intention of harming her baby, while Anna submitted uneasily to questions and comments by the social worker:

> *I'm happy that she thought...I was like you know, taking good care, responsibility and everything, but in a way I was like...it's not fair for her to expect worse just because I'm a teenager. That was a bit upsetting. (P8 403-407).*

Cathy described childbirth, and having a child as a "real miracle", and was emphatic that it was an experience every woman should go through: *"We only live once, so...that's why I think everyone should have kids*"...She could not imagine life without her baby now, even if she had at first considered an abortion. She believed that people who chose not to have children were depriving themselves both of the understanding of what childbirth is, and what it is to have a child.

Overall, the adolescents were overwhelmed with pride in their babies, and in themselves for having gone through childbirth. All the worry, pain, uncertainty or fear which they had felt during pregnancy, labour and birth were worthwhile in the end because of the 'reward' they got at the end, the baby. Feelings of joy, pride and incredulity were all intermingled and caused memories of less pleasant parts of labour and birth to be put aside.

## Childbirth as a Maturing Process

Assuming motherhood. Even before seeing him, thoughts of the baby's wellbeing sometimes came ahead of the adolescent's, in her desire to protect her child. During labour Cathy endured several hours of pain rather than accept an epidural for fear that it might harm her baby, although in the end she gave in through weariness and assurances that her baby would not be affected.

First contact with the baby was often overwhelming, with the young mother lost for words; some cried, some laughed, some told their babies how much they loved them, and one mother fell asleep immediately after the birth from sheer exhaustion! Karen described a mixture of emotions when seeing her baby for the first time. She was so overwhelmed that she felt unable to hold him:

> *I was like, I dunno, I was tired,...they put him on my knees, and on my hand, but his face was facing...towards like everybody else, and I'm like "Oh, my god, oh my god", crying and everything, so I just passed him to my boyfriend and his mother...I was losing my breath, you know,...he was so nice and warm and everything. (P1 302-313)*

Two of the mothers described how they were able to touch their babies before they were fully born. As soon as there was a glimpse of her baby's head in the mirror, Melanie was invited by her midwife to touch it:

*...so I was caressing his head (laughs) so it was exciting...and once his head came out completely, it was really exciting...I caressed his head, and I was very excited. (P4 191-205)*

Clare was helped to catch her baby herself, and draw him out onto her stomach:

*And when they said the head was out...part of the way, and they put my hands to touch, and [my husband] said "Oh, you should have seen the expression on your face, you know, just ecstatic"...and after the arms came out, they put my arms so I could catch the baby, and he slithered out,...and I'd never a seen a baby being born before,...and I was...and he just made that 'Ah', when he started to breathe, and I was so happy after...(P3 113-130)*

Both teens also mentioned the calm and uninterrupted time they had afterwards to hold and nurse their babies and become acquainted with them.

Labour and birth were sometimes described not only in terms of their own experience, but as that of the baby's too. Clare described how she paced her pushing so it would be easier for the baby and herself, and used candles so the baby would not be shocked by harsh lighting in his first view of the world. Melanie spoke appreciatively of how her midwife helped her focus on her baby during her contractions:

*She told me to relax, and to stay with my baby,...to think of my baby...cause he's experiencing it with me, and...I'm not sure if they would do that in the hospital (P4 140-145)*

Breastfeeding. Seven of eight participants chose to breastfeed their babies for periods varying from a few weeks to six months. Help received in initiating breastfeeding in hospital seemed to be variable; some nurses helped,

and some didn't. Two of the young mothers found that nurses had given bottles to the breastfeeding baby, despite their opposition to it. Rebecca was happy about the help she had received in learning to breastfeed from one particular nurse, who spent time urging her reluctant baby to suckle. She was distressed by other nurses, however, who tried to dictate the amount of time the baby should have on each breast, or who told her she was starving her baby by not giving him formula:

> *One thing I'm really glad about is the breastfeeding, they helped me to breastfeed, cause he didn't know how to latch on, he didn't have any sucking reflex....and they had to teach him by massaging his cheeks, and sticking his pinky in his mouth, and moving it around, and finally he got it....if I hadn't had as much help, I wouldn't have been able to ...but one thing I refused to give him formula when they kept saying, "Oh yeah"...they were like...I remember one nurse was like "Oh you're starving him, give him some formula...he needs to eat", and this nurse was yelling at me...and I was like, what the hell, there was only so much I could do. (P2 465-488)*

In the end Rebecca successfully breastfed her baby for six months with no problems, and only wished that she had continued for longer, "*but there's always more kids in a few years*!" she joked. She felt very strongly that there should be much more help for breastfeeding, and that it should be much more widely promoted amongst teenagers. In her experience not many were encouraged to do so, and that apart from its other benefits, it was also much cheaper. She had found that she alone amongst her friends had spending money because she had not needed to buy formula. Her conviction about the benefits of breastfeeding had influenced another participant, who mentioned Rebecca as a big influence in her decision to breastfeed: *they [nurses] didn't encourage me, but I was always like,...cause at [school] there was this girl...she was always telling me to breastfeed, and I did. (P7 347-351)*

Few participants it seemed, needed help in initiating breastfeeding, in fact most found it came quite naturally. Joyce refused the help that was offered to her saying that it was easy for her to do on her own. Clare first breastfed her baby when she took a bath with him shortly after the birth. She gave him the breast "*to comfort him...and he stayed plugged In for a long time, and he was fine*" (P3 149-153). Melanie breastfed immediately after the birth, and conjectured that her baby was fast in catching on because a mark on his thumb showed that he'd probably been sucking it in the womb.

Anna breastfed her baby as soon as he had been cleaned off and handed to her. She was very upset later on however when she found that nurses had given the baby formula when she had expressly asked them not to, afraid that it would interfere the establishment of breastfeeding. She did not find it easy to express her dismay to the nurses however: *She's like, they gave him a bottle, and I'm like, I didn't say nothing, cause I'm too shy to say anything...but I wasn't happy about that, I was mad. (P8 308-316)* Anna felt, however that she had learned by her experience, and in future would be more prepared to defend her own point of view against those that she felt were wrong.

Tessa was the only participant who chose in advance to bottle-feed her baby. She did not feel comfortable with the idea of breastfeeding, and did not feel that bottle-feeding in any way detracted from her determination to be the best mother she could for her baby.

Lifestyle changes. Motherhood brought radical change in lifestyle to most of the young mothers in the study. Sometimes this was recognised as the adaptation to caring for a young baby, curtailing of their freedom, limiting their social life, and changing their priorities, but often there were more fundamental internal changes they had observed in themselves brought about by their having passed through the experience of childbirth. This was described by one mother as an ordeal that made one stronger afterwards:

*If you can go through that, I mean, you can do almost anything. I mean, bearing and raising children is the hardest task I think you can go through, and in your life it's the greatest and most rewarding job like a lot of people say, but it's true...to have gone through that, you can deal with other stuff, and it doesn't seem as hard.(P3 415-423)*

Another mother remarked that her whole way of thinking had changed, so that she now feels twice as old as her friends. Things that in the past had seemed so important to her now seem trivial, and her friends' preoccupations with boyfriends, or what other people think about them, make her feel that she no longer fits in with her old friends. Thoughts about her baby and his welfare come ahead of any concerns of her own:

*I think more of him, along the lines of the future, you know, I want what's best for him,...I'm scared if I do something, because whatever I do now is going to make him who he is later on, so that's my main concern now. (P8 604-605)*

Connecting with their mothers. More than one adolescent mentioned improved relations with their mothers since the birth, and a sharing in the experience of caring for the baby. Some of the teens thought of their mothers during their childbirth, either feeling a connection with them because of the shared experience, or because their mothers were present at the birth. Being faced with the reality of caring for a small baby made them appreciate their mothers more:

*My Mom...was a really good Mom. I never used to see it though, but now that I am a Mom, I can see it...now I'm so much like my Mom, everyone used to tell me that before, but I never used to see it.(P7 175-183)*

Taking responsibility and finding meaning. Childbirth thrust the teenager into adulthood, and a sudden assumption of responsibilities that come with motherhood. The mothers accepted these responsibilities for the most part with equanimity, and were ready to put the baby first before their own interests if needs be. Sometimes that meant making do with less food in order to ensure the baby had enough. Sometimes it gave them the motivation to return to, or carry on with their education in order to be able to provide the baby with a better future. Anna felt even during her pregnancy that it was her destiny to be a mother and raise children, and was willing to forsake her education or other ambitions at least until her baby is older:

> *I just knew this is how I'm going to spend the rest of my life...this is my destiny basically...that's how I'd pictured myself, having a baby early, and then later on, like going back to school, and doing my stuff when he's older. (P8 613-622)*

One mother who said that she had had little interest in school prior to her pregnancy, managed to finish high school during her pregnancy, and was now attending CEGEP through adult education: "*Now I know how important it is if I want to support her...protect her...and be able to provide for her*" (P7 149-150).

