Young Women’s Experiences of Being a Mother to Preterm Infants:  
An Interpretative Phenomenological Analysis (IPA) Approach.  

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Abstract

The purpose of the current research was to explicate the experience of being a mother for young women who experienced a preterm birth over the first year of the infant’s life. Research has suggested that being born to a young mother and being born preterm are separate risk factors for adverse maternal and infant outcomes (Furstenberg, Brooks-Gunn, & Chase-Lansdale, 1989). However, little research has focused on the small group that are born both despite this theoretical ‘double risk’ (Thurman & Gonsalves, 1993). To achieve the aims of the project an Interpretative Phenomenological Analysis approach was utilised to analyse in-depth guided interviews from 14 young women (aged 15-19) who provided three interviews over a 12-month period. Four young mothers had given birth to a full-term infant and 10 young mothers had given birth to a preterm infant. Interviews occurred at time of infants’ discharge from hospital, 3-4 months post discharge, and 12 months post discharge.

Three core themes emerged: the dual nature of motherhood, actual/ideal incongruence, and transforming self. Overall, the results of this study suggested few differences in the experience of being a mother for young mothers of preterm and full-term infants. The universal experience of being a mother was described in terms of polarities – good moments and challenging moments – highlighting the dual nature of parenting. However, there was considerable variability in the perception of the challenges faced by young women over time, with highly resourced mothers perceiving fewer challenges and greater enjoyment. Preterm birth compounded the everyday challenges of motherhood for young women by emphasising transportation difficulties and placing women in more frequent contact with people who they perceived negatively judged them. While preterm birth did lead to more challenges while the infant was in hospital, it did not detract from the enjoyment and knowledge that the young women were now mothers, which shaped the young women’s experiences.

The experience of being a mother was fundamentally about a change to the self. The young women constructed themselves differently as a result of being mothers both in positive ways, as they moved away from delinquent behaviours, developed internal resources associated
with maturity, gained a positive view of self, and gained meaning for their lives, and in negative ways, as they idealised motherhood and fought against the social construction of teenage motherhood.

Some young women idealised motherhood and the reality of the lived experience often did not marry with the idealised image. It was proposed that idealisation served a self protective role for some of the young women, to help them defend against fears of not being good enough or not being able to cope and/or idealisation served as a coping strategy for others as they wished for an easier future. Young women with large discrepancies between their ideal and actual images of self were less likely to ask for help for fear that others would label them as inadequate mothers and thus emphasise the discrepancy between their idealised and actual views of self.

Support and family background factors interacted with the core themes but were not central to the experience of being a mother. Instead, young women differed in their willingness and capacity to access support and it was internal factors that influenced the young women’s ability to access available support.

The current research challenges the prevailing assumptions about young women who have preterm infants by suggesting that preterm birth does not adversely affect the experience of being a mother. This research provides a further challenge to the dominant conception that early motherhood is detrimental to young women by demonstrating both the heterogeneity of the group of young women who become parents and how young women manage the polemics of enjoyment and challenge on a day-to-day basis.

A limitation of the current study was the heterogeneity of the group, with factors such as infant gestational age and degree of difficulties post birth varying and possibly influencing the degree of distress and perceived challenges. Future research should consider investigating experiences of young mothers of low and high risk preterm infants and the dynamic relationship between hospital staff and young mothers in order to understand how these factors influence the young women’s experiences of a preterm birth.
Statement of Original Authorship

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

___________________________________________________________________

Nicola Jane Sheeran
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Chapter 1: Introduction

The purpose of the current research was to elucidate the lived experience of being a mother for young women who had a preterm infant during the first year of the infant’s life. Of particular interest was how being a young mother of a preterm infant differed from what might be considered a ‘normal’ transition to motherhood for young women who had a full-term infant. In addition, the current research was interested in understanding the young mothers’ experiences over time so as to explicate how things might change as they grew and developed. By studying the life of individuals over time, a picture of what it was like to be a young mother developed. This picture presented a multifaceted view of what was lived through and what influenced the young women’s adjustment during the transition. Whilst grounded in the particular history and cultural context of the young mothers in the present study, the results provide information that could help shape current practices and challenge widely-held beliefs about adolescent mothers.

Why study the experience of being a mother in the context of a preterm birth?

The origin of this question stems from research with adult women who become mothers to preterm infants. Currently in Australia, 8.2% of all babies are born prematurely. This increases to 8.6% in Queensland with over 9800 infants admitted to special care nurseries each year (Laws, Li, & Sullivan, 2010). Preterm birth is considered a stressful event with acute and chronic difficulties for both mother and infant (Affleck & Tennen, 1991; Davis, Edwards, & Mohay, 2003; Davis, Edwards, Mohay, & Wollin, 2003; Doucette & Pinelli, 2000). Adult mothers have also reported that it is the worst life event they have experienced (Whitfield, 2003). For many adult mothers having a preterm infant is associated with a delay in development of the maternal role and a period of adjustment occurs as the infant transitions home from hospital (Griffin & Pickler, 2011; Griffin & Abraham, 2006; Jones, Rowe, & Becker, 2009; Mercer, 1995; Rowe & Jones, 2008; Rowe & Jones, 2010).

However, one limitation of the current body of literature on the experience following a preterm birth is that it has primarily been conducted with adult mothers, most of who were educated, in stable relationships, and employed (Affleck, Tennen, & Rowe, 1991; Doering,
Dracup, & Moser, 1999; Doucette & Pinelli, 2000; Jones, Rowe, & Becker, 2009; Miles, 1989; Pinelli, 2000). These factors have been found to assist in positive maternal adaptation to the situation (Cronin, Shapiro, Casiro, & Cheang, 1995; Davis, Edwards, Mohay et al., 2003). The few studies that have recruited younger mothers have collapsed over age, making it difficult to know if there are aged-based differences in the experience (Cleveland, 2008). As such, the question remains as to how young ‘teen’ aged mothers, who may be contending with a number of other challenges in addition to those associated with a ‘normal’ transition to motherhood, experience the transition to motherhood with a preterm infant.

The transition to motherhood can be one of life’s more challenging and complex transitions (Cowan & Cowan, 2000). Having an infant fundamentally changes the woman and the way that she interacts with the world, regardless of age (Reilly, Entwisle, & Doering, 1987; Smith, 1999). While it often represents a time of joy and happiness, for some, childbirth can be experienced as traumatic and for others becoming a parent is associated with increased depression, anxiety, and stress (Alcorn, 2006; Fleming, Ruble, Flett, & Shaul, 1988; Fleming, Ruble, Flett, & Van Wagner, 1990; Goldstein, Diener, & Mangelsdorf, 1996). In addition, this transition can also be a demanding time for the couple, with relationship satisfaction often declining (Belsky, Lang, & Huston, 1986). Reported challenges include changes to gender roles, which often become more in line with traditional sex roles (Belsky et al., 1986), an increase in stress over time with a corresponding decrease in perceived partner support (Goldstein et al., 1996), and self pressure to live up to an ideal image of a ‘good mother’ (Brown, Small, & Lumley, 1997; Currie, 2009). Women can hold overly optimistic views of parenting, which when contrasted with the day- to-day demands of parenting can result in a decline in relationship satisfaction, increased conflict in the relationship, and increased ambivalence about parenting over time (Belsky, 1985). Alternatively, adult women have also reported that motherhood leads to a positive change in priorities, life direction and self-perception (Smith, 1999). Given the sometimes significant challenges of becoming a mother for adult women, much research has
been concerned with how young women simultaneously manage these demands with the developmental demands of adolescence.

Adolescence, usually defined as the second decade of life, is a time of prolific change. During the adolescent period both girls and boys undergo major changes in areas such as cognitive functioning, physical functioning, affective regulation, social functioning, moral reasoning, and identity (Kroger, Martinussen, & Marcia, 2010; Meeus, 2011; Piaget, 2001; Trad, 1995). Although parents continue to be important during adolescence, young people tend to seek more support from peers as they move outside the family and seek more autonomy, exploring who they are and will be in the future (for reviews see Zimmer-Gembeck & Collins, 2003; Zimmer-Gembeck, Ducat, & Collins, 2011). Cognitively, formal operational thought develops between the ages of 10 and 18 for many young people and this involves the ability to envisage alternatives, reason about alternatives, and plan for the future (Byrnes & Overton, 1986; Crone, 2009; Fischhoff, 2008; Trad, 1995). With these new cognitive skills, adolescents are becoming more facile at predicting the consequences of their actions and adopting the perspective of another (Gilligan & Belenky, 1980). However, these skills may not yet be easily accessible and this, along with their level of egocentrism, role experimentation, and identity formation, may influence their ability to parent successfully (Hunt-Morse, 2002).

In Australia approximately half of adolescent pregnancies are parented and the other half are terminated, with relinquishment of the infant for adoption almost non-existent (Condon & Corkindale, 2002). Australian figures from 2008 suggest that 4.2% of births were to women under the age of 20 (Laws et al., 2010). In Queensland in 2008, the number of births to women under 20 was higher at 5.7% or 3456 births per year (Laws et al., 2010). Comparison of the percentage of births to young women in Australia from 2000 to 2008 indicates a slight decline over time (AIHW NPSU, 2003; Laws, Grayson, & Sullivan, 2006; Laws & Hilder, 2008). Nonetheless, and while involving only a small percentage of mothers, parenting as young women has been considered a major societal problem requiring intervention (Furstenberg, 1991).
Parenting as a young woman is a complicated issue that has received sustained attention from researchers and policy makers over the past few decades (Furstenberg, 1991; Montessoro & Blixen, 1996). A large body of literature has amassed, suggesting that young mothers are a heterogeneous group whose ability to parent effectively is influenced by a number of factors that interact in complex ways (Abrahamse, Morrison, & Waite, 1988; Schellenbach, Whitman, & Borowski, 1992). Many negative outcomes for both young women and their infants have been posited and a large number of factors that moderate and mediate these outcomes have been proposed (Knaak, 2008; Schellenbach et al., 1992). While the extent of the difficulties and challenges young mothers face is still being debated in the literature, it appears that there are a number of important factors that contribute to a positive maternal adjustment. These include external resources (such as social support), internal resources (such as cognitive readiness, age, learning ability, psychosocial adjustment, self-care, realistic ‘core’ expectations and beliefs about parenting), and system level factors (such as socioeconomic status, access to housing, low situational stress; Hunt-Morse, 2002; Knaak, 2008; Schellenbach et al., 1992). Deficits in these areas are associated with less positive outcomes for mother and infant (Letourneau, Stewart, & Barnfather, 2004).

Less well researched is the proposition that pregnancy serves as a positive role for young mothers. However, research that has focussed on the positive aspects has suggested that young mothers report higher well-being post-partum than same-aged peers (Barratt, Roach, Morgan, & Colbert, 1996), that motherhood assists with the development of identity and role formation, and that adverse outcomes may be overstated (Hunt-Morse, 2002). A growing body of related qualitative research investigating young women’s experiences of motherhood has also recently emerged (see Spear & Locke, 2003 for review). The qualitative literature found that young mothers did not want to stay on welfare payments, often returned to school and valued education, and were committed to providing the best life for their children that they could (Arai, 2003; Arenson, 1994; Spear & Lock, 2003). Similarly, becoming a mother was described as the best thing that had happened to them, often serving as a catalyst for change in lifestyle (Arenson,
Despite this, young women who were mothers faced negative attitudes and harsh stereotypes from members of communities and health and community service providers (Fessler, 2008; Hanna, 2001). Policy decisions designed to make motherhood a less attractive option for adolescents often meant that young mothers were treated differently to adult mothers, possibly exacerbating the stigma and perpetuating the poverty cycle (Fessler, 2008). As well, young mothers faced a host of difficulties associated with access to transport and housing (Jones, Rowe, & Sheeran, 2009; Mollborn, 2007). How a preterm birth interacts with the complex lives of young mothers is unclear.

Estimates on the percentage of preterm or low birth weight (LBW) births to teenage mothers based on US figures suggests a much higher risk compared to most adult mothers with figures ranging from 8.6% to 15% (Partington, Steber, Blair, & Cisler, 2009; Roth, Hendrickson, & Stowell, 1998). There is ongoing debate in the literature as to whether the higher risk of preterm birth for teen aged mothers is due to biological or ecological factors, as much of the increased risk disappears once SES has been controlled for (da Silva et al., 2003; Ekwo & Moawad, 2000). Regardless, in Australia, women under 20 years and Indigenous women are over-represented in LBW admissions to Level II and Level III neonatal (special care and intensive care) nurseries (Laws et al., 2006; Mohsin, Wong, Bauman, & Bai, 2003). An increased risk of preterm birth is also more likely for young women who live rurally (Robson, Cameron, & Roberts, 2006). These figures suggest that teenage mothers who give birth to preterm or LBW infants are a small but potentially vulnerable group of mothers.

Research has suggested that being born to a young mother and being born preterm or LBW are separate risk factors for adverse maternal and infant outcomes (Furstenberg et al., 1989). This led researchers to posit a double risk hypothesis whereby young mothers of preterm infants are at twice the risk of poor maternal adjustment and their infants are at twice the risk of poor developmental outcomes (Thurman & Gonsalves, 1993). However, little empirical research has investigated this proposition. Most of the limited literature that has focused on the dual-risk group has been concerned with infant outcomes (Field, Widmayer, Stringer, & Ignatoff, 1980).
and not the psychological health or maternal adjustment of the adolescent mother. Field et al.’s (1980) study suggested that infants born preterm and to an adolescent mother were subjected to less desirable childrearing attitudes and developmental expectations placing them at much greater risk of developmental delay and possibly abuse (Field et al., 1980). However, there were no differences between adult or teenage mothers of full-term or preterm infants in reported anxiety. Preliminary research investigating young women’s adjustment compared to adult mothers also found that young women were reporting less distress than adult mothers of preterm infants (Farnell, Jones, Rowe, & Sheeran, in press) suggesting that the double risk hypothesis may not be supported, at least for mothers. However, further research is warranted and the current study will address this by exploring young women’s experiences of having a preterm infant, both as they consider taking their infants home from hospital and over the first 12 months of their infants’ lives.

Research to date is also unclear about what being a mother means to young women, especially for those who have delivered a preterm infant. Arguably, it is important to understand the meaning ascribed by young women to the experience of being a mother at a young age, not only to further our understanding but also to assist young women at this time. Yet, only a few studies have focussed on the young women’s experiences of being a mother (Arenson, 1994; Seamark & Lings, 2004; SmithBattle, 1995; SmithBattle & Leonard, 1998). As such, little is known about what it means to be a mother at a young age or whether having a preterm infant changes the meaning of being a mother for young women. The current study will address this gap in the literature by investigating how the meaning of being a mother differs for young women who have preterm infants compared to young women who have full-term infants.

Experience is also socially and culturally situated (Gergen, 1985). To date, the vast majority of research investigating parenting for young women has been conducted in the United States of America or the United Kingdom. Very little research has utilised Australian samples of young women (Farnell et al., in press; Hanna, 2001; Miller-Lewis, Wade, & Lee, 2005; Quinlivan, Tan, Steele, & Black, 2004; Robson et al., 2006). Research conducted in the US
consistently finds differences in maternal and infant outcomes between Black and white samples (Henly, 1997; Rudd, McKenry, & Nah, 1990) highlighting the cultural situatedness of the experience. Similarly, countries (and even states) often differ on their social assistance policies, employment and educational opportunities, and support services (Montessoro & Blixen, 1996). The current project seeks to bridge the gap in the current research by providing a situated understanding and scope of the issues for this potentially vulnerable group.

Given how little is known about the experience of being a young mother in the context of a preterm birth, a methodology was used in the current study that would allow young women to share their experiences without researcher imposed variable selection that would make assumptions about their experiences. The current research used a qualitative methodology that allowed the idiographic nature of the experience of a preterm birth to be at the fore to complement the majority of studies that have focussed on nomothetic or group level claims (Smith, 2004). When qualitative methodologies have been utilised in research with young mothers, the findings have provided an in-depth description of the experience, often highlighting the complexities or nuances of the experience and both the negative and positive meaning that becoming a mother has for the young women. The positive meaning and nuances of the experience have often not been the focus, so have not been detailed in findings from studies using quantitative methods. Hence, such qualitative studies have been particularly useful for incorporating idiographic perspectives into current theoretical models. Yet, it has been rare for researchers to use these methods in studies of young mothers of preterm infants, whose experiences may differ from young mothers of full-term infants. In fact, there has been only one previous qualitative study of young mothers of preterm infants and this study included 13 young Hispanic women living in the South US. To meet the aims of the current research a qualitative phenomenological methodology (Interpretative Phenomenological Analysis) was selected to explore the lived experience of the young Australian women who gave birth to preterm or full-term infants.
It has also been acknowledged that researchers are unable to completely remove themselves from the research process, and in fact, that the researcher is intimately involved in the meaning-making process (Smith, Osborn, & Jarman, 1999). While every effort was made by the researcher to ‘bracket’ off preconceived notions of the area under investigation, this was not entirely possible. Hence, it is important to acknowledge and make transparent the underlying assumptions on which this research study was founded and to actively explore and account for their impact on the research through a reflexive process. This reflexive process will be incorporated throughout the thesis and in ownership of my influence on the project, I will write these sections in first person.

**The role of the researcher**

Consistent with the hermeneutic tradition in Interpretative Phenomenological Analysis (IPA), it is important to consider what I, as the researcher, brought to the research project (Smith, Flowers, & Larkin, 2009) through my history and the assumptions I held at the start of this project. I was born to an adolescent mother and, although I was not born preterm, my mother’s accounts of her early parenting years left me with the feeling that this was a challenging experience for her.

Through my professional background in Psychology, community education in sexual and reproductive health, women-centred counselling around unwanted pregnancy and through my personal choice not to have children, I was intimately aware of the impact that society’s expectations can have on our experiences. I also have strong social justice values. With this background in mind it is with a curious expression that I share that I too began this project assuming that young mothers would be struggling, with the birth of a preterm infant adding additional stress above and beyond that experienced by an adult mother or young mother of a full-term infant. My attitude began to shift as I met and listened to young mothers in my project as they described the positive changes that were occurring because of the birth of their infant. The notion that being a mother might be positively affecting a young woman was something I
had not considered and was reflected in my early assumptions and use of a deficit model to frame the larger project. The shift in my thinking early in the research process allowed me to challenge my own assumptions, and to view the data and experiences of these young mothers in terms of positive change as well as challenges. Consistent with a hermeneutic circle, I have come back to the consideration of challenges for young mothers (and also their infants) but while being consciously aware of being open to the nuances and complexities, and bringing with me my newfound knowledge and appreciation for positive changes that occurred concurrently.