Another mother had led a troubled life as a teenager, had failed many high school courses, and had been several times in detention. Having a baby had given her a reason to try to succeed in school and plan a career as a teacher. She was proud to say that she had received the highest average school marks ever during the past year. As she put it, she felt her life was more deprived before she had her baby, and was convinced that being a good mother does not exclude also having fun:

> *I was ready to die then [before pregnancy], but, you know, I'm not ready to die now, cause I have [baby], so like even if I was ready to*

*stop my life, I would have done it for him so, and I'm still having fun. (P1 1082-1086)*

Even her relationship with her parents had improved she said, since the birth of her baby "*Like I don't beat them up anymore...I don't beat anyone now*" (P2 893-900).

In brief, childbirth transformed the adolescents in this study into mothers ready to take on responsibilities for their own life and that of their child's. The responsibility they have come to feel for their child changes their priorities and preoccupations. Social activities take on a lesser importance, and relations with friends are altered. The mothers enjoy caring for their babies, and some even deprive themselves in order to ensure that the baby is adequately provided for.

Having a baby seemed to provide these teenagers with the motivation to improve their lives, giving them new goals and ambitions, healing family breaches, or consolidating family relationships.

In summary, descriptions of the experience of childbirth by the eight participants in this study gave rise to five themes. Each theme was presented and illustrated using extracts from the participants' descriptions. Distillation of these themes allows one to arrive at the essence of the meaning of childbirth for adolescents as follows:

*Childbirth can be an empowering experience for the adolescent which precipitates the attainment of adulthood.*

During labour adolescent mothers have a great need to be heard, to be supported and accepted in relations of trust, and to feel a sense of control and participation in decision-making. Childbirth can be a great experience for adolescent mothers, when they are given information and support by loved ones

and caregivers. The experience of childbirth can bring a sense of accomplishment to the adolescent, providing them with meaning and a sense of purpose to their lives.

The next and final chapter discusses the findings as presented in this chapter in the light of relevant literature.

# DISCUSSION

This final chapter centers around a discussion of the study findings in relation to relevant literature. Unless otherwise mentioned this literature relates to the adult experience, since research concerning the adolescent experience of childbirth is limited. A few points are made about study participants before each of the five themes is discussed in turn. Some methodological issues are examined, then limitations of the study are outlined, as are implications for nursing practice. Finally some recommendations are made for further research in the area.

## Participants

Participants for the study were all adolescents between the ages of 16 to 18 who had given birth in the Montréal region. All described their experiences of giving birth to their first child. Interviews were all conducted in English, a minority language in the province of Québec, although several claimed to be conversant or bilingual in French, the predominant language. Some participants lived with their partners, others with their families, and others at school, but all maintained some type of relationship with their partners. With the exception of one, all partners had been present at the birth, a situation which would seem unusual, when instability seems to mark most adolescent relationships. In fact, the degree of stability of the relation between the participants, and their partners was not always known. One, for example, had only recently been reunited with her partner. However, five participants lived with their partner, either alone, or in the family home. One participant chose to live by herself, and two lived at school but all appeared to see their partners periodically.

Roughly half of the participants had not completed high school, three had some CEGEP, and one had been home-schooled, but had no diploma. None of the adolescents were working at the time of the interviews, but were dependent on partners, family, and/or social services for financial support.

Adolescents participating in this study cannot strictly be said to represent any other group of adolescents. There is some debate about the generalisability of findings from qualitative studies such as this. At the very least it is hoped that findings will provoke some reflection, as a first step towards understanding their lived experience, in order to improve the care of all adolescents during childbirth.

## Some Methodological Issues

This study was conducted using the Husserlian phenomenological method guided by Giorgi's system for analysis. This is a method that is oriented towards discovery rather than the testing of hypotheses (Giorgi, 1989), the goal of this study being to describe how adolescents experience childbirth. As Giorgi (1989, 1997) himself has stated, the method he proposes is structured, but hesitant, and requires much pondering, creativity and last-minute changes. It cannot hope to provide the ultimate description of an experience, but one of several possibilities according to the participants, the researcher, and the discipline.

There are many studies employing Giorgi's methods, including in the field of nursing, but with many variations on the application of his methods. Wide and varied reading, as well as consultation with experts in the field provided guidelines in pursuing this research project.

Where this research has diverged from Giorgi's method, is in bringing participants into the validation process by showing them transcripts, and asking for their criticism of initial conclusions. This concurs with other phenomenological methods (Colaizzi, 1978), as well as with some phenomenological researchers such as Bergum (1997), and Beck (1992). Walters (1995) claims that it is essential to seek confirmation from participants in the research process as it is they who have an intimate knowledge of the phenomenon. Since this study aimed to describe a phenomenon experienced by the participants, it therefore seemed important to seek validation from them, at least of initial conclusions. It also fits with Lincoln and Guba's (1989) criteria of credibility.

## Presence and Support

All of the adolescents participating in the study had family members, or partners present during their labour and delivery, even if they were left alone at certain moments. For several, there were a number of family members and friends, some of whom also waited outside the room, and for others there was just one person present. Each adolescent emphasised the importance of this family presence to them in traversing labour. Families and partners provided love and support, and often actively participated in the labouring process, holding, massaging, encouraging, guiding the adolescent, and sharing in the joy of the birth.

According to Gagnon and Waghorn (1996), a number of randomised, controlled trials have shown that women provided with a lay supportive companion during labour experienced better labour and birth outcomes than those labouring alone. These include lower caesarian birth rates, decreased use of oxytocin, epidurals or other forms of analgesia, improved Apgar scores, fewer operative vaginal births, fewer admissions to neonatal intensive care units, and longer breastfeeding duration. Enkin, Keirse, Renfrew and Neilson (1995), in their widespread review of current research, also stressed the importance of support during childbirth. This, they found, can affect mothers' ability to feel in control, to have worry-free labours, and to increase their likelihood of breastfeeding their babies. Mere physical presence is not enough they state, but supportive activities need to encompass physical comforting measures as well as emotional support. Exactly what form these measures take will vary from culture to culture, and vary from one woman to another depending on her wishes, but should include continuous presence, hands-on comfort, and praise and encouragement (Enkin et al., 1995).

Except in one instance, each adolescent had her partner present during labour and birth. Some found inspiration in the voice of their partner urging them

on, some were comforted by their partner's presence, even when they could not specify what actions he had taken. One mother's partner took a very active role, applying compresses and warm oil to her perineum, and holding her while she pushed. Enkin and colleagues (1995) found that hospitals in North America have increasingly permitted and encouraged men to take active roles in caring for their partners during labour, since nurses and hospital-based midwives often have little time for psychological support. It has become usual for the woman's partner to remain with her throughout labour and delivery. These researchers mention a Canadian study which found that women rarely expected to have the nurse with them throughout labour, and tended to rely on their partners for support, help with breathing techniques and comfort measures (Hodnett, 1983; quoted in Enkin et al., 1995). The women felt nurses would be too busy, were strangers they did not welcome, or were viewed as being present for purely technical support. The amount of support the partner is able to give can however, depend on the relationship between the woman and her partner, his own desire to be present, and the partner's own need for support.