Similarly, my background in quantitative research methods, my need to access training in qualitative research approaches and methods, and the indoctrinated stance within psychology generally that it was through quantitative research paradigms that truth could be found and shared – or at least truth could be disproven, meant that I initially struggled to embrace and accept an interpretative/hermeneutic research paradigm. Over time I came to grow, understand, and trust in myself that the current research was important; that sharing the stories of young mothers was equally, if not more, important than asking young women to fill in a questionnaire to develop our shared understanding of the experience of being a young mother.

What also became clear to me during the course of this research was that I had initially adopted the predominant view of young mothers that had been presented in the extant literature; associating the young women with an adolescent or teenage identity. That is, I thought of them as adolescents first and women or mothers second. However, the adolescent mothers in this study did not see themselves in the same way. Instead, they described themselves as women and mothers first and foremost with adolescent a less salient identity in that context. I came to realize that this difference in labeling contributed to and perpetuated the difficulties that the young women faced in their journeys as mothers. Accordingly, I have chosen to use the term young women in this thesis where possible, in preference to adolescent or teenage mothers, in order to highlight that the focus is on young women who became mothers. Further reflection on my own role in this research project will be discussed throughout this thesis.
Overview of the thesis

The current chapter has provided an overview of why the current research was necessary and the foundations of the methodological approach utilized. Chapter 3 provides a detailed overview of the methodology including the philosophical underpinnings and assumptions of the approach used. Chapter 4 provides details of the method including a brief description of the participants, the design, procedure, interview design, and analysis process. Chapter 5 provides the contextual and demographic information about each of the young women, including information about external resources such as support. Chapter 6 presents the findings of the analysis, with each theme and sub theme explicated and supported by direct excerpts from the interviews. Finally, Chapter 7 discusses and integrates the findings back into the extant literature, addressing the aims and research questions of the current project. To begin, Chapter 2 will provide an overview of the relevant literature.
Chapter 2: Literature Review

The purpose of the current chapter is to outline the research relevant to the experience of being a young mother of a preterm infant. To date, much research has been undertaken on being a young mother of a full-term infant. Further, much is known about the experience of preterm birth in adult populations. However, very little research exists on being a young mother of a preterm infant. As such, the following literature review draws together several separate bodies of literature and key theories to highlight what is known about being a mother; first, as a young woman; second, as an adult mother of a preterm infant; and finally, as a young mother of a preterm infant.

Transition to motherhood for young women

The first section of the literature review details what is known about the transition to motherhood for young women. An outline of the core arguments to be presented in this section is provided then each argument will be discussed in more depth below.

In recent decades becoming a mother during the teenage years has widely been considered problematic. Early research highlighted that young women who became mothers during their teenage years were at risk of poor outcomes (Furstenberg, Brooks-Gunn, & Morgan, 1987). These early studies on adolescent pregnancy focused on comparisons between adult and adolescent mothers and often found poorer outcomes for adolescent mothers and their infants when compared to adult mothers (Parks & Arndt, 1990). These differences then helped to reinforce the conception of adolescent parenting as a problem, resulting in adolescent mothers becoming a stigmatised group within society, with negative ramifications for the young women such as high levels of negative judgment from others. However, criticism of this early work highlighted that pre-existing differences between the groups (i.e., adult and adolescent mothers) were not considered (Furstenberg, 1991). When contextual factors such as SES were controlled, fewer differences and sometimes no differences, were found (Levine, Emery, & Pollack, 2007). The use of appropriate comparison groups rather than middle class white adult mothers
suggested that being an adolescent mother was not as catastrophic as first thought and that negative outcomes may have been overstated (Geronimus, Korenman, & Hillemeier, 1994). A growing body of research has also established the heterogeneity of outcomes for, and characteristics of, the group adolescent mothers (Abrahamse et al., 1988). Qualitative studies also found that the experience of being a young mother, while not without its challenges, is a positive for many of the young women, positively influencing their life trajectories (Arenson, 1994; Seamark & Lings, 2004). Despite the shift documented in the literature the stigma associated with adolescent parenting has not shifted and the discourses around adolescent mothers by professionals, politicians, and researchers alike have served to position young mothers as inappropriate parents.

Much of the research on adolescent parenting has focussed on identifying risk factors for poor adjustment, with a particular focus on social support (Alan Guttmacher Institute, 2002, February; Burke & Liston, 1994; Furstenberg & Crawford, 1978; Voight, Hans, & Bernstein, 1996). While this research has provided valuable information about which mothers may require assistance, there has been an ongoing neglect of the positive impact that pregnancy can have for many young women in terms of identity development, meaning of life, and lifestyle changes. Also overlooked in the literature has been how giving birth as a member of a stigmatised group interacts with the additional stress of a preterm birth. The current section begins by highlighting how parenting as a young woman is a social problem, constructed and maintained by society. This is followed by a review of the consequences of becoming parent as a young woman. The positive effect of parenting on the young woman and the factors associated with adjustment to motherhood are then discussed. Finally, how negative attitudes of others contribute to the young women’s poor adjustment is highlighted.

**Parenting in adolescence as a social problem.** One common factor in countries such as the US, UK and Australia has been the conceptualization of adolescent parenting as a social problem, with associated social health policies designed to specifically target the ‘problem’ (Rhode & Lawson, 1993). Adolescent parenting as a social problem is a 20th Century construct
Historically, most women married and gave birth in their adolescent years, with those that were not married either giving their babies away or being cared for by their families. It has only been in recent years that the practice of giving birth as a young woman has been defined as problematic due to factors such as societal changes, greater emphasis on education and career attainment for women, and changing social policies (Rhode & Lawson, 1993). Harari and Vinovskis (1993) undertook a historical analysis of adolescent pregnancy and concluded that problems associated with adolescent pregnancy in the 17th, 18th and 19th centuries were treated as part of broader social issues; young women were not singled out out.

In the 1970s and 1980s a combination of social, demographic, and political factors, such as a decrease in hasty marriage and the baby boom population reaching their teenage years and thus increasing the total number of births to adolescent mothers, lead to the conclusion that there was an unprecedented epidemic of adolescent pregnancy (Furstenberg, 1991; Harari & Vinovskis, 1993). Further, it was argued that this epidemic warranted concerted federal action (Harari & Vinovskis, 1993). A continued attention on adolescent parenting has remained despite the fact that rates of pregnancy to young women have been decreasing (Furstenberg, 1991). What this suggests is that although adolescent pregnancy has been defined as ‘the problem’, aspects of adolescent pregnancy that are analytically and empirically distinct – such as chronological age, marital status, and the planned or wanted nature of the pregnancy have been conflated (Macintyre & Cunningham-Burley, 1993).

Attitudes to adolescent pregnancy are both shaped by and shape policy. One example in contemporary Australia is the baby bonus government payment given to women once they give birth. This government initiative was introduced to increase the attractiveness of having children, as a result of the aging workforce and declining reproductive rates (Guest, 2008; Guest & Parr, 2010). However, one widespread belief was that providing young mothers with monetary incentives increased the attractiveness of becoming a parent at a young age. It was feared that there would be an increase in adolescent pregnancy rates as they became parents purely ‘for the money’ (Grattan & Nguyen, 2004). This attitude prevailed in the media and in popular discourse.
(Grattan & Nguyen, 2004), despite research that reported that nearly all adolescent mothers disliked being on welfare payments and few wanted to stay in the welfare system (Aber, Brooks-Gunn, & Maynard, 1995). Moreover, there was no discernable increase in rates of adolescent pregnancy following the introduction of the baby bonus (Laws et al., 2006; Laws et al., 2010; Laws & Hilder, 2008). Recently, discriminatory practises at a structural level have been introduced, for instance, forcing young women to return to study or work when their infants were 12 months versus 7 years for adult mothers, and issuing lump sum payments to adult mothers and part payments to young women (Milne, 2006). These practices serve to reinforce and maintain the predominant negative stereotypes of young women who are parents. Further, other overseas policies assume that low SES adolescent mothers choose motherhood in the absence of a promising future (Arai, 2003; Duncan, 2007). However, the belief that motherhood is chosen in the absence of a promising future negates the view that motherhood is a promising future and that social structures do not support or acknowledge this path (Arai, 2003). It is current society that dictates that motherhood is a substandard profession, not the young mothers (SmithBattle, 1995).

Further to this, discourse analysis has identified the common discourses used in medical literature to position the adolescent mother. Breheny and Stephens (2010) identified four scientific discourses commonly used: the public health discourse, the economic discourse, an ethnicity discourse, and a eugenics discourse. Through these discourses early motherhood is positioned one of four ways: as a “disease requiring surveillance” with a commensurate public health response (public health discourse); as financially draining society and also highlighting the cost of early motherhood on the mothers themselves (economic discourse); related to ethnicity by classifying young mothers by ethnic group (ethnicity discourse); and finally as unsuitable parents through metaphors of parenting as a biological priority (eugenics discourse) (Breheny & Stephens, 2010, p 307). Breheny and Stephens (2010) conclude that the common discourses used to position young mothers show that “concern about teenage motherhood is as much about the wrong sort of women becoming mothers, as mothering too soon” (p. 307). This
work built on earlier discourse analysis, which highlighted that medical professionals drew on ‘developmental’ discourses positioning adolescents as naive, distracted, and self-centred; ultimately reducing their ability to parent correctly (Breheny & Stephens, 2007). Breheny and Stephens’ research cautions against the positioning by researchers, politicians and broader society of young mothers as a ‘problem’. Further, their research draws attention to the possibly unintended motivations of these groups of people in positioning young mothers as a problem.

There is also research suggesting that researchers themselves conceptualize adjustment in adolescent parents differently to adult parents. Wilkinson and Walford (1998) note that psychological wellbeing in adult samples has been conceptualized as comprising two independent dimensions of wellbeing and distress. However, in research with adolescents, psychological wellbeing has been conceptualized as a single dimension, with wellbeing and distress at opposite ends. By contrast, Wilkinson and Walford found support for a two factor model of psychological health for adolescents, with psychological health consisting of two separate but related dimensions, namely wellbeing (comprising positive affect, satisfaction, and happiness), and distress (comprising anxiety and negative affect). Despite this research, the one-dimensional conceptualization of adjustment for pregnant and parenting young women appears to pervade the literature on adolescent parenting, with much focus on the deficits associated with early child-bearing and little focus on wellbeing.

The consequences of becoming a mother as a young woman. Childbearing in the teenage years has been linked to a range of negative outcomes for the young woman and her infant.

The psychological health of the young mother has been one area of concern to researchers. This literature has suggested that young women are more likely to become depressed, experience anxiety, experience more stress, and thus interact less with their infants than their older counterparts (Baldwin & Cain, 1980; Barth, Schinke, & Maxwell, 1983; Furstenberg et al., 1987; Reis, 1989; Williams et al., 1987). Of note, one study had to covary the participant’s age due to the disproportionate number of young women who were randomly
recruited in a study on post-natal depression (Field et al., 1988). Rates of depression in an American sample were as high as 48% for young African-American mothers (28% for White) compared to 25% in a sample of older African-American mothers (14% for White). In this sample adolescent mothers were more than twice as likely to develop depression following birth than adult mothers (Deal & Holt, 1998). More recent research investigating rates of depression in adolescent mothers compared to low and high resourced adult mothers found significant differences between groups, with adolescent mothers reporting higher rates of depression (Lanzi, Bert, Jacobs, & The Centers for the Prevention of Child Neglect, 2009). However, these studies have been criticized for not considering preexisting differences between the groups. Accordingly, young women (often African American) from low SES backgrounds have often been compared to middle class white adult mothers.

Research also suggests that young mothers have poorer life chances and are economically disadvantaged compared to women who delay child bearing. Being a young mother has been associated with having less education, having less prestigious jobs, less stable marriages, larger families, and an increased reliance on welfare (Card & Wise, 1978; Furstenberg et al., 1989; Furstenberg et al., 1987; Rudd et al., 1990). In addition, adolescent mothers have lower income, possibly due to welfare dependence, increased risk taking behaviours (including illegal activity and drug use), interruption to education, which had long-term implications for welfare dependence, lack of career options, and higher rates of poverty compared to adult mothers or peers who delay childbearing. These factors have then been associated with a host of psychological problems placing the young women in a high risk category (Bunting & McAuley, 2004a, 2004b; Condon & Corkindale, 2002; Fergusson & Woodward, 2000; Furstenberg et al., 1989; Hanna, 2001; Quinlivan et al., 2004; Rudd et al., 1990). Further, research with adolescent mothers had found that the group was highly mobile, with instability in areas such as relationships, accommodation, and employment creating additional challenges, and that these situational factors often interfered with tasks of daily living (Furstenberg et al., 1989; Quinlivan, Box, & Evans, 2003; Quinlivan, Petersen, & Gurrin, 1999).
Being a young mother has also been found to have a negative impact on the young mother’s children. Children of adolescent parents were more likely to be financially disadvantaged, have poor health, display behavioural problems, display less interactive behaviours, were at risk for developmental delays, were at higher risk of intellectual difficulties, were at an increased risk of abuse, and were more likely to become young parents themselves. (Baldwin & Cain, 1980; Condon & Corkindale, 2002; Hanna, 2001; Haskett, Johnson, & Miller, 1994; Levine et al., 2007; Rudd et al., 1990).

The causal role of young maternal age in outcomes for infants of young mothers has, however, been questioned in research. For instance, Levine, Emery and Pollack (2007) found that there was no direct effect of parents’ age on children’s cognitive test scores and some behavioural measures (such as child’s marijuana use as an adolescent) when background variables such as grandmother’s education level, location of residence i.e., urban/rural; South/North), family composition, race, birth order, and mothers armed forces qualification test (AFTQ-R) scores were accounted for. Similarly, the relationship between young maternal age and psychological health can be challenged when appropriate comparison groups are used.

When young mothers are compared to matched samples of same-aged peers and compared pre- and post-pregnancy, a more detailed picture emerges. Research has found few differences in levels of emotional distress during the first two years of parenting (Milan, Ickovics, Kershaw, Lewis, & Meade, 2004), parenting young women reported less stress than same aged peers (Barratt & Roach, 1995) and similar rates of depression were noted (Troutman & Cutrona, 1990) when young mothers are compared to matched same age peers. Milan, et al. (2004) investigated emotional distress, as measured by the brief symptom inventory (BSI), in adolescent mothers and non-mothers and found a decrease in distress over time from the third trimester to 18 months postpartum for adolescent mothers. The same trend was seen for matched adolescent non-mothers, although the level of emotional distress experienced by the adolescent mothers following the birth of a baby was significantly lower than the non-mothers (Milan et al., 2004). The fact that four months after the birth of the baby adolescent mothers were experiencing
less distress than comparable non-mothering teens suggests that giving birth may, instead, play a positive role in the adolescent mother’s life (Barratt & Roach, 1995). Further, research found no significant difference between distress in adolescent mothers and all other mothers after controlling for factors including parental education, grade point average, family structure, and previous sexual experience (Mollborn & Morningstar, 2009). Finally, a study investigating the prevalence and correlates of psychopathology in adolescent mothers found that they exhibited less severe and lower rates of pathology than comparison groups of never pregnant, and clinically referred and non-referred female adolescents (Wiemann, Berenson, Wagner, & Landwehr, 1996). Hence, what may appear to be a strong relationship between age of parenting and psychological distress may be accounted for by preexisting differences in the samples.

Similarly, the causal role of young maternal age in educational and financial outcomes for young women has been called into question. Research that controlled for preexisting background variables has found that much of the difference between mothers who delay childbearing until adulthood and younger mothers can be explained by pre-existing differences between the groups. For instance, longitudinal research with sister dyads found few differences in high school completion or employment rates for early or late child-bearers, despite differences in welfare assistance, education, marital and employment status when young mothers were compared to the overall sample (Geronimus et al., 1994). Further, longitudinal research from New Zealand found that many of the women who became mothers had disengaged from education prior to falling pregnant and not as a result of becoming pregnant, suggesting that there may be mutual risk factors for school disengagement and early pregnancy (Fergusson & Woodward, 2000).

There is also evidence to suggest that young women now have more opportunities to re-engage in education over the course of their lives than previous generations may have had. An ethnographic study which followed up mothers three to eight years post-birth found that the current educational system (such as TAFE) compared to previous more inflexible models of secondary schooling, allowed women who parented as teens to return to study at a later date; of
note, nearly all women in this study had completed high school equivalence (Carey, Ratliff, & Lyle, 1998). Further, several young women in Carey et al.’s study had gone on to complete or were completing technical and further education (TAFE) courses and university degrees via distance education. In addition, all placed high value on education attainment. Only one mother in the study had been unable to re-engage in education; she was the youngest mother in the sample, having first given birth at age 14 and having the greatest number of children (three) at follow-up (Carey et al., 1998). Consistent with Carey et al., Schultz (2001) found that of the women in her study, the adolescent mothers had more developed plans for the future than did non-parenting peers. The young women who had become parents reported that they had to take life more seriously because of their responsibilities (Schultz, 2001). This research suggests that the impact of adolescent parenting on education may not be as drastic as initially posited and that the negative effects of becoming a mother may be overstated for some young women.

Research that has investigated the process of being a mother (i.e., the maternal role development model) has found few differences in the process of developing a maternal identity for adult mothers and younger mothers. The maternal role development model (MRD: Mercer, 1981a, 1981b, 1984, 1995, 2004; Rubin, 1967a; Rubin, 1967b) was developed to explain the process that occurs when women transition to motherhood. This model, recently re-formulated as ‘becoming a mother’ (BAM: Mercer, 2004), explicates the psychological process of becoming a mother during pregnancy, leading to the achievement of the maternal role identity over time. For most women the process of becoming a mother begins in pregnancy when the woman fantasises about herself as a mother, seeks out expert role models, and role-plays being a mother, resulting in an introjection of others’ observed behaviours, projection of how those behaviours would work for her, and rejection of any behaviours she believes will not work for her. From this extensive psychosocial work, the woman creates an ideal image of herself as a mother, which is then incorporated as a maternal identity into her self-system (Mercer, 2004).

Mercer (1995) further explicated the process of becoming a mother over the first 12 months and suggested that mothers progressed through formal and informal stages as they
developed a sense of competence and moved towards an integrated maternal identity. Initially women adhered to social expectations of the mother role and relied on the directives of experts (Mercer, 1995). However, gradually mothers began to differentiate their own style of mothering through trying ways to meet their infant’s needs, often through trial and error. Role models were tested against the mother’s values and attitudes in order to be assessed as suitable (Mercer, 1995). The development of maternal identity is linked to the sense of competence and confidence in the maternal role and this was mutually influenced by the infant and by the father or partner. Among other roles, the father/partner helped to defuse tension that developed between the mother and infant (Mercer, 1995). In addition, the characteristics of the infant and mother interacted to influence the achievement and development of the maternal role identity and the child’s developmental outcomes. This model highlights that the experience of being a mother is intimately linked to others including the infant, who influences the development of the maternal role identity over time. This model also highlights the transition and development process that occurs for most mothers, including young mothers. However, Mercer also notes that there are age-based differences between adult and young mothers.

In the application of the theory of maternal role development to young women, Mercer (1980) found that all women experienced more enjoyment of their infants at 4 months of age than at 1, 8, or 12 months. This enjoyment corresponded to a spike in feelings of gratitude in the mother role and an increase in maternal competence behaviours at 4 months (Mercer, 1980). The pattern for young women (15-18 y/o) appeared to be very similar to that of older mothers with some notable exceptions. First, feelings of gratitude in the parenting role decreased for young women between 8 and 12 months while they increased for older mothers (Mercer, 1985). Second, younger mothers scored lower on maternal caretaking behaviours (competency). Third, the standard against which the young mother rated herself as a parent also appeared to be different to older mothers, with a focus on the more concrete tasks of parenting as opposed to developmental needs of the infant (Mercer, 1986). There was, however, consistency across groups and high endorsement of their perceptions of self as fulfilling their ideals. It was argued
that the reason young women still reported high consistency between their actual parenting
behaviour and their ideal image was because of the way that they constructed their ideal images
(Mercer, 2004). Overall for young women, gratification in the maternal role was found to
outweigh the perceived deprivations, and feelings of role competence emerged for all but the
youngest mothers (14 years old; Mercer, 1980).

In order to account for the slight differences between adult and younger mothers, Mercer
(1995) highlighted that the transition to the maternal role may be affected by the young woman’s
psychosocial development, which was influenced by maturity of personality traits and child-
rearing attitudes. The normal developmental processes in early adolescence that Mercer posited
may interfere with parenting included a predominant concern with body image during puberty,
remaining largely present-oriented, and being inconsistent in the use of newly-acquired logic.
Mercer (1995) also reported that young women in early adolescence (<15 years old) did not
consider future or current events, were highly egocentric, and that this made it difficult for the
young woman to give herself to her infant in the way older mothers did. Similarly, middle
adolescents (15-17 years old) were reported to not routinely consider the consequences of their
behaviour, despite having the cognitive capacity to do so. Also characteristic of this middle
adolescent age group was the tendency to be idealistic, and inconsistently altruistic and
egocentric, though to a lesser degree than in earlier adolescence (Mercer, 1995). These factors
are consistent with developmental theories of adolescence (Bandura, 2006; Ginsburg & Opper,
1988; Piaget, 2001), and highlight the potential for psychosocial developmental factors to
influence the experience of being a young mother compared to an older mother by influencing
the dynamics between the infant and mother.

Taken together this model suggests that there are normative stages and processes that
occur as women become mothers and that these processes are similar for adult and adolescent
mothers. In addition, becoming a mother appears to be associated with many positive changes
(such as increased feelings of gratitude and confidence). However, much is made of subtle
differences in the process of becoming a mother for adult and young mothers (possibly due to
psychosocial developmental factors). Very little attention is paid to the similarities in the process for adult mothers and young mothers. In fact, the positive influence of parenting on the young woman is generally overlooked or not the focus of research.

**Parenting as positively influencing the young woman.** A limited number of studies have proposed that becoming a mother positively influences young women. These studies have found that motherhood assisted in the development of identity and role formation (Hunt-Morse, 2002), and that adolescent mothers reported higher well-being post-partum than same-aged peers (Barratt et al., 1996). Unger, Molina, and Teran (2000) found that motherhood provided an opportunity to secure love and fulfill an existential need. Similarly, becoming a mother was associated with increased self-esteem and sense of identity (Barrett et al., 1996). Spear and Lock (2003) reviewed 22 qualitative studies investigating adolescent pregnancy and found that most adolescent parents, across the studies, viewed parenting as a positive experience. Associated with the pregnancy was an often dramatic change in the young women’s trajectories. For instance, Arenson (1994) found the adolescent mothers’ lives improved by having a baby as they stopped taking drugs, stopped drinking alcohol, and their relationships with peers and family improved. Often, the young women described developing a positive outlook on life, stating that pregnancy provided them with a second chance at life (Williams & Vines, 1999). In a study of parenting young women at risk of homelessness, Hanna (2001) found that parenting provided opportunities for change and transformation in their lives. Similarly, SmithBattle (1995) found that young women who were parents did not share the social scientific view that mothering jeopardized or limited their lives. Instead, young women saw pregnancy and parenting as a positive experience and it was the stigma associated with the label that added to challenges that they faced.

Seamark and Ling’s (2004) study also challenged the assumption that an adolescent pregnancy ruins a woman’s life and demonstrated that alternatively, it can be the turning point to maturity and the development of a career. Seamark and Lings used Interpretative Phenomenological Analysis (IPA) to study the positive experiences of adolescent motherhood and found that most of the mothers interviewed up to eight years post-birth were developing or
carrying out plans for future careers, including completing their education. The study, while suggesting that adolescent mothers may well return to education and develop careers, implied that it might take time to achieve such goals. Most mothers were still at the point of considering their careers and only two were taking steps to achieve their goals. Adolescent mothers themselves recognised the importance of education (both formal and more general in life skills) to their successful adaptation to parenting and to meeting their goals. The young women also stated that they had a strong desire for independence and reported that they did not want to be dependent on welfare, government systems, or family for financial support (Scott Stiles, 2005). Young mothers were able to recognise their limitations as parents and knew what needed to be done to parent more effectively, demonstrating their developing maturity.

Motherhood has also been associated with increased maturity, whereby young women describe ‘growing up’ as a result of the pregnancy, with a reduction in the egocentric thinking typical of adolescence and a move toward thinking like a mother (Williams & Vines, 1999). Spear and Locks’ (2003) review of the literature found that many participants across studies viewed early childbearing as a normative, positive event that transitioned them into adulthood. Paradoxically, the young mothers in Arenson’s (1994) study documented that as they became more dependent on their families for financial support and shelter they were viewed by their parents as adults and were treated with more respect. These studies further emphasize the positive role that parenting can play in developing maturity, responsibility, and in transitioning the young women into adulthood.

Another general theme present in many of the adolescent mothers’ discourses focussed on their determination to raise their children better than they had been raised themselves, by talking to their infants, listening to them, and making sure they felt loved (Arenson, 1994; Seamark & Lings, 2004). In this way young women felt that they were able to provide the love that they did not receive themselves. Similarly, a general theme across studies was that adolescent mothers viewed parenting as important to their lives and demonstrated a desire to meet their children’s needs (Spear & Locke, 2003). The research provides an understanding of
the motivations and priorities of the young women, which is often lost in studies that focus on
the young women’s deficits in parenting ability.

A further consideration is the view that becoming a young mother may in particular be a
positive choice for women from disadvantaged backgrounds. Women from disadvantaged
backgrounds may see parenting as a positive life choice compared to alternative options. In a
qualitative study that investigated two possible explanations for adolescent pregnancy in the UK,
low expectations or poor knowledge about contraception, Arai (2003) highlighted that
motherhood was often an advantageous choice - especially for working class young women. For
some young women school and low paid employment were not regarded as viable options.
Motherhood, by comparison, was viewed as a preferable career, providing positives in terms of
receiving love and providing a meaningful vocation (Arai, 2003). As highlighted by SmithBattle
(2005a), postponing parenthood would not enhance the life experiences for some young women
unless the disadvantage that existed pre pregnancy was addressed. Arai argue that what needed to
be questioned was the political and middle class view of adolescent pregnancy as wrong, not
necessarily the women’s decisions to become parents.

**Exploring the complexities of adjustment to motherhood for young women:** Rather
than supporting the view that being a parent as a young woman is negatively influenced by their
stage of psychosocial development, the qualitative studies reviewed above highlight the ways in
which being a mother can *aid* young women’s psychosocial development (Arai, 2003; Arenson,
1994; Seamark & Lings, 2004). However, qualitative studies are also able to provide a nuanced
view of the experience by explicating specific challenges associated with the experience,
increasing the understanding of what factors help and hinder adjustment. Specifically, there was
an acknowledgement by the mothers that parenting increased demands and responsibilities, and
placed restrictions on the young women’s time (Hanna, 2001; Seamark & Lings, 2004; Spear &
Lock, 2003). In addition, Spear (2004b) made clear both the positive and negative aspects of
parenting for young women who were from poor backgrounds prior to their pregnancies (i.e.,
drug dealing, domestic violence, and extreme poverty). During pregnancy, the young women
expressed the sentiment that early maternity would have little effect on their lives (Spear, 2004b). However, in follow up interviews 1 ½ years later, this no longer held true (Spear, 2004a). The young women in the study maintained a sense of optimism and hope for the future. However, it was tempered by feelings of regret, isolation, and mourning for a lost childhood and this was related to the day-to-day realities and restrictions of being a young single mother (Spear, 2004a, 2004b). In a 4-year follow up of adolescent mothers, SmithBattle and Leonard (1998) highlighted the situated nature of identities and how the self was socially embedded. That is, while motherhood was a corrective experience for many of the young women, this was limited by the poverty, illness, violence and social exclusion in some women’s worlds (SmithBattle & Leonard, 1998). For these women, mothering did not provide a clear purpose or identity. Moreover, these mothers displayed a clear lack of agency in the mothering role that was also reflected in their other relationships with their own mothers and partners (SmithBattle, 2005b).

In sum, these studies show that aspects of motherhood are challenging and that the experience of parenting is constrained by the social context in which the mothers are embedded.

Early research on becoming a mother as a young woman began with the assumption that parenting would be overwhelming for the young woman who was simultaneously having to deal with the challenges associated with parenting as well as the developmental challenges of adolescence (Stevenson, Maton, & Teti, 1999). This proposition is in line with explanations posed by Mercer (1995) to account for differences between adult and adolescent mothers in the process of becoming a mother. However, from the research reviewed it is increasingly evident that not all young women struggle with the demands of parenting. Instead, young women differ significantly in their experience of being mothers demonstrating that they are a heterogeneous group. The acknowledged heterogeneity of the group has generated a large body of research that has investigated factors related to poor adjustment.

Although much of the research on risk factors for poor adjustment lacks a coherent framework, findings can be loosely grouped into 3 domains, which interact in complex ways (Knaak, 2008; Schellenbach et al., 1992). These include internal resources (i.e., characteristics
within the individual such as cognitive ability), system level or cultural factors (such as access to housing and neighbourhoods), and external resources (i.e., factors external to the individual such as social support; Knaak, 2008; Schellenbach et al., 1992).

In terms of internal resources, a number of risk factors have been proposed. These include inaccurate knowledge and inappropriate attitudes or realistic expectations and beliefs (Ketterlinus, Lamb, & Nitz, 1991; Knaak, 2008), lack of cognitive readiness or low IQ (Schellenbach et al., 1992; Sommer et al., 1993; Trad, 1995; Whiteside-Mansell, Pope, & Bradley, 1996), lack of maternal maturity (Hess, Papas, & Black, 2002), low self-esteem (Hess et al., 2002; Meyers & Battistoni, 2003), substance abuse, domestic violence victimization and history of physical and sexual abuse (Meyers & Battistoni, 2003), lack of social competence and problem solving ability (Passino et al., 1993), low self-confidence (Schiefelbein, Susman, & Dorn, 2005), or a low sense of personal mastery and control (Turner, Sorenson, & Turner, 2000), perceived stress during pregnancy and high parenting stress post birth (Holub et al., 2007), and interpersonal conflict (Hess et al., 2002).

At a system level, factors associated with increased risk of poor adjustment include ethnicity of the mother (i.e., being African American), lower socio-economic status (Schellenbach et al., 1992), neighbourhood characteristics (such as a lack of affluent neighbours; Brooks-Gunn, Duncan, Klebanov, & Sealand, 1993), housing, financial support, and availability of child care (Mollborn, 2007). Often these factors were also related (either positively or negatively) to external resources such as social support available within the mother’s sociocultural context.

Social support is the most researched external factor for a positive adjustment to motherhood for young women. Several review articles show that social support can promote successful adaptation to parenthood for adolescent mothers and their children (Bunting & McAuley, 2004a, 2004b; Clemmens, 2001; Letourneau et al., 2004). Similarly, social support tends to ameliorate many of the negative outcomes associated with adolescent parenthood (Barth et al., 1983). For instance, Spear (2004a) employed a naturalistic, qualitative case study approach
and highlighted that young women were able to adequately manage single motherhood with support from family. Moreover, social support has been found to moderate depressive symptomology for adolescent mothers (Turner et al., 2000). Related research indicates that greater help with care giving is positively associated with mental health and that support plays an important role in reducing stress (Barratt et al., 1996; Logson & Koniak-Griffin, 2005). Most commonly, research has focused on the source of social support for adolescent mothers. Typical sources of support include families, partners and friends and, to a lesser extent, professionals (Letourneau et al., 2004) though, for the most part, support is garnered from maternal mothers.

To illustrate, research from the US indicates that the majority of adolescent mothers live at home with their mothers following the birth of their child (Caldwell & Antonucci, 1997). Grandmothers were found to be a primary source of assistance (i.e., housing, financial, and child-care) and living at home was linked to increased educational attainment and stable employment for the teen mother, as well as better developmental outcomes for their children (Caldwell & Antonucci, 1997; Clemmens, 2001). Conversely, in one study although nearly all adolescent mothers reported their mothers as a source of support, over a third also reported that their mother was a source of conflict for them (Bunting & McAuley, 2004a). An interesting contradiction is that high levels of support from grandparents may be related to poorer parenting experiences for the young mother, suggesting that while it may be better for the infant’s development (Clemmens, 2001), support from grandparents may not be best for the adolescent mother (Voight et al., 1996). These studies suggest that the relationship between mother and daughter is not straightforward, with conflict diminishing some of the benefits that family support provides, leading to less optimal parenting behaviours (Bunting & McAuley, 2004a). For some young mothers relationships with parents were strained, and the mothers tended to become socially isolated (Rogeness, Ritchey, Alex, Zueler, & Morris, 1981). In such cases, peer and partner support may become an important factor.

Peers are also an important source of support for the adolescent mother (Bunting & McAuley, 2004a; Richardson, Barbour, & Bubenzer, 1995). Although it has been suggested that
peers are less able to provide support to a young woman once she became a mother, research has also suggested that peers are able to offer more emotional support and less interference than family (Richardson et al., 1995). It was thought that friends offer positive feedback and advice for mothers without the conflict that was often present in familial relationships (Bunting & McAuley, 2004a). In addition, Richardson et al (1995) found that parenting stress was buffered more effectively by support garnered from friends than family when the adolescent mothers’ infants were around a year old. However, many young women reported a reduction in peer support, with social isolation a common result of early childbearing. This reduction in support can then have consequences for adjustment, including increased rates of depression (Birkeland, Thompson, & Phares, 2005; Quinlivan et al., 1999). Overall, this body of research suggested that peers are an important source of support for young women yet they may not always be available.

Father involvement is another complicated issue, with repercussions for maternal adjustment. Although the father of the child has been found to be a valuable source of social support for the young mother, there can be variations in how involved the father is (Bunting & McAuley, 2004b). According to international research on adolescent parenting, most adolescent mothers give birth outside of marriage (Bunting & McAuley, 2004a; Coleman & Dennison, 1998) and have unstable relationships with the fathers of the baby (Unger & Wandersman, 1988). In one study approximately 30% of a large sample of welfare dependent adolescent mothers received child support from the baby’s father and only 4% lived with the father (Aber et al., 1995). Other longitudinal research found that 3.5 years postpartum, 56% of fathers were providing no instrumental or economic support for their children and only 28% of fathers paid for some or most of their child’s expenses (Larson, Hussey, Gillmore, & Gilchrist, 1996). Similarly, the number of adolescent mothers who give birth within marriage has been steadily decreasing in Australia (Kenny, 1995). One study in Australia found that 47% of pregnant adolescents reported that the relationship with the father of the baby had ended and that the father would not be involved in the care of the infant (Quinlivan et al., 1999). Fathers often cited
conflictual relationships with the adolescent mother or maternal grandparents as barriers to their continued involvement with their children (Bunting & McAuley, 2004b). In addition, fathers were less likely to stay involved if the young mother had experienced a large number of stressful life events during the pregnancy or in the first 6 weeks after the delivery (Cutrona, Hessling, Bacon, & Russell, 1998). Overall, these findings suggest that there is variability in the involvement of the father, and that involvement is influenced by a number of factors. Further, given that a preterm birth may be a stressful event for mothers, there is a concern that this may lead to less support from the father of the baby.

Although social support is heralded as an important factor in adjustment, less well-explored are the negative aspects of social support. However, as alluded to above, not all support is perceived as positive to young women and relationships are not straightforward. This is also true for adult mothers of preterm infants where too much support can have negative effects on wellbeing, especially when it is perceived as not required or needed (Affleck, Tennen, Allen, & Gershman, 1986; Affleck, Tennen, Rowe, Roscher, & Walker, 1989; Coyne & DeLongis, 1986). In addition, for some young women, accessing support places them in a position where they are exposed to negative judgements of others and this can have negative effects on their adjustment.