Gagnon and Waghorn (1996) say nurses should not assume that their support is not needed because the labouring woman already has a partner or family member, or is electronically monitored and medicated. Their study of supportive care by maternity nurses in a large Montréal teaching hospital, concluded that intrapartum unit nurses spent only a small amount of time providing supportive care to women in labour. The widespread use of technology they stated, seems to give more emphasis and value to technical expertise, and less on supportive care expertise (Gagnon & Waghorn, 1996).These researchers recommended that nurses, physicians, midwives, administrators, and educators must believe that supportive care is of equal or greater value than technical care, and should be provided to the woman throughout labour and delivery. Simpkin (1991) advised caregivers that they had a great influence on how women remember their birth, and have the potential for psychological benefits or damage. Enkin et al. (1995) for their part, urge that every effort should be made

to ensure all labouring women receive support from specially trained caregivers, as well as those close to them.

Results from this present study might seem at odds with these previous findings and recommendations. It did not generally seem that the participants in this study either expected, or relied on the caregiver to provide psychological or emotional support when their family or partner were actively involved in providing support.. When families and partners were present and actively involved in supporting and comforting the labouring adolescent, then hospital caregivers tended to be regarded as more concerned with the technicalities of labour, there to provide a safe and painless delivery. In fact, for some of the participants, nurses seemed almost like shadowy figures, with little real connection or rapport, except for carrying out particular tasks. Sometimes adolescents found it hard to distinguish between nurses and other hospital personnel, and no adolescent could remember any of the nurses' names.

However, this does not mean to say that the adolescent participants were not sensitive to the care provided to them or the attitudes of their caregivers. Rather the opposite is true. They were extremely sensitive to the way caregivers treated them, to the point of excusing nurses for being slow to answer the bell, or for being rude to them. Although findings in this study indicated greater reliability on family or partner to provide comfort and support, there were times when the caregiver was looked to for comfort and reassurance, particularly when the partner or family members were not present or sufficiently able to help. Sometimes a nurse would then establish a supportive relationship, explaining, comforting, staying with the teenager. Two mothers mentioned their appreciation of the time that nurses spent with them, and how pleased they felt nurses were when the baby was born. When caregivers provided hands-on support, or took the time to be with the adolescent, the adolescent was reassured, and her experience was enhanced. Women in a recent Icelandic study, also emphasised their need for both the involvement and presence of their partner, and a

competent and caring midwife (Halldorsdottir & Karlsdottir, 1998). Hodnett (1996) believes that support from the nurse is an essential complement to the partner's support. The effect of support on the woman by someone whose knowledge and expertise respects may differ from that provided by the person she loves. Findings from this present study would seem to bear this out. The nurse may also act as role model for the partner, reassuring him and helped him to find a useful role during this significant moment, as well as providing him with opportunities for respite (Hodnett, 1996).

Participants in a qualitative study of women's labour concerns two months after delivery, described behaviours by birthing attendants that had enhanced their experience (Fowles, 1998). These behaviours included being professional, supportive, encouraging, kind and patient; and giving words of comfort. For these women, negative experiences or frustrations related to the pain they experienced during and after the birth, their lack of control, lack of knowledge, and negative perceptions of caregivers.

In this study, there was a variation in the degree to which caregivers fulfilled adolescents' needs for comfort, explanation and understanding. When caregivers failed to respond adequately to participants needs, the adolescent was fearful or frustrated, and her experience was diminished. In the case of two mothers in particular, the adequacy of care provided by the nurses, they felt, was insufficient for their needs. In their opinion nurses did not appropriately respond to their appeals for help, failing, or being slow to answer the buzzer, or not giving credence to what the teen had said. Nor did these adolescents perceive an empathy for them on the part of the nurses. One young mother said she was told to calm down and stop yelling by the nurses, but was not given the explanation or reassurances which she would have liked from them. It was left to her sister to hold and comfort her.

An obstacle to the establishment or continuity of a supportive relationship between nurses and participants was the demands of work schedules which

could mean a change of nurses during labour. Although a supportive relationship may have developed through labour, the same nurse might no longer be there for the delivery.

The experiences of the two teenagers in this study who delivered outside the hospital differed substantially from that of the other participants. The fact that they took the decision to depart from the established system of care would already seem to set them apart from other participants, since midwifery care is not yet part of the mainstream in Québec. However studies reviewed by Burtch, 1994) have shown that those who choose midwifery care are not generally from marginalised groups. They tend to come from a wide variety of backgrounds, and have generally given a lot of thought to their decision (Burtch). It is less common however, for teens to choose this option, often apparently not being aware of the possibility of perinatal care outside the hospital system.

The two adolescents had the advantage over other participants in this study of establishing a relationship with their midwife during the course of their pregnancy that transcended the normal client-professional relationship. With visits that generally lasted forty-five minutes to an hour, they felt they had come to know their midwife, and also be well known by them. Through the prenatal period was built a consistent relationship of rapport and collaboration, preparing the participant for her childbirth, including discussions of their wishes for the birth, and the possible risks involved in childbirth. Midwives appeared to have achieved a degree of dialogue/interaction and the ability to nurture and provide 'comfort' that Paterson and Zderad describe as the basis of nursing (1988). One participant met her midwife early in her pregnancy, and the other changed her care from a doctor to a midwife towards the end of her pregnancy, however they had each established a relationship of respect and trust by the time of their childbirth. According to these adolescents the midwives offered a flexible, noninterventionist approach during the birth. The two participants were attended only by people that they knew and trusted, and both were completely satisfied

with their experiences. This is consistent with Hodnett's (1989) comparative study of home and hospital birth, where women felt a greater satisfaction with home birth midwives due to the continuity of caregiver, facilitating rapport and the sharing of control. Continuity of caregiver has been frequently reiterated as a factor important to women during pregnancy and childbirth (Brown & Lumley, 1994; Enkin et al., 1995; McCourt, Page, Hewison & Vail, 1998). Aside from the comfort of knowing the caregiver, there is evidence to show that women who have received continuity of care may require less pharmacological analgesia or anaesthesia, less augmentation of labour with oxytocin, have a shorter labour, and a better 5 minute apgar score (Enkin et al., 1995). As well, these researchers say, the mothers may feel better prepared for labour, feel the labour staff to be caring, feel in control during labour, and well prepared for child care. This seemed to be the case for the two adolescents in this study birthing outside the hospital. One participant who gave birth in hospital also mentioned the reassurance she felt when her doctor came to attend her birth. During pregnancy this doctor had become a non-judgmental confidante for her, and she was happy to put her trust in him for her birth.

It can be proposed that continuity of care was only one factor that made a difference in the childbirth experiences of the adolescents. Also relevant was the place at which they gave birth: hospital, home, or birthing centre. Women in the study by McCourt et al. (1998), for example, expressed a preference not only for continuity of caregiver, but also for care to be provided by midwives in a community setting. They found hospital-based care to be more fragmented, inconvenient and impersonal (McCourt et al., 1998). One adolescent in this study described the hospital building itself as being a "cold place", and two mentioned a lack of cleanliness. Hospitals can also be frightening places for those not used to them, even with efforts to 'humanise' their appearance. The birth setting characteristics valued by couples in the study by Morison et al. (1999) were ones that reduced stress and increased relaxation. They adapted their physical and social environment to made it conducive to childbirth. The childbirth experience of

these couples was facilitated by birthing in their own homes because they were able to create a beneficial environment where they took on the responsibility of birthing (Morison et al., 1998, 1999). One of the reasons for choosing a home birth, for the participant in this study who did so, was because she thought how nice it would be to have her baby at home where she felt comfortable. Both participants birthing outside the hospital described the creation of an atmosphere for the birth, by having candle light, soft music, or requesting silence. In comparing home and hospital childbirth, Hodnett (1989) speculated that the childbirth environment appeared to play a crucial role in experienced control. She hypothesised that in the absence of more research related to the childbirth environment, efforts made to decrease the load of the birth setting (e.g. Limiting the number of unfamiliar caregivers, lowering noise and light levels, etc.) could have a markedly positive effect on the subjective evaluation of the birth experience.