**Negative attitudes of others as contributing to poor adjustment.** The defining of motherhood as a social problem for young women has meant that there is stigma associated with being a young mother (Fessler, 2008). This stigma has resulted in negative attitudes towards young women who are mothers and they face high levels of criticism and few compliments. Hanna (2000), in an article reflecting on her research project with young women at risk of homelessness, noted her surprise at her participants’ reports that no one complimented them on their parenting practices, despite her seeing much that was worthy of praise. This lack of praise was also reflected in the findings of her study (Hanna, 2001), which highlighted the negative judgment the young women faced as they accessed health services and more generally from the wider community. Similarly, in a grounded theory study of adolescent mothers in Uganda, adolescent mothers reported that one of the factors that reduced their satisfaction with
motherhood was the rebuke by health workers, relatives and even strangers, who disapproved of the adolescent parent. Some felt that most people they interacted with considered them unfit parents by virtue of their age, and they experienced stigmatization (Kay, 2008). This theme was also echoed in Arai’s (2003) study, where young mothers automatically expected that coordinators of teen programs would express condemnation and negative attitudes around their decision to become mothers. Arai’s research highlighted that young mothers have come to expect rebuke from members of the community and health professionals alike.

Young women manage this expectation of negative judgement in many ways. Arai (2003) found that because participants expected this negative judgment, they took an adversarial position towards the coordinators. Fessler (2008) also found that young women actively responded to others by projecting an attitude of defiance and self-reliance. Relatedly, Hanna (2001) found that young women avoided placing themselves in situations where they would be judged as ‘bad mothers’ and Fessler found that participants used friends and family members as buffers in situations where they were likely to experience stigma. Fessler also noted that some of her participants managed stigma through relatively extreme measures such as dropping out of school and refusing prenatal care. Unfortunately, these ways of managing may make things worse for pregnant and parenting young women as they represent those actions that are often associated with the stereotypical young mother.

Research has also suggested that young women who have preterm infants in the SCN experience negative judgment based on group membership. Accordingly, adult mothers of preterm infants were treated primarily as mothers by hospital staff (Jones, Sheeran, Rowe, & Becker, 2011). In return, adult mothers reported that the staff were generally helpful and positive and any issues with staff were ascribed to individual difference variables. These individual differences were easily dismissed and did not reflect negatively on the staff as a whole (Jones et al., 2011). Alternatively, young women who had infants in the SCN felt they were primarily treated as adolescents despite seeing themselves as women. This discrepancy in categorization processes resulted in the young women perceiving the hospital staff as intrusive,
overbearing, and as providing differential treatment (Jones et al., 2011). These results suggest that young women do not perceive the same experiences on the ward as adult mothers, which may possibly influence their experience of being a parent of a preterm infant.

**Transition to motherhood for adult mothers of preterm infants**

The current section outlines the literature on the transition to motherhood for adult women in the context of a preterm birth. The experience of having a preterm infant has mostly been investigated from either a stress and coping framework, with preterm birth conceptualised as a stressor affecting psychological adjustment, or from an adjustment and adaptation model where family processes are investigated (Levy-Shiff, Dimitrovsky, Shulman, & Har-Even, 1998). The models predominantly used to investigate adjustment and adaptation in the context of a preterm birth are Lazarus and Folkman’s transactional model of stress and coping and McCubbin and McCubbin’s Resiliency Model of Family Stress, Adjustment, and Adaptation. A brief overview of these models is provided below along with relevant research findings. Similarly to research on adolescent parenting, this body of literature on preterm birth has focussed mainly on deficits or negative outcomes in terms of maternal adjustment. Adjustment here is a loosely defined construct that usually incorporates various measures to provide a picture of either individual or family functioning. Adjustment is usually operationalised as an absence of psychological distress, for example, a lack of depression or anxiety, or a lack of negative psychological symptoms (Lazarus & Folkman, 1984; McCubbin & McCubbin, 1993). More recently there has been a move towards considering prosocial behaviours or community engagement as markers of positive adjustment in the general health literature (Carey et al., 1998; Lent, 2004); however, this has not been fully explicated in the current models of adjustment used to investigate preterm birth. Regardless, these models provide a conceptual framework for the core research in the area and outline factors that may be important during the transition to motherhood in the context of a preterm birth.

**The transactional model of stress and coping.** Lazarus and Folkman (1984) developed the transactional model of stress and coping. This theory introduced the concept of psychological
stress, which explain the experience of stress as a transaction between the situation and the individual. According to Lazarus and Folkman (1984), psychological stress is “a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (p.19). According to their model, stress is a result of a poor person-environment fit, whereby the person’s resources are insufficient to meet the demands of the environment. Stress thereby results from the process of appraising the event as stressful, assessing coping resources as insufficient, and/or implementing inappropriate coping strategies (Lazarus & Folkman, 1984). Cognitive appraisal is posited to mediate the experience of the stressful event and is defined as “an evaluative process that determines why and to what extent a particular transaction or series of transactions between the person and the environment is stressful” (Lazarus & Folkman, 1984, p.19). This process enables the person to evaluate or appraise the significance of the event for his or her wellbeing and involves primary and secondary appraisal (Lazarus, 1999). Coping is defined as the “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984, p.141). Coping usually follows the appraisal of the situation as stressful, although there is some evidence that this may occur in a feedback loop with the appraisal processes (Lazarus, 1999).

Social support can be defined as “emotional, psychological, physical, informational, instrumental and material aid and assistance provided by others that directly or indirectly influences the behaviour of the recipient of these various kinds of resources” (Dunst, Trivette, & Hamby, 1994, p.152) and may reduce the negative effects of stress. In this way, social support is viewed as a buffer to stress and affects both the way a stressful situation is appraised and how the person copes (Lazarus & Folkman, 1984). Lazarus and Folkman’s model has been widely used in the context of stress and coping of adult parents of preterm or LBW infants (Lau & Morse, 2001).

The birth of a preterm infant and the subsequent transition home has been identified as a time of stress for mothers that affects their adjustment. Davis et al. (2003) found that higher stress in mothers of preterm infants was associated with increased depressive symptomology.
Similarly, Meyer et al. (1995) found that psychological distress among mothers of preterm infants was common, with 28% of mothers reporting clinically significant psychological distress, as indicated by the SCL-R 90. In addition, younger maternal age was associated with greater levels of distress (Meyer et al., 1995). In another study, stress was found to vary as a function of infant morbidity, with more distress experienced by parents whose infants were ill. However, the majority of parents whose children were classified as well still reported that the event was emotionally distressing (Pederson, Bento, Chance, Evans, & Fox, 1987). Similarly, Cronin et al (1995) found that the birth and upbringing of a very LBW infant was associated with long-term stress for all parents. Stress was related to the educational level and income of the respondent, with disadvantaged groups, in terms of low income and lack of education, manifesting more financial, familial, and personal stress (Cronin et al., 1995).

Particular stressors related to the context of a preterm birth include the uncertainty of the infant’s outcome, worry, anxiety and fear over the health and wellbeing of their child, the foreign environment of the NICU, the infant’s appearance, the sense of loss associated with the expectation of giving birth to a healthy infant and subsequent alteration to the parenting role, being separated from their infant, and relinquishing control for care of the infant to nursing staff (Affleck et al., 1991; Franck, Cox, Allen, & Winter, 2005; Hughes, McCollum, Sheftel, & Sanchez, 1994; Miles, 1989; Miles & Holditch-Davis, 1997; Seideman et al., 1997). Mothers reported that the experience was highly stressful, with many parents reporting that it was the worst major life event they have experienced (Doering et al., 1999; Whitfield, 2003). The strain experienced by parents at the time of hospitalisation was significantly higher than for parents who delivered full-term infants (Affleck et al., 1991; Carter et al., 2005; Taylor et al., 2001). Parents report that the experience of birth was contrary to their expectations and that they felt unprepared for the birth (Whitfield, 2003) and both mothers and fathers experience levels of emotional distress significantly above normative values (Doering et al., 1999).

During the acute stage of the experience, parents have reported their role as one of remaining vigilant, watching over and protecting the infant (Cleveland, 2008). They desired
accurate information, being included in the infant’s care, and a good relationship with staff (Cleveland, 2008). During this time, parents also reported a need for contact with their infants, which was often restricted due to infants being in isolettes or unwell (Cleveland, 2008). Nurses served a primary support role and were found to be either facilitative or hindering, influencing the mother’s experience of parenting (Cleveland, 2008; Fenwick, Barclay, & Schmied, 2000; Jones, Woodhouse, & Rowe, 2007). Communication between nurses and parents is particularly important, especially informal chatting, and has been found to influence parents’ perceptions of the experience and adjustment (Fenwick et al., 2000). Partner support was also very important during this time with virtually all mothers reporting that their partners were an extremely helpful source of support (Jones, Rowe, & Becker, 2009). Other factors found to influence adjustment have included appraisal of the situation as a challenge rather than as stressful (Jones, Rowe, & Becker, 2009) and use of coping strategies (i.e., not using avoidant coping). Overall, a number of factors, including support, appraisal, and appropriate coping strategies, influence adjustment of mothers after a preterm birth.

The transition home from hospital has been proposed as another avenue for research (Jones, Rowe, & Becker, 2009; Rowe & Jones, 2010). The majority of research has focussed on the acute phase of the experience, when the infant was in hospital (Shields-Poe & Pinelli, 1997), with much less research investigating later stages of the experience such as discharge and when the infant first went home. However, this may be another challenging stage of the experience as parents assume care of their infants, who prior to discharge received 24-hour care from hospital staff. In addition, the infants may continue to require ongoing specialised care, may remain immature, and may have a high risk of hospital readmission (Affleck et al., 1986; Bakewell-Sachs & Gennaro, 2004; Kenner & Lott, 1990; Miles & Holditch-Davis, 1997). As such, the transition home can be a time of adjustment for parents, who often experience high levels of anxiety during this time, making the homecoming of an infant from the NICU both a joyous and stressful transition for families (Bakewell-Sachs & Gennaro, 2004). In addition, mothers have struggled to adjust to the maternal role and have reported mixed feelings about going home.
Ten percent of adult mothers of premature infants experienced severe symptoms of psychological distress neonatally and one third experienced clinically meaningful levels of depression and anxiety one month after discharge from the NICU (Singer et al., 1999).

The birth of a preterm or LBW infant is also associated with a number of ongoing or chronic stressors. Some of these include ongoing health problems, readmission to hospital, developmental delays for the infants, the increased burden of childcare, behavioural problems and difficult temperaments of the infants, and possible ongoing financial commitments (Able-Boone & Stevens, 1994; Cronin et al., 1995; Frye, Malmberg, Swank, Smith, & Landry, 2010; Gray, Woodward, Spencer, Inder, & Austin, 2006; Taylor, Klein, Minich, & Hack, 2001). Premature infants continue to have special needs and remain at increased risk of health problems throughout the first year of life (Bakewell-Sachs & Gennaro, 2004). Mothers still report a fear of what the future will bring and concern about present challenges 6 months after discharge (Holditch-Davis & Miles, 2000). However, most parents seem to have recovered well by the time the child has reached the age of two (Tommiska, Ostberg, & Fellman, 2002), with parents of low risk infants reporting little or no distress by the 3-4 months post discharge (Rowe & Jones, 2010). These findings suggest that the process of adjustment may continue over the short and long term.

**Resiliency Model of Family Stress, Adjustment, and Adaptation.** A second framework that has been used in research on the transition to home with a preterm or LBW infant is the Resiliency Model of Family Stress, Adjustment, and Adaptation posited by McCubbin and McCubbin (1993). The resiliency model focuses on family types, strengths, and capabilities to explain why some families are better able to adjust to stressful events. In addition, this model focuses on the process of family adaptation over time and has been used in a range of settings to examine relationships among families, health, and illness. McCubbin and McCubbin’s model differs from Lazarus and Folkman’s as it acknowledges factors outside of the individual and the situation that may impact on adjustment. While Lazarus and Folkman highlighted the importance
of factors such as appraisal and coping, which are under the control of the individual, McCubbin and McCubbin focused on family level functioning and systemic factors.

The utility of McCubbin and McCubbin’s model lies in its comprehensive consideration of varied factors, which interact to facilitate or hinder adjustment. Accordingly, the illness or the stressor interacts with the family’s vulnerabilities. A family’s vulnerability is shaped by the pile up of family stresses, transitions and strains occurring in the same time period as the stressor (McCubbin & McCubbin, 1993). In the middle phase a number of factors interact including appraisal of the situation, coping strategies and problem solving abilities of the family, family resources, established patterns of family functioning, and social support (McCubbin & McCubbin, 1993) to shape the level of adjustment in the family. According to McCubbin and McCubbin (1993) some stressors do not create major hardships and families are required to make only minor adjustments. However, in the case of chronic illness, the hardships are numerous and severe and require substantial changes and adjustment.

McCubbin and McCubbin’s model has been used to investigate adjustment to a preterm birth for adult parents during both the acute NICU experience (Pinelli, 2000; Singer, Davillier, Bruening, Hawkins, & Yamashita, 1996) and ongoing adjustment and adaptation during the transition home (Affleck et al., 1991; Doucette & Pinelli, 2000; Jones, Rowe, & Becker, 2009). The findings from these studies demonstrate the utility of this model in considering factors within the family system that influence the adjustment of an individual and highlight that adjustment is a process over time. To date no studies have applied this model to adolescent maternal adjustment in the context of a preterm birth. However, this model does highlight the need to consider how the young woman’s experience of being a mother is grounded in the family context at that time. That is, the young woman’s experience of being a mother may be influenced by family functioning and resources and in the context of a preterm birth, the whole family may have to make adjustments.

The models discussed above have been useful in furthering our understanding of how and why the birth of a preterm infant may be associated with poorer adjustment to parenting, as well
as explicating the factors that may be important to adjustment over time. However, both models were primarily developed to explain adult adjustment and the applicability of the models to adjustment and adaptation for young women is not known. It would, therefore, be beneficial to undertake research with an idiographic focus on the experience of young women in context, which may help identify factors related to adjustment that are not currently articulated in models based on adult populations.

**Transition to motherhood for young mothers of preterm infants**

The transition to motherhood for young women who have preterm infants has received little attention in the literature despite a theoretical double risk and identified need (Cleveland, 2008; Thurman & Gonsalves, 1993). The double risk alludes to the fact that parenting at a young age and preterm birth are independent risk factors for poor maternal and infant outcomes. However, there has been little support for this in the literature. Instead, what little research there is suggests that differences between adolescent mothers of preterm infants and adolescent mothers of full-term infants are minimal and short-lasting.

Bell (1997) investigated which aspects of the NICU environment were major sources of distress for young women. The most stressful aspects were the alterations to the parenting role and the infant’s appearance and behaviour. These findings were similar to those in adult populations (Miles, Carlson, & Funk, 1996). Causing less stress were the sights and sounds of the NICU and communicating with staff. This result was somewhat in contrast with adult mothers who rated the sights and sounds of the environment as the second most stressful aspect (Bell, 1997). Also surprising in Bell’s study was the lack of stress associated with communicating with staff, as this has been found elsewhere to be a major challenge for young women (Jones, Rowe, & Sheeran, 2009; Jones et al., 2011). However, one explanation for this may be that Bell’s study was undertaken within 96 hours of admission, whereas Jones et al. interviewed mothers at time of discharge after prolonged exposure to staff, suggesting that negative attitudes towards staff may develop over time.
In an investigation of the posited double risk, Field, Widmayer, Stringer, & Ignatoff (1980) looked at the transition to parenthood for low-income African American adults and adolescents of full-term and preterm infants. The study was primarily concerned with infant developmental outcomes, and investigated the proposition that infants born preterm and to an adolescent mother were at risk for developmental delays. The study found no differences in infant development between adolescent mothers and adult mothers. The researchers suggest that the expected developmental differences between infants of teens and adults may have been attenuated by family support systems, as most of the adolescent mothers lived in their parent’s homes (Field et al., 1980). However, the study did find developmental delays for preterm infants born to adolescent mothers suggesting that the attenuating influence of the family support may not extend to adolescent mothers of preterm infants.

The Field et al. study also included the State-Trait Anxiety inventory (STAI) as a measure of maternal adjustment. Surprisingly for the researchers, the study failed to find differences between any of the groups on the STAI at birth or at the 4 month or 8 month follow-ups. The failure to find differences between the groups was inconsistent with the majority of research on the effects of preterm birth, which suggested that mothers of preterm infants experience more distress than mothers of full-term infants (Affleck et al., 1991; Carter, Mulder, Bartram, & Darlow, 2005; Taylor et al., 2001). The lack of difference suggested that in the context of adolescent motherhood the stressor of a preterm may not be significant enough to cause increased anxiety.

The failure to find differences was further supported by a follow-up of young mothers of full-term and preterm infants who had participated in early intervention programs (Stone, Bendell, & Field, 1988). Stone et al. investigated infant development using a number of standardised tests as well as maternal self-esteem, stress, and interactions with the infant when the infant was 5-8 years old. They reported no differences between the mothers of preterm infants and mother of full-term infants (Stone et al., 1988).
A recent study directly exploring the double risk proposition for adolescent mothers of preterm infants compared adolescent mothers of preterm and full-term infants to adult mothers of preterm infants. Contrary to the double risk hypothesis, results suggested that adult mothers were experiencing more distress and appraising the situation as more threatening than were adolescent mothers of full-term infants. There were no significant differences on any of the measures between the two groups of adolescent mothers (Farnell et al., in press). However, this study was limited by a small sample size and high attrition over time. Together, these studies suggest that there may not be any immediate or long-term effects of having a preterm infant on the experience of being a mother for young women but further research is warranted. Particularly needed is research that explores the experience of a preterm birth from the young woman’s perspective. In this way, aspects of the experience that are meaningful to the young woman can be ascertained.

Only one study has investigated the impact of having a preterm infant from the young woman’s perspective. Neu and Robinson (2008) used naturalistic inquiry to obtain subjective descriptions of the postpartum experience of 12 Hispanic adolescent mothers who gave birth to preterm infants in the US. Neu and Robinson’s study, which looked at the strengths and challenges of the young mothers during the early adaptational process post discharge, found three key themes. These themes included devotion to the baby (by way of providing loving care), responsibilities (initially to the infant but then incorporating care of family members and responsibility for household duties), and relationships. Relationships included the sub-themes of family support and its importance, and estrangement from family and friends that had a significant impact on the mothers’ early adaptation (Neu & Robinson, 2008). Of note, the descriptive themes generated were not associated with stress or challenge relating to the preterm birth. Instead, the results of this study were similar to the results of qualitative research studies investigating the experience of being a mother for young women of full-term infants, in that the mothers displayed devotion to the infant and support was an important component of the experience. These results again suggest that there may be few differences between the
experiences of parenting for young women of full-term and preterm infants. However, research directly exploring the experience of mothers of preterm and full-term infants would be beneficial to identify whether there are differences in the experience. In addition, Neu and Robinson’s study was conducted in the months post discharge and not during the hospital experiences, which may have reduced the salience of any challenges relating to preterm birth at that time. The current study will address these gaps.