The fact of being a teenager did not on the whole seem to participants to affect the type of care they received during their labour and delivery. There were two contrasting exceptions to this, with one participant feeling she had received more information because of her lack of experience, and another feeling she had received less respect. Teenagers in Bergum's (1997) study of the transition to motherhood, spoke of the pain of censure they had felt from others as occupying their thoughts more than the pain of the labour and birth itself. In this current study, participants felt that stigmatisation occurred not during labour and birth, but in the attitudes shown to them after the birth, on the part of some hospital personnel and other mothers in the hospital as they learnt how to care for their new baby. One of these teenagers was particularly anxious to return home after the birth, feeling she was treated like a child, slow to understand and follow instructions. Two participants were offended by receiving a visit from a social worker after the birth, feeling that it was assumed they would not be capable of caring adequately for their baby.

## Pain and its Meaning

Each participant in her own way described her reaction to the pain she felt. In choosing to deliver outside the hospital system, two of the mothers had also chosen not to receive pharmacological pain relief, knowing that this would simply not be available to them in normal labour. They chose ahead of time to endure the pain, as a natural part of the process of birthing a child, and try alternative means of coping with it, even if one mother said that she might have been tempted to ask for an epidural if it had been available at the time because of the intensity of her pain. Those who followed the established order of care expected to have their pain relieved, usually an epidural, without probing too far into the pros and cons of the types of anaesthesia available, or the necessity to banish pain. This was with the exception of one mother who refused an epidural for several hours despite her induction, in the fear that her baby would be harmed.

It emerged through the adolescents' descriptions that most had accepted and for the most part expected, not only the relief of their pain, but a managed labour that often included induction, fetal heart monitoring, bedrest, and fasting. They did not seem to have questioned hospital procedures or protocols. All nonetheless experienced pain at some time or other, prior to the epidural, or when it had worn off, but this did not detract from their sense of achievement. This accords with other studies where it has been found that a positive birth experience does not necessarily exclude pain and distress, but that the birth experience is multidimensional (Waderström, Borg, Olsson, Sköld, & Wall, 1996; Scuiling & Sampselle, 1999). This also concurs with Oakley's (1980) findings that a woman's feelings about the birth and her ability to cope, are more important to her than the amount of technology used in childbirth.

Epidurals appeared to be the method of choice for pain relief in hospital, the only other option apparently being intramuscular medication. Some hospitals were equipped with whirlpool baths, but did not permit the

labouring adolescent to use them because of reasons that were unclear, although one participant believed that it was because of the possibility of infection once dilation had started. This is despite evidence to the contrary that well-maintained whirlpool baths offer little danger of infection, even after membrane rupture (Hartley, 1998), and that at least for some women, water can reduce the pain of contractions. Participants delivering in hospital were not permitted to ambulate once in labour, and epidurals of the type they received would have most likely precluded this possibility once in place. The option of other types of epidurals, such as "walking epidurals" did not seem to be available, despite their growing popularity elsewhere (Iglesias, 1996; Tan,1998). Although three of the participants presented at hospital with partial or complete rupture of membranes, it is not clear whether the fetal head was engaged or not, since participants did not specify this. No participant mentioned it as a reason given to them for not ambulating.

Freedom of movement throughout labour is a practice that the World Health Organization recommends should be encouraged (1997). The fact that none of the hospitalised adolescents in this study seemed to be permitted freedom of movement during labour calls into question the flexibility of care at these three different teaching hospitals.

Lundgren and Dahlberg (1997) proposed that a key to how women handle their pain during childbirth is their ability to see meaning in suffering. Paterson and Zderad suggest that experiencing discomfort or suffering can contribute to an individual's growth or more-being (O'Connor, 1995). One aspect of health in humanistic nursing theory is the process of finding meaning in life, in a person's willingness to be open the experiences of life (Praeger, 1995). Some of the mothers rationalised their pain by seeing it as a necessary step towards the reward of a baby. One mother endured the severe pain of induced contractions rather than take a medication she was afraid would hurt her baby. Another was able to discount it, by concentrating on the work of pushing that had to be done.

Still other participants were happy to have all sensation dulled, and count on their caregivers to tell them when it was time to push or not. For the majority of the adolescents in the study, pain did not serve any function, and was to be avoided, even it this meant the loss of most or all sensation. However, when they did experience pain, they were often able to withstand it if they could see it as a necessary step in the delivery of their baby or if they felt in control of the situation.

The two mothers who delivered outside the hospital not only chose ahead of time not to have pharmacological pain relief (even if one felt that she might have succumbed at the time if it had been available), but were also active participants in deciding before, and during labour on other aspects of their labour and delivery such as the labour environment, i.e. using candles, music, or silence, or deciding what position to assume for delivery. They were proud of their ability to endure the pain of labour, and had not resorted to artificial means of taking it away. The experience of pain for these adolescent mothers had become a type of rite-of-passage that they had passed through. Having plumbed the depths of pain, they found strength and confidence, that one said would help to prepare for the vagaries of life with children. In the case of these two teens delivering outside the hospital, their sense of pride and achievement was all the greater for having gone through the pain without anaesthetic. This finding is supported by Lundgren and Dahlberg's (1996) study where the essential meaning of childbirth pain was described as 'being in one's body', i.e. the woman being present in the delivery process and allowed to interpret signals from her own body. Women in this study regarded pain as a natural part of delivery process, and found the strength and power to cope with it within their own subjective bodies (Lundgren & Dahlberg). Trusting the people around them, and receiving affirmation from them were also important to women in handling their pain. Pain as part of labour and delivery was found in this study to give strength and power, to move the woman closer to, and into contact with her baby, and to give meaning to the transition to motherhood (Lundgren & Dahlberg).

Green's (1993) prospective study about expectations and experiences of pain in labour, also found that in general, women were more satisfied if they had not used a drug than if they had used it. In her questionnaire-based study of over 700 women, Green found a strong link between expectations and experience. Expectations about the degree of pain during labour, the avoidance of drugs, and the usefulness of breathing and relaxation exercises were generally fulfilled (Green, 1993). These expectations were also associated with higher levels of satisfaction about the birth, so that Green found high expectations to be good for women. Based on this conclusion, the expectations of the two adolescents in this study that they would be able to contend with the pain, could be proposed as a factor in their ability to cope. This view is reinforced by findings from a study on home birth by Morison, Hauck, Percival and McMurray (1999). Participants in their phenomenological study viewed childbirth as an experience involving conscious involvement towards achieving personal expectations. They did not see birth as a frightening event, but as a natural positive, physiological process which a woman can achieve without resorting to pharmacological assistance (Morison et al., 1999).

Bergum's (1997) insightful discourse on labour pain does not deny the difficulty women may have in enduring this pain, particularly over a long labour. However she also describes the modern day low tolerance for pain, and the distancing from visceral experience, that results from removing all knowledge of pain. Women in Bergum's hermeneutic study found a new awareness of themselves and their inner strengths and capabilities through their labour pain, as well as a connectedness with other women in the shared experience. Support from partners, friends and caregivers in the form of recognition of her pain, as well as encouragement, touch, suggestions, or quietness, is crucial in helping the women to use her special capacities (Bergum, 1997).

Niven (1994) contends that the caregiver's appreciation of the pain felt by the labouring woman helps in the construction of a good relationship. This in turn

enables the labouring woman to maximise her own coping abilities. When adolescents were told to stop yelling, or calm down, a clear indication that the caregiver did not appreciate the pain they were feeling, this did not help them. It only served to compound the distance they felt between themselves and the caregiver. In contrast, enhancing comfort may enable women to find the strength needed to transcend the birth pain, with less need for medical intervention (Schuiling & Sampselle, 1999). These authors hypothesise that interventions that increase comfort during labour support a woman's effort to be an active participant in the birth, connected to her body, emotions, and experience. The importance of the caregiver during childbirth has been put in no uncertain terms by Simkin (1991) who said that women may remember their caregiver forever. The caregiver can directly contribute to a woman's long-term satisfaction, and indirectly to her self-esteem (Simkin). It would seem that the more a caregiver is aware of this, the more heightened their sensitivity should be towards the woman they are caring for.

**The need for a Sense of Control**

The idea of coping with pain seemed to be associated with feeling a sense of control over events. Although they felt the pain, the adolescents outside the hospital were able to tolerate it by using a variety of means, including ambulation, hot oil compresses, massage, or having a shower or bath. For the teens in hospital, who had less alternative means of pain relief, being able to receive pharmacological pain relief helped reinforce their feelings of control. A recent descriptive qualitative study of women's labour concerns by Fowles (1998) corroborates this. According to her findings, feelings of unrelieved pain often resulted in women feeling a lack of control over their birth experience, which itself exacerbated the intensity of the pain. Schuiling and Sampselle (1999) offer another perspective on the notion of control and pain during labour in their examination of the notion of comfort in childbirth. They deplore the widespread beliefs that women are unable to give birth under their own power without

medication, and that childbirth pain is pathologic (Schuiling & Sampselle, 1999). Little encouragement is given to women to give birth under her own power, they say, despite the fact that most women are capable. These authors however, insist that pain and comfort in labour may be central to the woman's perception of mastery over the birth event. Rather than following the medical paradigm of the necessity for medication during labour, other supportive measures can reduce risks to mother and baby, and strengthen women during childbirth. Comfort given during labour has the potential to assist women to realise the power they possess to cope with labour (Schuiling & Sampselle, 1999). Certainly the majority of adolescents in this study seemed to be subject to this dominant view of pain, and expected pharmacological pain relief. As pointed out, however, when they did feel pain, they often found themselves able to withstand it, when it was seen as necessary, when they felt in control, and when they were supported by caregivers or loved ones. Halldorsdottir and Karlsdottir (1998) also conclude that a midwife perceived as caring, who is competent and involved in the woman giving birth, can help the woman retain or regain control and hence increase the woman's satisfaction with her birth experience.

Parents' desire to assume control and responsibility for their birth led them to choose a home birth in an Australian study by Morison and colleagues (1998). Participants in this phenomenological study sought health care professionals with whom they could birth in the way they wanted to, sharing power and decision-making. The researchers advocate a model of care where there is a sharing of responsibility for care with clients; breaking what they call the patriarchal culture of control within the profession of midwifery in their country (Morison et al., 1998). The manner in which the midwives cared for and guided the adolescents under their care, as described by participants in this study, seemed to come closest to this new model of sharing responsibility for care.

The way in which women dealt with contractions in the study by Morison et al. (1998) also demonstrated the intertwining of coping with pain with a sense of

control, in common with this current study. Women used internal control, taking charge mentally and physically, to work with their bodies and accept the pain of labour. This ability to assert control, they speculate, may have been assisted by values, beliefs, past experience, informal support, and professional support from the midwife (Morison et al., 1998).

Possessing a sense of control for adolescents in this study seemed to begin during the pregnancy, and develop over the course of time in the preparation for childbirth. Some mothers read extensively about pregnancy and childbirth, others paid attention to their diet and exercise patterns. A number attended a nutrition service where they received free milk, oranges and eggs (OLO) throughout their pregnancy, as well as dietary advice. All attended at least a few prenatal classes, although opinions varied widely on their usefulness and applicability to their age group. One mother decided to use a birthing stool for labour after seeing it demonstrated at a prenatal class. Another felt that her irregular attendance at prenatal classes put her at a disadvantage in labour when she did not know how to push properly. One adolescent felt that her sound preparation for childbirth had helped make her more relaxed, because she understood what was happening.

Adolescent mothers delivering in hospital often felt that they had actively participated in their labour, regardless of if they had been induced or not. They did not usually question hospital childbirth protocols, but felt that in asking for an epidural for example, that they had excercised a degree of control sufficient unto them. Sometimes it would seem that they obeyed directives from hospital staff out of timidity or in the belief that the nurse or doctor must know best, even if certain practices, such as amniotomy, or provocation of labour after rupture of membranes are controversial or of dubious benefit to the labouring woman (Enkin et al., 1995).

The attitude of the caregiver seemed to be an important factor in the adolescent's perception of control even when there was no clear evidence of their participation in decision-making. One participant stated that she had felt in control, even while admitting that she had been told, rather than consulted about certain procedures that would be taken. This participant felt that she had been actively supported by medical and nursing staff who had her interests at heart. It appeared that if the adolescent was given a satisfactory explanation for the necessity of a particular intervention, and felt that she had participated in the decision-making process, she retained some sense of control in this way. Similarly women in the randomised trial carried out by Lavender et al. (1999) welcomed the opportunity to contribute to decision-making in their labour management. It was also found in this study that the concepts of control, pain, information, decision-making and support interrelate (Lavender et al.). McCrea and Wright (1999) conclude that being involved actively in their care may help to promote women's' feelings of control as well as enhancing their confidence in their ability to control pain. Women find reassurance in having a sense of partnership, within which they may take directions from the person they regard as expert (McCrea & Wright). Trust in the caregiver, and the receipt of information have already been linked with retaining a sense of control (Lundgren & Dahlberg, 1996; Halldorsdottir & Karlsdottir, 1996; Morison et al., 1998,1999). Feeling a sense of control in childbirth has also found to be an important factor in women's long-term satisfaction, and their emotional well-being after the birth (Green et al., 1990; Simkin, 1991), as well as their transition to parenthood (Lundgren & Dahlberg, 1998).

Both participants who delivered outside the hospital talked in terms of their own decision-making, even though one participant said that she had not thought much about the concept of control as such prior to her delivery. She had wanted a 'natural' birth, and had sought out the birthing centre as being able to provide her with this. But it was only afterwards in reflecting about the birth with her midwife and with her participation in the study that she thought more about the

idea of control and the importance to her, even as a young mother, of having been able to take control through pregnancy and birth. The other participant, delivering at home, had had clear ideas about how she would like her childbirth experience to be, including the use of candles instead of electric lighting, communication by gestures, rather than by talking, and a number of other specifications. As well, being allowed to trust in, and listen to her body at each stage of labour was of paramount importance to her, with the help and guidance of the two midwives present. When seen as instinctively knowing how to birth, encouraged and assisted by those around them, women have a greater perception of control (Morison et al., 1998). This finds echoes again in humanistic nursing theory and the imperative for enabling choice in a nurturing relationship in order to promote the 'more-being' of the other (Paterson & Zderad, 1988).

## Childbirth as an Accomplishment

To young women who had perhaps not had many achievements in their lives to look back on, their birth experience gave them a real sense of accomplishment. Each participant delivered a baby in good health, with no apparent complications, for baby or mother, except for one uterine inversion which was repaired. Each had been through a gamut of physical and emotional sensations, and at the end found that they had created a healthy baby, a tangible award for their efforts. Having a baby, made the doubts and worries of pregnancy, and the pain of childbirth all worthwhile. One mother felt that it was her destiny to be a mother. She was not alone in saying that she could not wait to have another baby.