**Summary**: The review of the literature on adolescent parenting found that early qualitative research studies tended to compare and contrast adolescent mothers with adult mothers, with little consideration of pre-existing differences between the groups. These studies tended to find that young mothers and their infants were at risk for poor adjustment and parenting as a teen was regarded as incompatible with their stage of psychosocial development. In addition, there was little attention paid to the similarities in experiences between adults and teens in their transition to motherhood. However, more recent research has challenged the causal link between age and poor outcomes, while also highlighting the heterogeneity of the group of young mothers. This research spawned a search for factors that may contribute to negative adjustment to motherhood with much of the focus on identifying risk factors. In contrast, a growing body of qualitative literature highlighted that the experience of parenting for young women was both positive and challenging, often providing the young women with direction and meaning for the future. Further, these studies explicated the diverse difficulties these mothers face, often due to the context in which they were parenting. The richness and depth of experiences elucidated in these qualitative studies has been useful in describing the nuances of the experience for young women.

It has also been argued that adolescent pregnancy is a socially constructed problem, with common discourses around adolescent parenting perpetuating the negative stereotypes. These negative stereotypes and attitudes then feed into the stigma experienced by the young women, negatively influencing their experiences of parenting. In order to minimise the perpetuation of stereotypes and stigma it is important for research to provide a balanced view of motherhood for
young women that is free from researcher imposed values. Arguably, this balance seems to be most aptly achieved by using qualitative methodologies, which allow an in depth exploration of this complex experience.

A small body of research exists on the experience of being a mother for adolescent mothers of preterm/LBW infants. This research is beginning to challenge the posited double risk for poor maternal outcomes, as few differences appear to exist between adolescent mothers of full-term and preterm infants, and younger mothers appear to experience less stress during the transition to parenthood than adult mothers of preterm infants. Similarly, the narratives of young mothers of preterm infants seem consistent with research on young mothers of full-term infants suggesting preterm birth does not alter the experience of parenting in a meaningful way. However, to date no research has investigated the experience of being a young mother in the context of a preterm birth from the young woman’s perspective as they prepare to leave the hospital to transition home. Nor has the experience for young women of having a preterm infant been compared to that of having a full-term infant in terms of meanings and processes.

Theories related to stress, coping, and adjustment to a preterm birth and to the transition to motherhood for both adolescents and adult mothers suggest a vast number of factors that may influence the young woman’s adjustment to motherhood. However, it is not known if or how these factors will relate to a specific group of young mothers with preterm infants. The dominance of quantitative research, which takes a deficit view of parenting for young women, and the contrary findings emerging from more recent qualitative inquiry highlight the need to question our own presuppositions as researchers and to analyse our role in perpetuating the ‘problem’ of adolescent parenting. The current project seeks to bridge the gap in the current research by providing a better understanding and scope of the issues for this potentially vulnerable group. By utilising an approach that can elucidate the experience of being a mother for the young women in the study, but that can also dialogue with the extant literature, it is hoped that this research will increase our understanding of the experience of being mothers more generally.
Given the lack of research in this area and the complex lives of the adolescent mother, the current study was designed as an interpretative phenomenological study (IPA). IPA’s focus on in-depth exploration of each case from a small homogenous sample meant that each mother’s experience of a preterm birth could be explicated and integrated into a coherent narrative. The situated knowledge gained through these stories could then be linked back to the extant literature on adolescent mothers and preterm birth, adding to our conceptual knowledge. Further, the focus of the research could be firmly situated in the experience of being a mother. While experience is a complex concept, the current research was particularly interested in what happened when the everyday lived experience took on significance for the participant. At an elemental level, and for the most part, people are caught up in the everyday flow of experience (Smith et al., 2009). However, becoming aware of this experience marks the beginning of ‘an experience’ rather than experience. Further, while it is possible to focus on the smallest units of experience (such as perception and sensory experiences) a focus on the comprehensive unit of experience allows elucidation of ‘parts of life’ that are linked by a common meaning (Smith et al., 2009). The comprehensive unit of experience is, then, where ‘an experience’ has a larger significance in a person’s life (i.e., an experience is connected to important events in the past or serves as a meaningful marker; Smith et al., 2009). Investigating an event that is of major significance to the young women means that the young women will be engaging in reflection, thinking and feeling as they work through what this experience means to them (Smith et al., 2009). The current research aimed to engage with these reflections to identify any common meanings.

In summary, the aim of the current research was to explore the complexities of being a mother for young women by developing our understanding of how young women experience the transition to motherhood in the context of a preterm birth. As such, the questions this research sought to answer were:

- How do young women experience being a mother in the context of a preterm birth?
o How does having a preterm infant change the experience of being a mother for young women as compared to young mothers of full-term infants?

o How does having a preterm infant alter the experience of being a mother over the first year of the infant’s life?

Consistent with IPA, secondary research questions were posed relating to literature and theory, with the acknowledgement that there was no certainty that these questions would be able to be answered due to the open nature of qualitative research (Smith et al 2009).

o How does the young women’s experiences of having a preterm infant fit with the posited double risk in the extant literature?

o To what extent can the process of being a mother in the context of a preterm birth for young women be accounted for by current transactional models of adjustment?
Chapter 3: Methodology

The purpose of the current chapter is to highlight the underlying assumptions of the current research and to position these assumptions in relation to a) research paradigms in psychology generally; b) the philosophy that underpins the assumptions and; c) the methodology used in the current study. Accordingly, it will be argued that qualitative methodologies are a necessary and complementary form of investigation within psychology; a discipline dominated by the positivist and post-positivist paradigms. In addition, key tenets of phenomenological philosophy proposed by Heidegger and Husserl will be reviewed, providing the philosophical basis of the current investigation. The philosophical basis will then be linked to the methodology used in the current study, Interpretative Phenomenological Analysis (IPA), and issues of rigour will be addressed. Finally, the chapter will conclude with a reflexive note on the methodological process. To begin, the researcher’s assumptions are presented. These assumptions were generated by the researcher in line with a constructivist epistemology and based in the phenomenological paradigm (Gergen, 1985; Kvale, 1983; Smith et al., 2009).

The first assumption underlying this research project was that focussing on human experience is a topic in and of its own right. Further, that our understanding of various phenomenon can be explicated by a concern with meaning and how meaning arises within the experience.

The second assumption is that we construct knowledge intersubjectively through language. That is to say, the participants were constructing the meaning of events through the use of language, and as they were engaging in the process of telling their experiences.

The third assumption is that the participant and researcher cannot be objectively separated. It is through the process of research, for example interviews, that the meaning of an experience is constructed by the participant. In this way, the researcher is an active participant in the meaning making process that the participant is undertaking.

A fourth assumption is that the researcher’s role then is to make sense of participants’ attempts to make sense of an event or phenomenon. The researcher co-constructs knowledge of
the topic under investigation, while appreciating that all experience must be understood in context.

This way of knowing, though growing more popular within psychology, has until recently been neglected and is at odds with the dominant paradigms of the discipline.

**Qualitative research in psychology**

Mainstream psychology did, and still does to a certain extent, subscribe to a positivist paradigm, by which knowledge is gained about a real world that exists using statistical methods (Langdridge, 2007). In recent decades there has been a shift towards a post-positivist paradigm in which a real world is still assumed, but where researchers are critical and sceptical of our knowledge of it; therefore, seeking to disprove that which is known and assumed (Langdridge, 2007). This positivist/postpositivist viewpoint has been commonly adopted among the natural sciences, forming the model for psychology. The dominance of the scientific/objectivism epistemology in psychology, where the researcher is objective, value free, and detached, and the participant’s role is one of reporting, has led to a neglect of the value of other epistemological views (Langdridge, 2007). The notion of objectivity, or the state of being without bias or prejudice, suggests reality pre-exists experience, experience serves to find what is in existence, and suggests a distance between the researcher and the participant independent of the social context (May, 2001). There is no acknowledgement of the role context plays or its effect on researcher or participant. Similarly, there is little recognition of the impossibility of taking an unprejudiced stance; in that researchers influence the research in multiple ways including through the choice of measures and variables selected. However, recently there has been a growing tension within the discipline as researchers argue that this is an inappropriate paradigm for psychology and the study of human nature (Langdridge, 2007). This recent shift recognises the inadequacies of the positivist/post positivist paradigm in the face of complex human existence (Wetherholt Cugliari, 2005). While the positivist/post positivist approach has given us much knowledge about human behaviour, the lack of attention to the individual in context limits the applicability of these universal rules to many people (Willig & Stainton Rogers, 2008). The
growing argument that psychology is not like the natural sciences opens the discipline up to considering other ‘ways of knowing’ (Langdridge, 2007). This view is not new, however, and builds on sentiments expressed by William James in 1908 that psychology focus on both experimental and experiential (Eatough, 2008 #255). However, it is only recently that this shift has gained legitimacy and momentum. Accordingly, psychology, particularly areas of health, clinical, and counselling psychology, have been experiencing a shift in research paradigms, with qualitative methodologies emerging as an important avenue of discovery (Smith et al., 2009).

The positivist paradigm was founded on philosopher Descartes, whose tenet ‘I think, therefore I am’ expresses the belief that we can only have direct knowledge of our own mind, and all other knowledge must be obtained through observations (Yardley & Bishop, 2008). Consequently, researchers must make all observations as accurate as possible to gain a correct understanding of the world. The scientific method is seen as a way of achieving the most accurate observations, by controlling the environment to remove sources of variability. This scientific approach has been successful in helping understanding of the physical world (Yardley & Bishop, 2008).

An alternate constructivist view is that an awareness of the world is completely mediated by subjective and socio-cultural experiences. Therefore, it is impossible for humans to set aside the assumptions and values that form their identities in order to achieve ‘objective’ knowledge (Gergen, 1985). While the scientific method is a useful tool for gaining some types of understanding it is not appropriate to gain other types of understanding (i.e., how people relate to the world). Understanding how people relate to the world requires critical examination of normative concepts and habitual practices that shape our perceptions, including the assumptions of the research process itself (Yardley & Bishop, 2008). Consistent with the constructivist perspective, the current research project ascribes to the notion that there is more than one reality, and that the researcher and researched co-create knowledge (Gergen, 1985).

One stream of qualitative enquiry starting to be used in psychological research and that is particularly concerned with challenging our assumptions and moving beyond our habitual
practices is represented in approaches that draw on phenomenological methodology. In contrast to the objectivist viewpoint, phenomenological thinking focuses on the experience or narrative of the participants rather than a real knowable world (Langdridge, 2007). Methods are then targeted to be participant close rather than participant far. That is, the methods used are subjective and involved and designed to illuminate the lived world of participant, the researcher and others who have experienced something similar (Langdridge, 2007). Phenomenological philosophy, when applied to psychology, is concerned with the person’s perceptions of the world in which they exist and what this means to them. The focus is on the ‘lived experience’ (Langdridge, 2007) and the participant is understood primarily as a knower as opposed to a reporter of experience (Laverty, 2003).

One core difference between the positivist/postpositivist and phenomenological paradigms in psychology relates to the object/subject dualism. Within the positivist/postpositivist tradition there is a separation between the world as it is and how it appears to us through perception (Langdridge, 2007). Alternatively, phenomenologists argue that there is no sense in separating objects from our subjective experience or perception of them, as an object enters our reality only when we perceive it, i.e., when it enters consciousness. In addition, perception changes depending on context, the positioning of perceiver in relation to object as an example. As such, there is no once- and-for-all knowledge to be found about a real world (Langdridge, 2007). The focus of phenomenology is, then, on our perception of the world, recognising that how this is experienced will be differentially meaningful to people.

**Phenomenology as a philosophy**

Phenomenology describes both a philosophical approach and a range of research methods (Giorgi & Giorgi, 2008). The concern of phenomenology is with the way things appear to us in experience. In addition, phenomenology espouses that the reality in which we live is an experiential one, in that we experience reality through practical engagements with things and others in the world; and, moreover, that this is inherently meaningful (Eatough & Smith, 2008). Moran (2000) defines phenomenology as a form of philosophy “which emphasizes the attempt to
get to the truth of matters, to describe *phenomena*, in the broadest sense as whatever appears in the manner in which it appears, that is as it manifests itself to consciousness, to the experience” (p. 4). The principle philosophers who informed phenomenological philosophy and who are relevant to the current study were Husserl and Heidegger. Each of these philosophers added to the phenomenological perspective in distinctive ways, highlighting key considerations for research in this vein.

Husserl, often considered the father of phenomenology, famously argued that we should “return to the things themselves” (Husserl, 1913/1982, p. 35). In going back to the *things themselves*, Husserl desired that we examine phenomena free from all previous assumptions or suppositions and instead examine them as they appear. For Husserl this involved engaging in a process to identify the essential qualities of one’s own experience of a given phenomenon. Beyond this, Husserl believed that if we could identify the essence of a phenomenon, we could then transcend the particular circumstances of their appearance. This would mean that we could possibly illuminate the experience for others and set up the assumption that there is a relationship between object and subject (Husserl, 1969). Here the phenomena are prioritised, with the goal of phenomenology to articulate the essence of the phenomena by transcending our everyday understanding.

For Husserl the process of identifying the essential qualities was one of *phenomenological reduction*. Reduction is seen as a leading *back* rather than a process of simplifying things or reducing *down* (Husserl, 1969). In addition, this reduction involves examining and suspending all of our suppositions and prior assumptions about the phenomenon. Husserl explained that people’s *natural attitude* to the world is founded upon numerous assumptions, which facilitate our everyday doing and being. However, this natural attitude also obscures and distorts a proper or essential understanding of our experiences. For Husserl then, phenomenology was about *bracketing* these assumptions to transcend their everyday qualities. By adopting a *phenomenological attitude* in which we turn our gaze inwards rather than towards objects in the world, we are able to examine everyday experience {Smith, 2009 #414}. This shift
then is one away from being busily engaged in activities and instead disengaging so that we can examine the aspects of the experience, which are usually taken for granted (Smith, 2009 #414). Therefore, bracketing is an essential component in transcendental phenomenology along with a second method espoused by Husserl: the *eidetic reduction*. Through these processes, features of the phenomena are identified and examined with further explication of those aspects of the phenomena that are *essential*. Ultimately, a descriptive account of the universal features of ‘what something is like’ is produced, that transcends situational and individual variation, (Smith et al., 2009).

Husserl also placed *intentionality* at the centre of his philosophy (Larkin, 2011 #418). This key concept in phenomenology does not refer to a person’s intentions (what they ‘plan to do’ for example; Larkin, 2011). Instead, the term speaks to the relationship between consciousness and the object of attention (Crotty, 1996). Intentionality is the idea that every thought is a thought of something, every desire is a desire of something, and every judgement is a judgement of something (Crotty, 1996). Consciousness is always and essentially related to objects (Smith et al., 2009). In short, there is an indissoluble union between subject and object and while not suggesting that subject and object are the same this position also suggests that they are also not separate (Crotty, 1996). These acts of consciousness toward objects are then communicated to the world by careful description (Giorgi & Giorgi, 2003).

Husserl’s introduction of the concept of bracketing has helped researchers, and specifically IPA, to focus on the process of reflection during the analysis process. Moreover, although there is much debate about the ability of people to fully bracket off their preconceptions about a phenomenon, it has pointed to the need to be open-minded, exposing, and engaging with our presuppositions (Larkin, Eatough, & Osborn, 2011). Similarly, the concept of intentionality highlights that the phenomena being investigated cannot be divorced from the participant’s experience of that phenomena. Instead, it is through the participant’s experiences that we can come to know the phenomena. However, while Husserl was concerned with finding the essence
of the experience, the current research, in line with IPA more generally (Smith et al., 2009), has a
more modest goal of capturing a particular experience as it is experienced by specific people.

A second important philosopher in the phenomenological tradition is Heidegger
(Heidegger, 1927/1962, 1978). Heidegger’s approach marked the move away from
transcendental phenomenology towards a more existential and hermeneutic emphasis (Moran,
2000). Heidegger introduced the concept of Dasein literally meaning ‘being there’ but most often
referred to as ‘being-in-the-world’ (Heidegger, 1978). The “Cartesian dualism of person/world,
subject/object, mind/body” is dissolved because “individuals are Being-in-the-world with things
and with others” (Eatough, 2008 #255, p. 182). This highlights that we can never gain
objectivity and that the participant will always be a part of the social world being investigated.
Again, it is through the participant’s existence, their connectedness to their experiences, that we
can come to know the nature of the phenomena.

Heidegger also posited that Dasein is thrown into this pre-existing world and that it is not
possible to meaningfully detach from it. Consonant with this, Heidegger posited that we were
always and enduringly ‘person-in-context’, meaning that we were a fundamental part of a
meaningful world and that the world was a fundamental part of us that could only be fully
disclosed and understood as a function of our engagement with it (Larkin, Watts, & Clifton,
2006). Again, this points to a focus on human experience and on how the phenomenon that is
perceived appears to the participant.

In Being and Time, Heidegger (1978) discussed that the process of understanding Dasien
is hermeneutic (interpretive) because the concept of Being is such that it is not immediately
manifest, rather it is something hidden. This is suggestive of the importance of the role of the
researcher in making clear that which is hidden (Moran, 2000). Heidegger goes on to discuss the
fact that whenever we interpret something it will be founded essentially on our foreconceptions,
that our interpretation can never be presuppositionless. The researcher cannot help but bring
prior experiences, assumptions and preconceptions into the encounter, looking at the new
stimulus in light of our prior experiences (Smith et al., 2009). Importantly, Heidegger states that
while the forestructure is always there and may present a barrier to interpretation, the new object or phenomena should have priority over the forestructure (Smith et al., 2009). The suggestion noted by Smith et al is that it is through engagement with the text that we may gain increased understanding of what our forestructures were. Heidegger unpacks the relationship between interpretation and forestructures, questioning and re-evaluating the role of bracketing and posits a complex and dynamic notion of foreunderstanding, which suggests bracketing is a cyclical process and can only partially be achieved (Smith et al., 2009). That is to say, we can never fully remove our prior understanding from our attempts to understand the phenomenon that we are exploring. At best, we can acknowledge our prior assumptions, make explicit our prior knowledge, and engage in a reflexive process whereby we question our interpretations.