Giving birth to a child, particularly a first child is a momentous event for a woman of any age or of any background. Simkin (1992) described childbirth as an event that in itself involves a range of emotional and physical stressors, and also brings a permanent role change. For adolescents in this study, the birth was of even more consequence, being often one of the few things they had actually

completed, or succeeded in during their lives. No matter what type of experience they had during labour, the end result, the baby, ultimately made it all worthwhile to them. Through the baby they achieved a social recognition, as mothers, and as adults.

Oakley (1980) described childbirth as both a biological and cultural act. The way that birth is managed, in her view, has important implications for society as a whole, its view of reproduction, the position of women, family relationships, child socialisation and the construction of adult personality. The essential message is however that becoming a mother is an important transition that is not without difficulty, and needs considerable personal adjustment.

Whatever the adolescent's reasons for becoming pregnant in the first place, research has shown that they often have a conscious or unconscious desire to have a child of their own to love (Adler & Tschann, 1993; Bélanger & Charbonneau, 1994; Secrétariat de la condition féminine, 1997). Something seems to be lacking in their lives that leads them to see motherhood alone as a fulfillment, and to put this before any other goals. This goal is incongruent with the expectations of our times when motherhood comes secondary to career aspirations. Hendricks (1982) wrote of adolescents' difficulty in finding a meaningful role in contemporary society that translated into suicide, accidents, and homicide. In becoming mothers, adolescents in this study have avoided complete alienation, and found a meaningful role for themselves.

Oakley (1993) warns however of the idealization of the state of maternity where women are deprived of the chance to understand the benefits and the hazards that motherhood may pose to their own identities and lifestyles. In an idealised mother-child relationship, women do not begin to solve their basic problem, says Oakley, that is to develop a sufficiently individuated sense of self for themselves or their daughters. They possess unrealistic expectations for what they may achieve for themselves through biological reproduction. While

motherhood is broadly esteemed as necessary, it is also a very socially undervalued occupation (Oakley, 1993). Adolescents in this study have greatly valued their childbearing experience, as providing them with both as sense of achievement and a worth in society and in their own eyes. Although immersed in, and conscious of the day to day attentions that a young baby requires, they have not yet had to struggle with the lack of interest or support that society is ready to give them for simply being mothers.

## Childbirth as a Maturing Process

Woven through all the testimonies of the teenage mothers was the profound desire to be a good mother, whatever their individual interpretation of this was. This intention had begun well before the birth, in their preparations for labour and motherhood, and in their efforts to learn about their pregnancy. It continued in their adjustments to their lives, in putting the baby's needs ahead of their own, and in re-organising their futures so as to more adequately provide for their child.

The relationship between mother and baby developed through her pregnancy. Some mothers talked about how they had thought about their babies prior to the birth, how they had tried to eat well or exercise, to have a healthy pregnancy and a healthy baby, even if it was not always easy for them to be consistent. During her pregnancy one mother repeatedly spoke to her baby, telling him how much she loved him. Another had done her best to eat heartily and well when pregnant, and was convinced that her baby was big and healthy for this reason. At the same time, this caused some internal conflict, as she had felt unable to stop herself from eating large quantities, and worried that in future pregnancies she would not be able to handle her compulsion to eat. Logically this teen understood the importance of good nutrition for her developing baby, but was still caught up in typical adolescent conflict over food and body image (Mercer, 1990).

Even if the baby was unplanned, as seemed to be the case for the majority of participants, or the pregnancy had been stressful at the beginning, by the time of the birth the mother was reconciled, and determined to do the best she could for her baby. The adolescents concern for their baby's welfare led them to reorganise their lives, and re-think their goals. Bergum (1997) also sensed that childbirth can bring a deeper sense of confidence to young women, and a determination to improve their lives for the sake of their baby. Smithbattle's (1995) study found that teenagers' experience of mothering and connection to their infant were catalysts for becoming more responsive to self and the infant, contributing to new narratives of the self and transformed visions of the future. The teenage mothers in her study tried to correct for their children what they felt to have been lacking in their own childhood (Smithbattle, 1995). Smithbattle and Leonard's more recent study (1998) also affirms that mothering can actually be for some a corrective experience that cultivates moral sensibilities which are more fully developed over time. These researchers challenge the dominant view that early pregnancy compromises the future and development of young women.

Participants in this study described their changed attitudes and behaviour that occurred with the birth of their child. They all had intentions to complete their education, to take on 'boring' jobs in order to take care of their children, to become responsible, or give up their previous notions of looking out only for themselves. The usual preoccupations of middle and late adolescence have been altered. The peer group so important to this phase of life, now has little in common with the teen mother (Mercer, 1990). The need for independence from their families has been replaced by their need for help and support from their families, combined with the desire to assert themselves as principal caregivers of their babies. The baby has taken priority in their lives now, and they are determined to do the best they can by their child. Smithbattle (1995) heard the same avowals from three groups of teenagers in her study of motherhood. Motherhood for impoverished teens 'granted them a more hopeful future' rather

than risking their future. Even the third group of teen mothers in her study, whose backgrounds were not as deprived as that of the first two groups, and with perhaps more to lose, felt that motherhood involved more gains than losses. The ability to succeed in their ambitions is more likely to be hindered by professional views and social policy condemning teenage pregnancy and mothering than by the teens' individual efforts (Smithbattle & Leonard, 1998). She contends that instead of focusing on the deficits and failures of young mothers, there must be recognition of how their decisions and actions make sense of the social world, and a commitment to public policies that enable their future. Bergum (1997) also alluded to the prevalence of this negative view of teenage motherhood in the Western world, and questioned its inculcation in social policies affecting teen mothers. There is little doubt that the birth of a child accelerates the maturation process of the adolescent, changes her priorities, and gives her new focus to her life. She cannot succeed without help however, and battling against negative attitudes in society only adds to her burden.

## Limitations of the Research Study

The purpose of this study was to describe the meaning of the experience of childbirth for adolescent girls. The eight adolescents who participated in the study gave birth in a variety of facilities in the Montréal region, including three different teaching hospitals, one birthing centre, and one adolescent who had delivered at home. Although this represents a range of experience, it cannot be said to represent adolescents in general. The fact that participants were English-speaking can be said to be a limitation in a city like Montréal where the predominant language is French, even though a number of participants claimed to be at least partially bilingual. As previously mentioned, studies of this size and nature can only truly be said to reflect the experience of those who participated in it, and even then represent one of several possible descriptions. Generalisability of the findings is debatable. As Giorgi (1989) has himself said, the data obtained

from a phenomenological study cannot reflect the totality of the experience, nor can a research situation capture the way that humans live spontaneously in the world.

Another limitation of the study concerns the intrusion of the researcher of self in the study. Although one brackets one presuppositions about the phenomenon prior to undertaking the research, and does one's best to remain open to hearing the experience of the other, there is the inevitable presence of the self in the interview process, i.e. the type of question posed, the tone used by the researcher to pose a question, the interest the researcher holds in the subject matter, the nature of the relation established between the participant and the researcher All these elements will vary from one researcher to another, and have some influence on the interpretation and results obtained. Paterson and Zderad (1976) have stated that a person cannot be completely without perspective, but one strives nonetheless, to remain open to the perspective of the other. As recommended by Giorgi, I bracketed my preconceptions about the adolescent childbirth experience (see Appendix A), and did my best to remain open to each participant, both during the interviews, and in review of and reflection about the transcripts.

A discussion about limitations must include mention of the credibility of the participants' testimonies. I believe that the adolescents participating in this study spoke frankly and from their hearts about their experiences. A number expressed their desire to help generate more knowledge and understanding about the teenage experience of childbirth, and not one person disembarked from the study, although two moved away after the first interview and contact was lost. In each case, I as researcher felt privileged to have these young mothers confide in me, and tell their story as they remembered it.

## Implications for Nursing Practice

Findings from this study demonstrated that despite their immersion in the experience of childbirth, and their dependence on family or partner support, the adolescents were also very aware of the degree of help and support provided to them by their caregivers. The degree of attention and comfort given to the adolescents by the nurse appeared to vary from one individual to another. Continuity of care is practically impossible in the way most teaching hospitals are set up, but it was nonetheless possible for nurses who took the time to provide a great deal of support to the adolescent. Caregivers needed to get beyond any displays of bravado that might have been assumed by the adolescents in this study, and to be sensitive to their needs for help and comfort even in the presence of partner or family members, as well be as flexible in their care.

Findings from this study also indicate the needs of some labouring adolescents to have a number of support people around them, which might include their partner, mother, other family members and friends. Respecting her choice of support persons should be implicit in nurturing the adolescent during childbirth.

Facilitating the ability to exercise responsible choice is fundamental to humanistic nursing theory, in the development of well-being and more-being. Adolescents in this study frequently referred to the importance of participating in decision-making and feeling in control. Those caring for adolescents in childbirth should involve them in decision-making concerning the management of their labour and birth, and the making of responsible choices. Caregivers also need to help the labouring adolescent retain a sense of control by providing information and encouragement and helping them to be aware of what is happening with their bodies.

Efforts have been made to 'humanise' hospital settings for childbirth, but the dialogue has not ended on the effects of environment on the childbirth experience. Hodnett (1989) and Morison et al. (1999) raised the issue of how 'place' influences peoples' perception of health care. There should be more reflection on how to adapt the hospital environment to make it more conducive to birth, as well as more possibilities of giving birth outside hospital.

The British study by McCourt et al. (1998) has recommended re-structuring of care so as to allow for more widespread one-to-one midwifery care. With changes coming to the Québec health-care system in the form of legalisation of midwifery care, perhaps it would not be so far-fetched to recommend structural changes also allowing more one-to-one care by nurses and midwives. Hospitalised adolescents described a minimum of comfort measures provided to them during labour and birth. Perhaps hospitals could look at using other forms of comfort measures offered to women in labour, such as massage or counter-pressure, other forms of epidural that allow sensation without pain, and in general increasing the value of emotional versus technical support.

In conjunction with well-established guidelines from the WHO, every effort should be made to help women in the establishment and continuation of breastfeeding, and to abstain from placing obstacles to this such as offering formula to breast-fed infants, as was the case in some instances according to participants in this study.

Finally, health care practitioners and public policymakers in Canada should start to recognise the positive aspects of teenage motherhood, and the desire of adolescents mothers to do the best they can for themselves and their children. This would be preliminary to devising social, economic and health-care policies that would enable these young mothers to fulfill their potential, and contribute meaningfully to contemporary society.

## Recommendations for Further Research

Since this study as noted above was done with an English-speaking population in a predominantly French-speaking city, it would seem appropriate to suggest a similar study made with French-speaking adolescents. This might capture a different aspect of the experience, not only because of difference in language and culture of the participants, but also because there is a different set of health care establishments and support organisations in Montreal that cater to the French-speaking population.

This study concentrated on the childbirth experiences of adolescent mothers. In all but one instance, the 'babyfather' was present. There is in general a lack of literature exploring the father's experience of childbirth. It is recommended that a similar study be made concerning the adolescent father's experience of childbirth, to discover more about their perspective and needs, particularly in view of the fact that many adolescent relationships fall apart within two years of the birth of a child (MSSS, 1993).

A surprising finding of this study was that seven out of eight adolescents decided to breastfeed. This seems like a high proportion relative to the low average percentage of Quebec women who breastfeed (Ruby, 1996). A research study could be carried out to explore the adolescent mother's initiation and persistence or cessation of breastfeeding.

This study intended to recruit across a wider age spectrum, from early to middle or late adolescence. Because of difficulty recruiting the younger age group, it focussed on the experience of childbirth for the middle to late adolescent mother. It would also be of interest to pursue a study with a younger adolescent population, as was the original intention of this study, keeping in mind the difficulties of recruiting such participants.

This chapter has discussed the study's findings in the light of recent research. Various aspects of the study were discussed, including methodological issues, the participants, limitations of the study, nursing implications, and recommendations for further research.

# CONCLUSION

Findings from this study indicate that the adolescents shared many of the same needs and aspirations for their childbirth experience as adult women. In common with more mature women they found comfort in having their partners and family actively present during the birth. Distinct from the usual requirements of the adult woman, a number found a need to have several family members and friends around them. The adolescents also found comfort in being provided with information and a chance to participate in decision-making during labour and birth; in knowing and trusting their caregiver, in being listened to and allowed to trust in their own bodies. The adolescents felt a need for encouragement and reassurance and the personal implication of the caregiver in their experience. They also needed to be treated with respect and dignity, and were extremely sensitive to any perceived slight made to them because of their youth.

The adolescents were not always forthright enough or knowledgable enough to question certain protocols concerning their labour and birth. The majority of hospitalised participants appeared to have accepted interventions or directives without protest, even when these divurged from recommendations made in the research. Nonetheless, it was important to each of them to feel some sense of collaboration in decisions made, even if it was in ceding control to the caregiver.

It was unusual that two of the participants had chosen to seek care outside the hospital system. This is in a province where hospital care for childbirth is the norm, and midwifery care is not yet fully legalised or accepted. Both adolescents felt that they had received a quality of care which would most likely not have been available to them at the hospital. Each felt they had received personalised care given only by those whom they were familiar with, and felt complete trust in the actions and guidance given by their midwives. They felt proud that they had found the strength within themselves to cope with an unmedicated labour and birth. The sense of empowerment they gained from their childbirth experience

was reinforced by the type of care they had received from their midwives through the perinatal period.

Childbirth brought each adolescent an overwhelming sense of accomplishment, perhaps even greater than that of adult women since they had few previous achievements to boast of. Any pain, worry, discomfort and fear which they had felt during their pregnancy, labour and birth were all worthwhile in the end because of the joy they found in the creation of a healthy baby.

The birth of their child brought them a new sense of purpose and a determination to improve their lives for the sake of the baby. Each was resolved to be a good mother to their child, however they might interpret this to be. Most of the teens planned to continue their schooling, and some were already pursuing this ambition. All found a re-organisation of priorities in their lives, so that consideration of the baby and his needs came first. Some of the young mothers with less resources even deprived themselves in order that the baby should be properly looked after. Some found there was a healing of family breaches, including a new connection with their own mothers in the sharing of a common experience, and in caring for the baby.

It would be simplistic to assume that each participant will succeed in her goals and live happily ever after. There will no doubt be many pitfalls which they will encounter, especially when they come to realise how little value is given to women today for simply being mothers. However, as has already been demonstrated, teenage motherhood often involves more gains than losses. What is needed is not a condemnation of teenage motherhood, but a re-evaluation of the limited life chances they have possessed prior to pregnancy, combined with social policies than enable good mothering.

This study grows from several years of reflection, both as a mother and a nurse, on the impact of the process of childbirth itself on women's lives. Added to

this is a more recent awareness of the increasing numbers of adolescents in Québec who are not only becoming pregnant, but deciding to keep their babies. In conjunction with both the philosophy of phenomenology, and the essence of nursing that the human experience is of great importance, this study has looked at the lived experience of adolescent childbirth. There is no doubt that the experience of adolescent childbirth is a subject that has been largely neglected in the research literature. It is my hope that findings from this study can provoke more reflection on the adolescent experience of childbirth so as to ultimately provide them with improved, more appropriate care.

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# APPENDIX A

# BRACKETING

# THE RESEARCHERS PERSPECTIVE

My perspective on childbirth as it pertains to both adult women and adolescents has grown from several years of discussion with both mothers like myself, plus a variety of people working in the health sector, as well as extensive reading and reflection.