The key ideas posited by Heidegger, which inform both the current research approach and IPA more generally (see Smith et al., 2009), are that human beings are thrown into a pre-existing world, from which they cannot detach. Making sense of their experiences then is to consider their relationship with the world; a world that is one of people, objects, language, culture, and relationships (Smith et al., 2009). In addition, Heidegger positions phenomenology as an inherently interpretative activity in which we uncover that which appears, but with researchers playing a role in facilitating and making sense of this appearing, never able to be completely separate to the research process. This suggests that in order to investigate phenomenon of interest we must consider it through the experience of those living it (that is the participants) and through the researcher’s involvement.

**Phenomenology as a research method**

Several research methods have emerged based on the phenomenological philosophical theory. These include Goethean pre-philosophical experimental phenomenological tradition, which began in Europe, Grass roots phenomenology, which developed in the USA independent of existing approaches in Europe, pre-transcendental Husselian phenomenology and finally interpretive phenomenology (Giorgi & Giorgi, 2008). There are similarities between all of these approaches in that they all stem from the Husserl’s call of ‘to the things themselves’ and honour
the intention of phenomenology to describe how the world is formed and experienced through conscious acts (Giorgi & Giorgi, 2008). However, for interpretative approaches, such as IPA, the goal is not to describe the essential structures of the experience, but rather to understand the meaning of a particular experience as it is experienced by specific people (Smith et al., 2009). So whilst IPA is based in phenomenology, in that it is concerned with the lived experience of its participants, it differs from traditional phenomenological analysis in that it moves beyond only describing the meanings as they present themselves towards interpreting the meanings and involving the hermeneutic circle (Smith et al., 2009). As such, both phenomenology and hermeneutics are important theoretical touchstones for IPA.

**Description of IPA**

Interpretative Phenomenological Analysis (IPA), though relatively new, has gained in popularity as a research method for psychology, becoming one of the best known and most commonly used qualitative methodologies (Smith, 2011). A recent review of the use of IPA in the health psychology domain indicated a steady increase in the number of IPA studies published since the initial paper was published by Smith in the mid 1990s (Smith, 1994, 2011). The posited reason for its gain in popularity, especially in health psychology, is related to how well it lends itself to understanding major life experiences, of which illness and disease are significant to the individual (Brocki & Wearden, 2006; Smith, 2004).

IPA was first developed as an approach that could capture the experiential and qualitative while still being able to dialogue with mainstream psychology. Smith (1996) developed this approach in line with the pluralistic psychology envisaged by William James, one that could be both experimental and experiential (Smith et al., 2009). IPA is a qualitative research approach, which is committed to examining how people make sense of their major life experiences (Smith et al., 2009). Goals of the research include trying to understand the experiences an individual has in life, and understanding both how they made sense of that experience and the meanings that the experiences hold (Smith, 2004).
IPA is idiographic in that it is focussed on the individual’s particular lived experience. This idiographic focus on the particular means that the concern is with what the experience is like for this person, elucidating what sense this particular person is making of what happened to them (Smith et al., 2009). Most often, this manifests as a detailed analytic treatment of each case until some degree of closure or gestalt has been reached before moving to across case analysis of patterns and a detailed focus on individual convergence and divergence across themes (Smith, 2011). This focus on the idiographic represents an important and necessary shift to considering the individual in context rather than nomothetic psychology, which only allows actuarial or group level claims and is not able to say anything substantive and specific about the particular individuals who provided the data for the study (Smith, 2004).

IPA is also inductive. Larger research questions are developed which lead to the collection of expansive data as opposed to specific hypotheses developed from the extant literature. The techniques employed are flexible, allowing unanticipated topics or themes to emerge during analysis. Although there may be an interplay between inductive and deductive processes, inductive is always at the fore (Smith, 2004).

IPA is interrogative and its psychological centre is important as IPA aims to make key contributions to psychology. This is achieved through interrogating or illuminating existing research and relating case study analyses back to the extant psychological literature (Smith, 2004).

Smith and colleagues have generated a clear guide to the steps involved in undertaking an IPA project (Smith et al., 2009; Smith & Osborn, 2003; Smith et al., 1999). There has been some criticism that this has resulted in a formulaic approach to qualitative research, however, it has also been acknowledged that following the steps alone will not result in a good analysis (Smith, 2004). Instead, the quality of the output depends on a rigorous treatment of the data combined with the interpretative skill of the researcher. The guidelines simply provide some guidance to novice researchers. The key steps in an IPA study, as outlined by Eatough and Smith (2008), are documented in box 1.1.
Doing IPA

- Research questions are directed towards aspects of the lived experience
- The idiographic commitment encourages the study of small homogenous samples
- Semi-structured interviews are the exemplary data collection method for IPA
- Other methods include diaries, unstructured life history interviews
- Data collection is dialogical with the participant taking a significant role in determining what is said
- Analysis is an iterative inductive process, beginning with several close detailed readings to provide a holistic perspective, noting points of interest and significance
- Step-by-step analysis then proceeds to the description of analytic themes and their interconnections, taking care always to preserve a link back to the original account
- Analysis continues into the writing-up stage and finishes with a narrative of both participant’s and researcher’s meaning making of the topic under investigation
- Ideally the final narrative should move between levels of interpretation: from rich description through to abstract and conceptual interpretations.

Box 1.1 The Methodological Practice of IPA (Eatough & Smith, 2008, p. 187)

IPA, with its theoretical roots in phenomenology, hermeneutics and idiography, draws from phenomenology in that it is concerned with exploring experience in its own terms rather than through fixed predefined categories or overly abstract categories (Smith et al., 2009). As discussed above, phenomenological philosophers have also converged on the need to explore the lived experience by providing a detailed examination of the experience as it appears (Giorgi & Giorgi, 2003). However, Smith (2011) also highlights that IPA research is really about getting “experience close” rather than “experience far”, as there is no direct route to experience (p. 10).

IPA endorses social constructivism’s claim that how we experience, understand, and talk about our lives is steeped in sociocultural and historical processes (Eatough & Smith, 2008). Language is important, with our sense of self emerging in part from constant intersubjective
communication (Eatough & Smith, 2008). This is cognizant with symbolic interactionists, such as Mead and Blumer, who viewed human beings as creative agents who construct their social worlds through their intersubjective interpretative activity (Eatough & Smith, 2008). The focus then is on mapping the cares and concerns of the participant and in understanding how the phenomenon has been understood by the person, within the context of their cultural and physical environment (Eatough & Smith, 2008). For IPA then, the telling of events in our lives has both relevance and an ongoing significance to the person telling the story (Smith, 1996). As such, IPA attempts to understand how the phenomenon are understood by people and what that means for that person in that particular context.

IPA highlights that the researcher co-constructs knowledge of the topic under investigation, understanding that all experience must be understood in context (Smith et al., 2009). In order to understand the experience of others researchers must engage in a process of engagement and interpretation, closely tying it to hermeneutics (Smith, 2004). As such, IPA is interpretative, drawing on hermeneutics and acknowledging that people are sense-making creatures and, as such, their accounts are their attempts to make sense of the experience (Smith et al., 2009). The IPA researcher is engaged in a double hermeneutic process as they make sense of the participant trying to make sense of the experience (Smith et al, 2009).

In summary, the methodology adopted for the current study stems from the assumptions of the current research, which are based on a constructivist epistemology, by which it is assumed that participant and researcher co-construct knowledge. In addition, the phenomenological underpinnings support the return to investigating phenomenon in and of itself. A further, assumption of the current research is that the participant and the researcher cannot be objectively separated and that it is the researcher’s role to make sense of the participant’s attempts to make sense of an event or phenomenon. As such, the analysis process will make explicit the role of the researcher. Finally, in line with the assumption that we construct knowledge intersubjectively, through language, the current research utilised guided interviews as the method of collecting data.
The use of guided interviews

A guided interview data collection method was chosen based on several theoretical considerations. First, consistent with Smith’s (1995) position, the theoretical position of the current research is that the things that respondents say have significance and reality for them that is beyond the bounds of the specific occasion. Instead, the psychological reality, manifested through what they say - their self-stories representing their psychological world, is what is of interest to the researcher (Smith, 1995). Smith and Osborne (2003) also note that semi-structured interviews are the exemplary method of data collection in IPA studies.

Second, utilising an interview technique with adolescents helps give rise to their own interpretations and thoughts rather than relying solely on adult interpretations of their lives (Elder & Fingerson, 2002). Booth and Booth (1994) also argue that the use of interviews with vulnerable and devalued groups (such as adolescents) can help to access knowledge that may not be available via other methods. An interview approach also allowed for the raising of topics that were salient in the participant’s lives but which may not often be discussed. Further, interviews allowed for the building of rapport with the participants, which was particularly important in maintaining participation over time and for encouraging honest and open answers to questions with this population (Elder & Fingerson, 2002; Hoyle, Harris, & Judd, 2002).

The guided interviews used in the current project differ from semi-structured interviews in that while a schedule was created it was not adhered to in any systematic way. Instead, participants led the discussion and the interviewer guided the process based on the topics of the interview schedule. This enabled the participant to provide a richer, fuller account than would have been possible with questionnaires and allowed considerable flexibility in probing interesting areas as they emerged (Smith, 1995). In addition, the interviews permitted questioning and exploration of the complex and multifaceted issue of being a mother in the context of a preterm birth and helped to discover the complex interconnections in their social worlds (Hughes, 1996). The use of guided interviews was particularly useful for gaining information on constructs that were less well defined and constructs that were important to the
young mothers (Liamputtong & Ezzy, 2005) and allowed the interviewers to test, challenge, and discover factors that contribute to the experience of being a mother.

**Credibility and quality of qualitative research**

Qualitative research is often criticised as being less rigorous than quantitative research. However, the divergence of these perspectives is overstated and maintained by misleading conceptions of what science is. By adopting a broad definition of science, i.e., “Science, defined in its broadest sense as a systematic, rigorous, empirical endeavour that needs to be carried out properly if it is to produce knowledge which is trustworthy and reliable” as proposed by Giorgi and Giorgi (2008), science is not defined purely in terms of the hypothetico-deductive method (Willig & Stainton Rogers, 2008, p. 10). This is similar to the stance proposed by Brickman “contrary to what is sometimes asserted science is a question of aim and not method. Science is an effort to make accurate observations and valid causal inferences, and to assemble these observations and inferences in a compact and coherent way” (Brickman, 1980, p. 10 as cited in Willig & Stainton Rogers, 2008). Qualitative methods can be equally rigorous and valid as quantitative methods. Qualitative research is empirical as it collects data, analyses it, interprets it, and draws conclusions based on engagement with the material. Similarly, it openly acknowledges that the relationship between the social world being studied and our experience of it is not simple or direct, meaning that the analysis of the data will always be mediated by the researcher (Willig & Stainton Rogers, 2008).

It is impossible and unsuitable to judge qualitative research by the standards developed to assess quantitative research. Despite this, several quantitative research criteria are often inappropriately applied to qualitative research such as sample size and reliability. As such, it is often expected that research will use large representative samples. However, a large statistically representative sample cannot be analysed in depth due to the large amounts of data this would generate. It is often preferable to use theoretical sampling, and for IPA in particular it is important to have homogeneity within the group rather than representative diversity (Smith et al., 2009; Yardley, 2000). Similarly, if the purpose of the study is to provide one of many possible
interpretations of a phenomenon, criteria such as reliability and replicability are inappropriate (Yardley, 2000). Inter-rater reliability can be argued to simply be a statement that two people at any one time agreed on what they were seeing and is not necessarily a measure of objectivity or truth. It is simply an interpretation agreed upon by two people (Yardley, 2000). Thus it has been argued that application of criteria developed for quantitative research to qualitative is misplaced (Yardley, 2000). However, it is still important for qualitative methodologies to have guidelines which can be evaluated.

The development of a single set of criteria for all qualitative methodologies is not possible or desirable due to the divergent aims of the various approaches (Yardley, 2000). Instead, different qualitative methodologies develop guidelines for assessment of quality and credibility to be adhered to. The assessment of quality and credibility in IPA studies has mostly been addressed by using the four broad principles developed by Yardley (2000). However, more recently Smith (2011) has provided a detailed guide developed specifically to assess the quality of IPA studies. This section will present each of Yardley’s principles incorporating how the current research addressed the criteria. Further, Smith’s criteria will be integrated where relevant.

Yardley outlined four broad guidelines for assessing quality in qualitative research:

1) Sensitivity to context.
2) Commitment and rigour.
3) Transparency and coherence
4) Impact and importance

It should, however, be noted that these are considered broad guidelines and not prescriptive requirements.

Yardley highlights that good qualitative research acknowledges the importance of the many facets of context and sensitively addresses them. The facets of context that should be considered include theoretical, relevant literature, empirical data, sociocultural setting, participant’s perspectives, and ethical issues. Further, Smith (2011) states that acceptable papers
are deemed to have clearly subscribed to the theoretical principles of IPA (i.e., phenomenological, hermeneutic and idiographic). The current research addressed the sensitivity to context criteria in several ways. This included providing a sensitive review of the substantive and theoretical literature in the area of teenage pregnancy and by highlighting the assumptions both research and society have been making in regard to adolescent adjustment and preterm birth. Further, this research outlined the rationale for the phenomenological study and provided a grounding in the philosophy underpinning the methodology. The participant’s perspectives were prioritised and the researcher presented a challenge to the dominant discourse used about young mothers by honouring their perceptions of themselves as mothers first and foremost. The current research also considered the sociocultural context and actively addressed it through thorough description and integration of contextual factors within the analysis. Finally, sensitivity to context was addressed via the researcher’s prolonged engagement with the participants, the topic and the data. Thus, the researcher spent several hours each week at the hospital sites interacting with participants prior to recruitment over a period of 18 months. In addition, participants were usually visited on several occasions after they had given birth or while their infants were in hospital prior to the time 1 interviews. The researcher also had infrequent contact between interviews over a 12-month period and spent several hours in the participant’s home conducting follow-up interviews. In addition, the researcher had prolonged engagement with the data as the interviews were listened to several times and were content coded multiple times due to reporting requirements of the funding body. This lead to a high degree of familiarity and engagement with the data.

Yardley’s second and third principles are closely related and include commitment, rigour, transparency, and coherence. In IPA researchers can enhance transparency by carefully describing how participants were selected, how the interview schedule was constructed and the interview conducted, and steps used in analysis. Smith (2011) states that there should be sufficient transparency so that the reader can see what was done. The analysis should be coherent, plausible, and interesting. Rigour should be demonstrated via sufficient sampling from
the corpus, showing the density of evidence for each theme. This may include a measure of prevalence, but should also show the depth and breadth of the theme, including divergence, convergence, representativeness, and variability (Smith, 2011). Coherence can also refer to the fit between the research carried out and the underlying philosophical assumptions of the approach.

The current research meets these principles by ensuring transparency and reflexivity in each of the steps of the research process including question selection, recruitment, and analysis. A breakdown of the theme selection by participant is provided in appendix (A) to show the distribution of the quotations used, and justification for the use of the specific themes is provided in the results section. A step by step guide to the analysis process is provided and reflexively discussed in the chapter 4. In addition, an example of an analysis is provided in appendix (B). Breadth and depth, including convergence and divergence for each theme, is provided when the findings are discussed.

Triangulation is another process that can help ensure that the findings are rigorous (Lincoln & Guba, 1985) and can include the use of either multiple sources of data, multiple methods of investigation, multiple theories to guide the inquiry, or multiple investigators. In this case, two investigators collected the data and discussed the initial interpretations on a regular basis. In addition, the researcher met frequently with her supervision team during the analysis process to discuss emerging themes and the analysis process. The coding process, emerging themes, and researcher’s interpretation were also subjected to auditing by both the supervisory team and a group of independent researchers in order to examine the methods and final theme extraction.

Finally, Smith (2011) highlights that good IPA papers should be well focussed, offering an in-depth analysis of the specific topic, where the reader is engaged and finds it particularly enlightening (see table 5, p. 17). This overlaps with Yardley’s fourth principle of impact and interest. Further, the research should have influence on the thoughts and behaviours of others.
The current research meets this criteria by providing a focussed analysis of the experience of being a mother in the context of a preterm birth. The depth of the analysis provides a detailed examination of the experience for the young women in the study and questions the assumptions in the extant literature.

**Reflexive note regarding the current research.**

In line with these principles, and in the interests of transparency and acknowledgement of the researcher’s significant role in the research process, I offer these reflections on the project development, progress, and rigour.

Initially this research project was designed, in post-positivist psychological tradition, to be a test of a model, which could explain and predict adjustment in adolescent mothers of preterm/lbw infants, with some interview data to highlight core concepts and to highlight any gaps the model may have with this population. Here the qualitative data component was to play an illustrative role to the primary quantitative analysis. However, as the study began, I realised that this type of focus was based on assumptions that had not been explored and possibly detracted from what was truly important and needed; understanding the experience of preterm birth from the young mother’s perspective.

Personal and pragmatic considerations also shaped the focus of this research. First, I felt very strongly that cultural factors and context play an important role in adjustment during the transition to motherhood. This can be exemplified through different government policies between countries, states, and even local governments. These policies potentially influence adjustment via welfare payments, support service availability, and access to childcare to name but a few. A young mother in the USA, whom in some states must live at home to receive welfare payments or else must engage in vocational programs, will have different experiences to adolescent mothers living in Australia where a payment of approximately $5000 is paid to all mothers who give birth and parenting payments are available to all permanent residents. Similarly, mothers in Brisbane, where multiple support services exist, may have a different experience than mothers in the outer rural areas, where few or no services operate (Jones, Rowe,
& Sheeran, 2009, 2010). It would have been possible to conduct a study in which the conclusions state that locality is a risk factor for adjustment, thus providing a nomothetic explanation of why differences in adjustment exist. However, I felt that this research should be able to document the idiographic experiences of the mothers throughout the locales and to attempt to understand the complex interaction of factors that influence the adjustment of these mothers, at this time, through their eyes.