My belief is that childbirth is not only significant as an experience in itself, but also as the threshold through which one passes into mother/parenthood. It marks the end of one period of life, and the beginning of another, with all the responsibilities, worries, frustrations, and of course joy that children can bring. The type of childbirth experience one has can have an effect on the mothers perception of her own adequacy of a mother, on her relationship with her baby, and her partner, and her adjustment to her role as a mother. It can be an experience of fear and loss of control, or submission to numerous procedures, or it can be a transformative, exhilarating experience that one wishes to relive and recount for many years to come.

For the teenager, the experience of childbirth is no less of a momentous event. For the first time in her live she may feel pain, as well as a range of emotions that she never realised were possible. Her experience of childbirth may not necessarily be equated with that of her more mature counterpart. She may be more vulnerable due not only to her age, but also her lack of life experience, lack of support, and her jeopardised future.

The teenager tends to be shy about her body, but throughout pregnancy, and then childbirth she is exposed to various health professionals, and questioned about her bodily functions. This can exacerbate the degree of stress she feels about her pregnancy and birth.

Teenager mothers may come to labour ill-prepared and frightened. Although it is often proposed that their experience is usually easy and uncomplicated I would conjecture that subjectively this is not always necessarily

the case. They might be too shy or embarrassed to ask questions during their prenatal preparations for childbirth, and so may come to the experience less well-informed than a more mature woman. They might not have attended prenatal classes regularly. Once at the place of birth, they may also be too shy to question procedures or make requests, out of a lack of knowledge or the fear of appearing difficult. The adolescent might not understand all that happens to her during her birth, unless lucky enough to have someone explain to her without being specifically asked.

Nurses and physicians may use models of care based on adult behaviour and expectations which may differ from that of the adolescent. There may also be unspoken disapproval from caregivers about teenage pregnancy that could colour the care they give.

After the birth the adolescent suddenly finds herself no longer with just her own interests to attend to, but also those of a baby who can not just be put aside or told to wait. She is undoubtedly proud of her baby, and finds she is granted a certain status or respect as a mother that she most likely did not have before. However, she also has to endure the disapproving glances of others, casting judgements because of her young age. When one is a teenager, with little life experience, an unstable relationship with one's partner, and little family support, coping with a baby can be even more difficult than that of an older woman in a stable relationship. Rosy dreams of a cuddly obedient baby may be shattered by nights without sleep, and days of worry and loneliness. Her experience of birth can affect her image of herself, her confidence, her bonding with her baby, and her relationship with her partner, as well as her ability to cope with her baby.

# APPENDIX B

# REQUEST FOR COLLABORATION

Montréal, 14 April 1998

Dear [School Director]

I am a Master's student in the faculty of nursing at the Université de Montréal. My advisor is Mme Céline Goulet. As per our telephone conversation of the 23 March 1998 I would like to request your permission to interview some of your clients as part of my Master's research study. My research concerns the experience of childbirth for adolescents between the ages of 14 and 17. Since there is little research to date specifically about this age group, I would like to discover more about how they describe their experience. My goal is to recruit between four and six participants, with whom I would have an interview approximately four months to nine months after they have given birth. The interviews would last approximately an hour, with possibly a subsequent interview to share my findings with them, and fill in any missing gaps. Before the interviews occurred, I would have a preliminary meeting with the participant in order to explain the object of my research to them, as well as to obtain their official consent.

Once I have been given approval by the comité d'approbation of the Université de Montréal, to commence my research, I will give you notice, and hopefully arrange with you an appropriate time that interviews could begin. I enclose a copy of the resumé of my intended study that I used for my research seminar presentation at the university.

I thank you for your help and cooperation in this matter,

Yours sincerely,

Fiona M. Hanley, B.A., BScN

# APPENDIX C

# PARTICIPANT INFORMATION

Hello,

My name is Fiona Hanley. I am a nurse and a student in the Master's of Nursing program at the Université de Montréal. I am currently undertaking a study of the experience of childbirth for adolescents.

Since you have recently given birth, I would like to ask for your help and participation in this research study. Participation in this study entails one or two interviews of approximately one, to one and a half hours with myself, the researcher.

Interviews will occur approximately five to nine months after the birth of your baby in a private room at Elizabeth House, or the Adolescent Clinic, at your home, or a place of your choosing. The first interview will be to ask you about your experience of childbirth, and the possible second one will be to present you with some of my findings, and to find out any missing information. Interview(s) will be tape-recorded.

Your participation is extremely important both for nurses and future adolescent mothers. The study will allow more knowledge about the adolescent childbirth experience, providing nurses with more guidance for care, and increasing the satisfaction future adolescent mothers may have.

All information received during the course of the study will remain stricktly confidential. Your name will not appear on any document, and all tapes will be destroyed at the completion of the study. You will be free at any time to withdraw from the study, without fear of any penalty, and you may refuse to answer any questions during the course of the interview.

Thank you for your collaboration. I am available to answer any questions you may have. My research advisor Dr. Céline Goulet, is also available to answer any inquiries.

Fiona Hanley, B.A., BScN
Tel. [redacted]

Research Advisor
Céline Goulet, RN, Ph.D
Faculté des sciences infirmières
Université de Montréal
Tel. [redacted]

# APPENDIX D

# CONSENT FORM

# THE LIVED EXPERIENCE OF ADOLESCENT CHILDBIRTH STUDY

## CONSENT FORM FOR PARTICIPANTS

Student Responsible for Study
Fiona Hanley, B.A., BScN
Tel: [redacted]

Research Advisor
Céline Goulet, RN,Ph.D
Faculté des sciences infirmières
Université de Montréal
Tel. [redacted]

This research study is interested in exploring the experience of childbirth of the adolescent mother. We would like to understand more about how adolescents experience childbirth. This study will result in a description of the experience of adolescent childbirth which will help in guiding nurses to better plan their care of adolescents during childbirth, and contribute to the satisfaction of adolescents during birth.

Each interview will be tape-recorded to permit a more accurate receipt of information. All information received during the course of the interview will remain confidential, and your name will not appear on any document related to this study.The tape-recordings will be for the exclusive use of the research team, and will be kept under lock and key during the research process. Tapes will be destroyed once the study is complete.

Your participation is sought on a strictly voluntary basis. You are free to withdraw from the study at any time, without explanation or justification, and may refuse to answer any question during the interview(s), with no fear of risk or consequence to you or your baby.

Participation in this study will bring you no direct benefit. However, your participation is very important in helping nursing research. Information gained from the interviews can help nurses and other health professionals understand more about the adolescent experience of childbirth, and therefore provide improved care for future adolescent mothers.

If you require any further information about the study, do not hesitate to contact the student researcher or the research advisor at the telephone number above.

## CONSENT FORM

I_____(name of participant in capital letters) agree to participate in Fiona Hanley's research study about adolescent childbirth experience. I have discussed with Fiona Hanley the subject, goals, nature, advantages, risks and disadvantages of the study in question, and freely consent to participate in this study.

My participation in this study will be sought within the period of approximately five to nine months after the birth of my baby. Participation in the study will involve one or two interviews that will last approximately one to one and a half hours each. The interviews may take place at my home, at a private room at Elizabeth House, or another place of my choosing.

_____ _____

Date Signature

Name: _____

Address:

_____

_____

Tel: _____

Date of Delivery: _____

Hospital where Birth Occurred _____

Prenatal Class: Yes No (Please circle correct response).

Where attended _____

# APPENDIX E

# INTERVIEW GUIDE

## INTERVIEW GUIDE

1. Can you tell me about your experience of giving birth to your baby?
2. Was your experience similar or different to what you had expected it to be?
3. Did you have someone there to support you? Who was this person? In what way did they help you?
4. How do you feel about the care you received during your childbirth?
5 Can you tell me if your experience of childbirth has changed you or your life in any way?