A second pragmatic consideration centred on the small number of mothers who experience a preterm birth. Early interviews with key stakeholders at various hospitals highlighted that despite statistics, which suggested that the number of mothers meeting study criteria could be as high as 120 within the study period, they were seeing very few mothers in the special care nurseries. This suggested that we were potentially dealing with a small number of young mothers, whose adjustment may have been hindered due to the assumption that they could be incorporated into the larger category of ‘adolescent mother’. This shifted the focus from wanting to explain and predict adjustment based on research that was not specific, or necessarily applicable, to these young women, to wanting to understand the experience of this small group of young women, thus allowing in-depth analysis of their stories to occur.

Finally, a purely positivist/post positivist or functionalist approach would provide only part of the individual’s story. I believed that in order to meet the aims of the current research, this research required a methodology which allowed the essence of the experience to come to the fore. This required a methodology with characteristics that

- allowed flexible investigation of the experience of the young woman as mother and allowed them to provide the information that was most pertinent to their experience
- ensured a high level of trustworthiness and rigour
- provided avenues for critical reflection on current practises and assumptions regarding this population
- generated new knowledge in relation to the process of adjustment for adolescent mothers
described in depth the experience and processes of a small homogenous group of young mothers to attempt to understand the experience from their perspective.

- expanded Australia’s current epistemological thought and knowledge regarding the use of qualitative methodologies

- provided information that could be utilised by hospital and service agencies to inform practice.

This combination of characteristics highlighted the need to use a methodology that was accessible, flexible, and applicable. IPA’s links to phenomenology, with its exploration and focus on the ‘lifeworld’ of the participant, allowed me to utilise a methodological approach which met the research aims and answered the research questions with the highest degree of trustworthiness and rigour.

To have taken a purely quantitative approach with this population would have meant that the researchers would assume that we understood the variables that were most important to the mothers, thus ascribing to and not critically reflecting on the current assumptions. The current methodology allowed the knowledge produced by individuals, as they perceived it, and as interpreted by researchers, to build our understanding of the phenomenon of being a mother.

The current research sought to understand the experiences the young mothers had as they transitioned home from hospital with their preterm infant, how they made sense of this experience and what meanings those experiences held, making the aims compatible with an IPA approach (Smith, 2004). At the heart of IPA is a clearly stated phenomenological emphasis on the experiential claims and concerns of the participant (Larkin et al., 2006). I had two aims as I approached my data. My first aim was to try to understand my participants’ world and to describe what that world was like. However, I also recognised that access to this ‘experience’ is both partial and complex (Smith, 1996). The account of this experience was constructed by both the participant and myself as a researcher (Larkin et al., 2006). Therefore, my aim was to produce a coherent, third person, psychologically informed description as close as possible to my participants’ views. My second aim was then to develop an interpretative analysis, which
positioned the description in relation to a wider social and cultural context. It is this second order account that enabled me to provide a critical and conceptual commentary to my participants’ sense making activities (Smith & Osborn, 2003)

My commitment to this type of analysis was also demonstrated by equally prioritising the broader themes that the participants shared and the specific experiences of the individual person. This enabled us to learn something about the important generic themes associated with the experience, but also enabled us to learn something of the world of the participants and how their experiences converged and diverged from each other (Smith, 2004).
Chapter 4: Method

This chapter describes the process of conducting the research. To begin, the chapter describes general information regarding the participants included in the research. This is followed by an overview of the design and materials used, including the interview schedules and support activities. The procedure utilised, including the ethical approval process, the generation of the interview schedule, and recruitment of participants are then discussed. Finally, an overview of the analytic process used is provided and researcher reflections on the method are offered.

Participants

A total of 15 young women were selected for inclusion in the current research from a sample (N=40) recruited for a larger research. Inclusion criteria are discussed below and Appendix A tables reasons for exclusion. Of the 15 young women, 10 had given birth to a preterm infant and 5 had given birth to a full-term infant. The size of these groups was selected to be in keeping with IPA’s commitment to idiography and recommendations for small sample sizes (Smith et al., 2009), while still allowing a breadth of experiences to be considered. Similarly, the larger group of mothers of preterm infants represented the core aims of the research; to explicate the experience of being a mother in the context of a preterm birth. In keeping with the idiographic approach of the research, and to aid with the reader’s assessment of transferability of the results, an in-depth introduction to each of the participants is provided in chapter 5. Table 2 in chapter 5 also provides basic information about each of the mothers.

Criteria for selection of the 15 young women in the current research included being a primiparous female aged 15-19 years old who had recently given birth to either a preterm (<37 weeks completed gestation) infant who was in the special care nursery (SCN) or a full-term infant (≥ 37 weeks). Women under the age of 15 years were not recruited due to the difficulties associated with obtaining informed consent at this age without seeking parental consent. To the researcher’s knowledge, no young mothers under the age of 15 were available for recruitment at any of the recruitment sites during the recruitment period. Participants with ongoing maternal
health issues or child alert notifications regarding cognitive or intellectual impairment were not included in the research. Participants were required to be English speaking and were required to have provided data at all 3 time points. The 15 young women selected for inclusion in the current research were the first 15 young women recruited as part of a larger research project who met all of the above criteria.

Participants were recruited from four hospital sites in South East Queensland. Further details of the recruitment procedures are provided below. The larger research project used a total sampling strategy whereby all young women who met the inclusion criteria during the recruitment periods were approached. Estimates of the recruitment rates for the larger research project are included in Appendix C. Although other researchers were involved in recruitment of the larger sample, all of the women in the current study were interviewed by the author.

Design

The current research employed a longitudinal design, to investigate time as a factor in the experience of being a mother both within and across individuals and groups. Data was collected at three time points:

Time 1: 1 week prior to the infant being discharged from the SCN (preterm/LBW group) or within a window of 2 days post birth to 1-week post discharge (full-term group).

Time 2: 3-4 months post discharge.

Time 3: 12 months post discharge.

Materials

Time 1 interview. The guided interview gathered information about the young women’s response to the birth, their experiences in hospital, the progress of the baby, their expectations associated with parenting and the baby’s discharge home, and any current or anticipated challenges. Specifically, interviewers were assessing thoughts, feelings, and behaviours associated with becoming a mother. Background information such as intendedness of the
pregnancy, family reactions, antenatal care, and impact on school, work, and life was also gathered.

**Time 2 interview.** The time 2 guided interview gathered information about the infant’s current development and progress, what the experience of parenting had been like over the previous 4 months, the continued impact on the mother’s life in terms of school, work, social life, and friendships, the most challenging aspects of parenting, and the most enjoyable aspects of parenting. Young women were also asked whether there was any advice they would tell another young mother that they had not been told or felt was important, and whether they felt there were additional challenges associated with being a young mother. Time 1 interviews had been read and questions related to their specific experiences were asked.

**Time 3 interview.** The time 3 guided interview gathered information about the infant’s current development and progress, what the experience of parenting had been like over the previous 12 months, and the continued impact on the young women’s lives in terms of school, work, social life, and friendships. Young women also reflected on the most challenging aspects of parenting, the most enjoyable aspects of parenting, as well as their perceptions of themselves as a parent (i.e., strengths, weaknesses). Young women were also asked whether there was any advice they would tell another young mother that they had not been told or felt was important and whether they felt there were additional challenges associated with being a young mother.

Wording of all questions was framed using terminology familiar to the participants’ own level of understanding. Similarly, the interviewer tended to match the participant’s guise during the interview, adopting similar use of slang, primarily in order to develop rapport. Open questions were identified as essential for encouraging participants’ dialogue on their experiences. Closed questions were also used to clarify or summarise what the participant said, to ensure a thorough understanding of the information. Closed questions were also used when participants were shy or had difficulty explaining their ideas.

Although an interview schedule was employed at each time point, the interviewer followed the participant’s lead and used prompts to gather information important to the
participant’s story. Interview questions were not necessarily asked in the order they appeared on the schedule and questions were asked in a non-directive way. The interview schedules for time 1, 2 and 3 are provided in appendix D.

**Construction of the interview protocol.** Several factors influenced the construction of the final protocols described above. First, consistent with an IPA approach, the questions were designed as a guide as opposed to a structured protocol. As such, the protocol was designed with open general questions followed by prompts that could assist the interviewer if required. However, the interviewer also followed the lead of the participant and explored topics that participants initiated.

A second influence on the interview protocol was the acquisition of funding from the Department of Communities for the larger research project. The funding body asked that several questions be included on the protocol on topics in which they had an interest. As such, while the researcher intended to discuss the formal and informal support systems available to the adolescent mother, more specific prompts relating to specific service usage were included and more depth was encouraged.

Another influence was the ethics committees who provided approval for the research. Due to the possibility of disclosure of a crime (i.e., sexual assault, incest, drug use, sexual intercourse under the legal age of consent etc.), participants were asked not to provide specific names, dates, or places for illegal activities and researchers did not explore in depth issues associated with these legal issues other than to assess risk. Participants were neither encouraged nor discouraged to discuss these topics but were warned not to provide specific information that could be subpoenaed.

**Demographics:** Participants were asked to provide details on their age, marital status, level of education attained, living situation, and number of children and were also asked to provide a range of contact details at each interview so that follow-up interviews could be conducted (see appendix E).
**Social support activity:** In order to assess the extent of the young women’s social support network and the perceived help provided by members of the network, young women were asked to list all those individuals, family, friends, neighbours, professionals with whom they had had contact during the past 3 months. Then they were asked to place dots that bore the names of those individuals on the rungs of a circle target that had the mother and baby located in the centre. Frequency of help (very frequently, frequently, occasionally, rarely, and never) was determined by the placement of the dots in relation to the mother and child. The more distant the placement, the less frequent the help. This procedure yields several measures of social contact and social support, including the total number of network members, the total number of network members who provided help frequently or very frequently, and the number of family members (including the baby’s father) who provided help frequently or very frequently and type of help provided by these supports. However, its main purpose was to facilitate the discussion on social supports to gain a deep understanding of the young mother’s perceived support network.

**Quantitative materials.** All participants completed a survey after the interview as part of data collection for the larger research project. Details of the specific measures used in the survey are provided in Appendix F.

**Procedure**

**Ethical Approval.** Ethical approval for this research was sought from all four hospital recruitment sites and from the Griffith University human research ethics committee (HREC). A number of ethical considerations for the research influenced the recruitment and data collection. First, the young women gave informed consent for their participation, parental consent was not required. Second, participants were given a minimum of 24 hours to consider participation in the research and to discuss participation either with a support person of their choice, an independent person on the ward who was familiar with the research but not a researcher, or directly with researchers, prior to consent being given. A minimum of two days post birth was allowed prior to data collection at time 1 in order to allow recovery from the birth and to minimise distress to the mothers. Participants who became distressed during the interview were provided with details of
two independent psychologists or were linked in with local support services. Participants were able to withdraw from the research at any time and withdraw consent for the data previously collected to be used. However, no participants chose to withdraw their data. In addition to research ethical considerations, several additional considerations arose due to legislation governing registration with a professional body (i.e., the registration of the researcher as a psychologist). Accordingly, all mothers who were identified as being at risk of harm to self or other (i.e., infants) via a risk assessment were linked in with support services and/or child protective services were notified.

**Recruitment process.** Two recruitment strategies were run concurrently, dependent on the hospital, in order to minimise the demands placed on Queensland Health staff and maximise recruitment for the research. At two hospitals nursing staff notified researchers of any young mothers on the ward who met inclusion criteria after nursing staff had given the potential participants a flyer (see appendix G) and received verbal consent for researchers to contact the participants directly. The researcher then followed up with the mother in person to see if she would like to participate and to organise an interview time close to discharge. The young women were also provided with participant information sheets and consent forms (see appendices H and I). At two other hospitals researchers worked with social workers and midwives to recruit mothers at their antenatal appointments or directly from the SCN or maternity wards. The researcher attended the specific session at the hospital for adolescent mothers and provided all young mothers with the recruitment flyer. Those indicating they may like to be involved in the research were provided with the participant information sheet to read over and the young mother signed an initial consent form. This consent form stated that the young mother consented to being contacted after birth to see if she was still interested in participating in the research and consented to having a form placed on her file which alerted staff to notify researchers when she had birthed. After the birth researchers followed up with the mother to see if she wished to participate, and to organise an interview time close to discharge. Participants were encouraged to discuss participation with a support person (friend, family member, or local youth worker) prior
to consenting to participate. In addition, an independent person was also available on the ward to discuss aspects of participation (the Nurse Unit Manager or Clinical Nurse Consultant).

Interview Procedure. The researcher conducted all interviews included in the current research. Mothers of preterm infants were interviewed approximately one week prior to the discharge of their infant from hospital, when the baby was stable, maintaining temperature, and feeding independently. Often the mother was ‘rooming in’, which involved the mother being readmitted to the hospital and mother and infant spending up to 3 days in a room adjacent to the SCN. Mothers of full-term infants were rarely interviewed in the hospital but more commonly at home within the week following discharge. Follow-up interviews occurred in the participant’s house or a neutral location of their choosing with most participants choosing their own houses. Participants were contacted primarily by telephone/text messaging, or on occasion by letter or email, to arrange follow-up interview times. As part of the ethical agreement of the research, participants were invited to have a support person present during the interview. Table 1 provides information on where interviews were conducted and whether a support person was present.

Data collection lasted from 45mins to 2 hours at each time point. Total data collection time for each participant over the course of the research was between 3 hours to 5.5 hours. In all cases, the young women first participated in the interview, then completed the social support exercise (s) and finally completed the survey.

Table 1:  
Data Collection Venue

<table>
<thead>
<tr>
<th>Name</th>
<th>Time 1</th>
<th>Time 2</th>
<th>Time 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronte</td>
<td>Home *</td>
<td>Home</td>
<td>Home</td>
</tr>
<tr>
<td>Emily</td>
<td>Hospital</td>
<td>Home</td>
<td>Home</td>
</tr>
<tr>
<td>Holly</td>
<td>Hospital</td>
<td>Home</td>
<td>Café #</td>
</tr>
<tr>
<td>Jade</td>
<td>Hospital</td>
<td>Home</td>
<td>Home</td>
</tr>
<tr>
<td>Juliana</td>
<td>Hospital</td>
<td>Home</td>
<td>Home #</td>
</tr>
<tr>
<td>Laura</td>
<td>Hospital</td>
<td>Home</td>
<td>Home *</td>
</tr>
<tr>
<td>Lily</td>
<td>Hospital</td>
<td>Home</td>
<td>Home</td>
</tr>
<tr>
<td>Lisa</td>
<td>Hospital *</td>
<td>Partners Home *</td>
<td>Partners Home #</td>
</tr>
<tr>
<td>Renee</td>
<td>Hospital</td>
<td>Home *</td>
<td>Home</td>
</tr>
<tr>
<td>Skye</td>
<td>Hospital</td>
<td>Home *</td>
<td>Home</td>
</tr>
<tr>
<td>Claire</td>
<td>Home *</td>
<td>Home</td>
<td>Home</td>
</tr>
<tr>
<td>Danielle</td>
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<td>Home #</td>
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<tr>
<td>Jenna</td>
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<tr>
<td>Tenielle</td>
<td>Hospital</td>
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<td>Home^</td>
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</tbody>
</table>
In all cases when a support person was present it was explained: a) that the research aims were to understand the mother’s experiences of parenting; b) that the interviews were being recorded; and c) permission and comfort regarding the other person’s presence was ascertained from the participant. For analysis purposes all comments provided by additional people were removed from the transcriptions prior to initial coding.

**Reflections on interviews**

The presence of a third person may have unduly influenced four interviews by possibly restricting the content the young women spoke about. The interviews identified by the researcher where this may have occurred were Renee’s time 2 interview and each of Lisa’s interviews. At the time, unknown to the researcher, Renee was involved in a domestically violent relationship with her partner. This may have led to reduced openness regarding the challenges related to co-parenting and an overly positive presentation of her relationship with her partner, as well as a lack of ability to self-disclose that the abuse that was occurring. However, Renee was able to openly discuss aspects of this during her final interview when she had left her partner. Similarly, Lisa’s partner or partner’s mother was present for periods of all three interviews at her request. This may have reduced Lisa’s openness about the challenges she was facing, possibly feeling that she could not openly discuss negative aspects of her relationship with her partner. Generally, Lisa provided short answers to questions and did not speak in depth about difficulties and challenges. She also tended to follow negative statements with a ‘but’ or justification. However, during analysis some of the challenges within both Renee’s and Lisa’s relationships did emerge across interviews and via more indirect comments (i.e., Lisa discussed struggling to parent on her own). For Lisa, the presence of her partner at two interviews and not at the third also provided behavioural evidence of her co-parenting relationship with the FOB and how this changed over time.
The interviews were often fast paced with the young women jumping around multiple topics within short time frames. Accordingly, as an interviewer I tended to summarise participants’ responses, to use minimal encourages to promote continued talking, and to draw them back to topics they may have previously discussed in order to clarify some of the points made. The use of summarising and paraphrasing enabled the participants to clarify or expand on what they had been discussing and demonstrated interviewer understanding. This helped build and develop rapport and demonstrated empathy for what were often very difficult experiences. However, it may have refocussed the direction of their interviews rather than remaining with the topics important to the young women. I also actively tried to take a non-judgmental stance to information that was provided, regardless of my personal feelings. This stance was taken to convey that no topics were ‘off the table’ in terms of sharing their experiences and to promote open disclosure of any difficulties they were having. However, on occasion I found that I would offer encouragement and support in order to sympathise with their experiences. This may have influenced the participant’s responses.

Analysis

Every interview was taped using a digital voice recorder. Interviews ran from 45 minutes to 1.5 hours in length. All interviews were transcribed verbatim either by myself or by a transcription company. The researcher undertook the following process in relation to analysis of the data.

1) All time 1 digital recordings were listened to whilst reading the transcript to ensure accuracy of the transcriptions and to become reacquainted with the emotional tone of the interviews.

2) Each time 1 transcript was read in its entirety at least once and usually several times, making note, line by line of any descriptive comments about the content of the interview. This included underlining of key ideas or phrases, noting of questions that arose for the researcher whilst reading the interview and any initial thoughts about what the central tenets of the story might be. The interviews were not analyzed in any particular order.
3) After the basic descriptive coding was completed, notations and transcripts were re-read and emergent themes were generated and noted in the right hand column of the transcript.

4) Once the emergent themes had been generated word processing software was used to type the emergent theme names and cut and paste segments of the transcript that represented that theme. This allowed connections across themes to be identified and synthesized.

5) On regular occasions, and at times when there was intrusion from outside sources onto the current analysis (e.g., theory that was being read as part of role as lecturer, previous mothers’ themes, pre-existing knowledge of what happened in future interviews or prior results of content analyses with same interviews), copies of the emergent themes were provided to the research team in order to provide feedback on whether the themes were remaining true to the participant’s intended meaning.

6) All interviews from time 1 were completed to this level of analysis before moving on to the next interview and before searching for and integrating emergent themes across participants. Interconnections between the emergent themes were then mapped.

7) These patterns across the interviews were then written up into a coherent narrative outlining core themes backed up by example quotes. However, the narrative remained much more descriptive than interpretative, with repeated checking that the participants’ voices were being represented accurately.

8) This process was then repeated for time 2 and then time 3 data.

9) Core themes were developed, synthesizing the material across time for each participant, visually representing this and writing a coherent story for each participant incorporating quotes from across the interviews. This stage also represented more of a shift away from pure description with the analysis becoming more interpretative. Engaging in such a process made it impossible not to become completely immersed in the data for an extended period.
10) Recurrent core themes across mothers and across time emerged during this process. These recurrent themes then formed the organizing core themes for the finalized synthesis across time and mother.

11) Cross checking was carried out to explore how earlier analyses across time and within participants were represented by the central organizing themes and to ensure that a Gestalt had been reached.

12) Analysis also continued into the write up of the results and discussions sections as integration and interpretation exposed new aspects of the data and identified aspects of the experience that were not adequately represented.

**Reflections and notes on the analysis process.** After generating emergent themes for each of the mothers, I looked back at the coding of interviews for the first three mothers. It was clear that there were differences between the types of codes I was using in the first interviews compared to the later interviews. My initial thought was that I had simply become more accomplished at analysis as my skills developed over time, and that perhaps the differences represented my changing comfort with engaging with the data. However, it was also possible that I had started to converge my thinking about the interviews and that I was not bracketing the previous participants’ experiences from the next. Examination of the early and later analyses by my research team and myself highlighted that early analyses were more abstract and less grounded in the participant’s words than later interviews. Given that this is an important first stage in IPA analysis, this supported the position that I had become more skilled in my analysis over time. As such, I chose to reanalyse the first two interviews. Comparison of the first and second analyses highlighted that the meaning associated with the experience had not changed but that the emergent theme names were more in keeping with the participant’s words than the researcher’s. Therefore, the second analyses were retained for inclusion in the integration process.

Also of note during the time one analysis was that initially the integration stage involved all of the mothers regardless of whether they were full-term or preterm. However, this proved
difficult due to the number of mothers and the emerging differences in their accounts. As such, analyses from all preterm mothers were initially integrated and synthesised and those of full-term mothers were integrated separately. The time 2 data was again synthesized and integrated separately for the mothers of preterm versus full-term infants. However, it became clear that there were no differences in the core themes at this time. As such, the synthesis and write up included all mothers and time 3 analysis did not attempt to separate the groups during analysis.

One other consideration during the analysis was the researcher’s focus on social support as a variable of interest to the funding body and the impact that this may have had on quantity and prioritizing of this data over others. In order to manage this, I attempted to separate out spontaneous mentions of others in the young women’s experiences as opposed to the interview instigated mentions of support. In nearly all cases, the young women mentioned their key support people early on in the interview and the activity later in the interview process explicated the frequency and type of support provided. The social support activity described above was completed towards the end of the interview. During analysis caution was made not to over interpret the importance of support whilst still acknowledging the key role that some people played. This information is provided as demographic information in the following section to provide contextual information for the young women rather than being a core theme.

In a similar way, questions on the interview protocol relating to the every-day experience of being a mother, such as the challenges and enjoyable experiences of being a mother, may explain why this emerged as a theme in the analysis. However, what is of interest for the current project is the properties of the theme and the inter-relationship between this theme and other core themes that emerged during the analysis process. This is not accounted for by the questions asked and, as such, this theme was retained.

Finally, given that the interviews were conducted over time, at structured and interviewer determined intervals, the analysis had to contend with the issue of time as a forced variable. Early analysis focused on differences in analysis over time, i.e., how the experience changed for the women over time. However, this focus on change and differences over time may have been a
result of the imposed data collection periods and not a reflection of the experience per se.

Therefore, it was important to attempt to integrate the narratives of the women without time of interview as a consideration, in order to establish whether this factor emerged in and of itself as important to the experience of being a mother.
Chapter 5: Meet the mothers

A contextual and demographic profile

Chapters 5 and 6 present the findings of the current research project. Chapter 6 provides the core themes generated via the IPA analysis while Chapter 5 provides an overview of each of the young women who participated in the research and provides important contextual and demographic information. The current chapter tells the stories of the 15 young mothers who were selected from the total sample initially recruited into the larger research project (n=40). Each of these 15 young mothers shared their stories and their lives with me for over 12 months and it with much gratitude and humility that I introduce each of these young women to you, the reader. In order to protect their identities, pseudonyms have been used for all involved.

**Bronte.** Bronte was 18 years old when I first met her and her son Archie. They had been discharged from the special care nursery suddenly the day before I interviewed them. Archie had been born early at around 35 weeks and weighing less than 2000 grams. He was discharged from the SCN after 3 weeks and primarily had problems with sucking and feeding. Bronte and her fiancé Joe had been together for 3 years and lived alone in a rented house. Joe was undertaking an apprenticeship and Bronte was on maternity leave from her part-time job at a bakery. Bronte and Joe had miscarried a son previously and Archie was a planned pregnancy. He was considered a miracle baby as Bronte had health concerns. Bronte and Joe were planning to get married but had delayed the wedding due to the pregnancy.

Both Bronte and Joe’s families were supportive of their relationship and this pregnancy, with Bronte’s single mother providing vital support to her daughter.

“I need mothering. I think that's the most important thing, someone who's being a mother needs their mother just as much so. You need that mothering yourself I think, in the end… the first night she came over and she saw bub, like me as just hysterical, she just took the baby and she put, ran a bath for me, just chucked me in, she said go and have a bath.” (Bronte time 2)
Joe’s mother also became increasingly supportive over time, despite initial conflict between her and Bronte, providing time out for the couple while they took time out to be young.

“Actually, she [paternal grandmother] does it quite regularly. I think every second week she takes him, so that helps us out a bit [laughs]. Let’s us be teenagers. Well, we’re almost 20 years now, but it lets us be us, young, ‘cause you don’t always get that with him”. (Bronte time 3)

Over time, Bronte returned to work at the bakery part time. Archie continued to have a number of ongoing health issues. Joe and Bronte had scheduled their wedding for the end of the year and were investigating options for future pregnancies that would be safe for mother and infant.

Claire. I first met Claire 2 days after she and her full-term son Austen were discharged from hospital. At the time, Claire was 18 years old. Claire and her fiancé James had been together for 3 years and were paying off the mortgage on their own home. Claire had completed grade 12 and had started a university degree but had left to pursue full-time work. She was currently on maternity leave from her office job in a finance company. Austen had been a planned pregnancy, following a miscarriage the previous year, and the couple planned to have three more children over the next 4 years. Claire and James both came from very close families with several siblings each, whom they saw most days of the week. Both Claire’s mother and Claire’s sister had been adolescent parents. This provided a close family network with some same aged infants, which met most of the couple’s social and support needs.

“if I need them [grandparents] to look after Austen to go to doctors or anything, just going out for a few minutes she will come and pop over and look after him. Anything at all, she will just do whatever is needed I guess in anyway” (Claire time 2)

Over the course of the research project, Claire returned to a work in a new position as a part time receptionist. At the end of the first 12 months, Claire reported that she and James had been trying for their second pregnancy and she thought she might be pregnant.
Danielle. Danielle was 17 years old when I first met her and her full-term son, Thomas. Both mother and son had been discharged from the hospital two days earlier and were settling into the rented house where the two of them lived. Thomas’s father, Steve, was still very involved in fathering despite he and Danielle agreeing that a relationship was not to be. Danielle lived in a small country town near a regional centre and had been working in hospitality prior to the pregnancy after completing grade 10. She had lived locally with her mother until mid way through the pregnancy when she set herself up in her house. Danielle also had her own car, which enabled her to access services in the regional centre as needed. Danielle reported very good relationships with Steve’s mother as well as her own mother, with both grandmothers’ providing support.

“We always go and see his Nanny. When we’re not at home, we’re always at his Nanny’s… she always offers to look after him, we’re always there, she takes, like I’ll stay there for a while and she’ll look after him. I can do my own thing...” (Danielle time 2)

Danielle was also close with her older sister who had two small children and who was able to provide current information about parenting. Danielle reported a large network of older friends in couples with children.

Shortly after Thomas was born, Steve and Danielle resumed their relationship and by Thomas’s 1st birthday, were talking about having a second child. Steve worked full-time and had moved into Danielle’s house. Danielle had considered returning to her previous employer, but had decided against it at the current time as her predominant focus was on being a homemaker.

Emily. Emily was 15 when I first met her and her daughter Lakeisha. Lakeisha had been born at 28 weeks weighing less than 1200 grams. Lakeisha had initially been transferred to a Metropolitan tertiary facility with a neonatal intensive care unit for 2 weeks. She was then back-transferred to a regional special care nursery for a further 9 weeks. At the time of first interview, Lakeisha was due for discharge within a few days. Emily was at risk of being homeless at this time as her mother had been evicted from the rental property in which lived. Emily was also
being completely supported financially by her mother, who was on unemployment benefits, as Emily had not yet received her own parenting payments. Her mother had allotted her $50 per week to buy formula and nappies.

Emily reported that prior to the pregnancy she was using drugs, primarily marijuana, and alcohol. She had disengaged from school completing half of year 8 and half of year 9. She had not held a job but was keen to find work.

Emily and Lakeisha’s father, Nathan, were no longer in a relationship and he had not had contact with the baby. Emily reported that he was physically abusive towards her throughout their relationship, was unemployed, and had both mental health and substance abuse issues. Emily’s mother was also in a domestically violent relationship and abused substances.

“…mum’s, if it’s a good day and look oh gosh, she goes off over the most littlest things and I’ve been telling mum that I’m not – I don’t want my baby around with that environment if you’re going off every day, like it’s a bit difficult. I don’t want Lakeisha to see the things that like smashing things around the house and stuff like that, yeah, yelling for no absolute reason, talking to herself. My mum’s going crazy I reckon”

(Emily time 1)

Emily was unable to rely on her mother to provide time out, support, or guidance. Instead, caretaking of her two younger siblings often fell to Emily. Emily reported few stable peer relationships but did have an older sister. Stable housing and financial stress were ongoing issues for Emily and Lakeisha with several moves between friends’ houses occurring over the first few months. Emily met a new partner, Chris, and found stable accommodation when Lakeisha was approximately 6 months old. This afforded them some stability and better financial security. Emily and Chris had discussed marriage but Emily preferred to wait until she was 18 to be engaged.

**Holly.** I first met 17-year-old Holly and her daughter Jayelyn when they were rooming in just prior to being discharged from hospital. Jayelyn had been born at 31 weeks weighing less than 1000 grams. Holly had been transferred to a Metropolitan tertiary facility where she gave
birth. Jayelyn remained in the neonatal intensive care unit at this hospital for 2 weeks before being back-transferred to a regional special care nursery for a further 4 weeks.

Holly lived with Jayelyn’s father, Lee, in a small country town outside a regional centre in Queensland. Holly had recently lost her licence and transport was a significant issue. Lee’s parents lived in the unit next to Holly but she reported that they had serious issues with alcohol abuse and mental health problems.

“…her [paternal] half of grandparents they don’t show no interest like they make out that they care and that but they don’t… They just sit there and drink wine all the time… she acts all dopey but um she um she used to be a heroin addict…I told them that they can’t be around Jayelyn because I would hate her to be around that kind of stuff.” (Holly time 1)

Holly’s mother and older sister were Holly’s main sources of support outside the relationship with her partner. Holly had been removed from her mother’s care by child safety in middle childhood due to her mother’s problems with drugs. She had lived with her father as well as in foster. Holly’s older sister had two children who had been removed from her care by child safety. Prior to the pregnancy, Holly had completed grade 10, was unemployed, and reported issues with binge drinking. Jayelyn was an unplanned pregnancy following a casual liaison with Lee.

Over time, Lee and Holly separated several times due to domestic violence and 12-months on Lee was in jail. Holly was still visiting him and planned to resume their relationship upon his release. Holly had acquired a rental property for her and Jayelyn after leaving Lee. However, they were evicted and Holly and Jayelyn were living between her sister’s house and Lee’s unit where her mother now lived. Despite her fears, Holly had not had contact with child safety about Jayelyn.

Jade. Jade was 17 years old when I first met her and her son James. James was born at 30 weeks weighing less than 1800 grams and primarily had problems with feeding and sucking. He was discharged after 4 weeks in the special care nursery. Jade did not find out she was pregnant
until she was 25 weeks pregnant, giving her only 5 weeks of preparation time before James was born. She was completing grade 12 at the time and managed to complete her studies shortly after James was discharged from hospital. Jade and her partner, Michael, lived with her mother, father, and extended family (siblings and aunty) in a rental property. Jade and Michael had been in a relationship for just under 12 months and he had gradually moved in to her house over the course of the relationship. Michael had recently gained full time employment. Jade had close relationships with her family as well as Michaels. She also had good peer networks and some same aged friends with babies. In addition, Jade was one of the few mothers to access a young mothers group prior to giving birth and she maintained contact over the first 12 months, giving her access to other young mothers, midwives, and social workers. However, Jade reported a lack of positive reassurance that she was doing well as a parent.

“Just like now and then, sometimes I want to hear, “You’re doing a good job,” but instead it’s not like that, sometimes, “You’re lazy,” or something like that. (Jade time 3)

Over the course of the research project, Jade and Michael moved into their own unit close to her parent’s house. Jade had engaged in several casual jobs over James’ first 12 months. At 12 months, Jade had also enrolled in a business course.

Jenna. I first met Jenna when she was 18 years old. She had just been discharged from hospital after giving birth to her baby Melissa. Melissa weighed over 3500 grams and was born at 40 weeks. Jenna had been completing an apprenticeship after leaving school at the end of grade 10 and was currently on maternity leave. Jenna and Melissa lived with Melissa’s father, Drew, in a rental property with Drew’s brother. Drew was also completing an apprenticeship. Drew and Jenna had been flatmates and friends for several years prior to Jenna falling pregnant and had developed their romantic relationship when Jenna became pregnant. However, the couple struggled to negotiate parenting roles and had little time to devote to their relationship.

“we’ve been fighting a lot just in the recent months, ‘cause …he’ll just leave her in the cot and just let her [whinge], and I’m just like “You can’t do that.”… And he doesn’t understand, when she’s asleep, don’t wake her… I got a call on the first night I went back
[to work] from Drew…so I rushed home and you know, she was just whinging for a feed and I was just like, you know there’s milk in the fridge. All you had to do was heat it up and give it to her.” (Jenna time 2)

Jenna had a very close relationship with her mother and two sisters who lived close by. Jenna would spend most of the morning at her mother’s house after dropping Drew at work. Jenna reported few peer relationships and limited contact with Drew’s family.

Over time, Jenna returned to work but did not resume her apprenticeship. At 12 months, she had applied to university to undertake a nursing degree.

**Juliana.** Juliana was 17 years old when I first met her and her daughter Kate. Kate had been born at 33 weeks weighing less than 1900 grams and primarily had problems with feeding and sucking. She was discharged from the special care nursery after 2 weeks. Juliana lived with Kate’s father Sam in a home that he owned. They had been together for approximately 12 months when Kate was born. Juliana had been working as a beautician after completing grade 10 and her beautician course. She finished working and moved in with Sam during her pregnancy. Sam worked as a tradesman. Juliana reported a close relationship with Sam’s mother who lived locally as well as good relationships with her father and stepmother who lived on the other side of the city. Distance meant that support from Juliana’s family was often less hands on. Juliana reported some close peer relationships though travel and contact were difficult.

“I’ve still got heaps of people who help me out – but they help me out with like little things and stuff…” (Juliana time 2)

Over the course of the research project, Sam and Kate sold their house and moved in with her father and stepmother and their two younger children while searching for another house to buy. Sam was also made redundant and was still looking for work at 12 months. There were no immediate plans for work, study, or other children.

**Laura.** Laura turned 18 years old while her daughter Morgan was in hospital. Morgan was born at 26 weeks weighing less than 800 grams. She was discharged 12 weeks later. Morgan had a number of health concerns early in life including a collapsed lung, a hole in her heart,
under developed lungs requiring constant oxygen flow (CPAP), blood transfusions to replace red and white blood cells, and trouble feeding and sucking. She was in the neonatal intensive care unit for several weeks before moving into the special care unit. Within the special care unit, she spent several weeks progressing closer to discharge before relapsing and requiring more intensive medical intervention.

Laura lived with her partner Mark, Morgan’s father, in his parent’s house. Morgan was an unplanned pregnancy following a casual liaison with Mark. Laura reported that initially she was shunned by Mark and his family resulting in a complete breakdown in their relationship. This was resolved mid way through the pregnancy and Laura now reported close relationships with Mark’s parents. Mark was employed full-time.

“Oh, they’ve given me a place to live, they help me get places, they support me when I’m feeling down. They sit down and give me cuddles. They just are very supportive… Um, my family don’t really have anything to do with me or my baby.” (Laura time 1)

Prior to the pregnancy, Laura reported living a ‘wild’ lifestyle with frequent drug and alcohol use, homelessness, disengagement from school, and a previous pregnancy termination. She had a poor relationship with her mother and a history of intervention by the department of child safety as her mother had mental health issues and her father had substance abuse issues.

Over 12-months, Mark quit his job to become a stay at home dad and Laura returned to work. Mark and Laura moved into their own rental house. However, this was a considerable distance from his family due to rental prices and Mark had lost his licence making it difficult to access family support. Laura and Mark had considerable support from an early intervention program designed to help families at risk of child safety issues. Morgan did not appear to have ongoing health issues, though the couple were watchful for developmental delays and disorders.

Lily. I met 19-year-old Lily and her daughter Grace whilst they were rooming in just prior to discharge from the hospital. Grace was born at 35 weeks weighing less than 2000 grams. She was discharged at 38 weeks after resolving her difficulties with feeding and sucking. Lily was living with her partner and Grace’s father, Ben, in her father’s rented house. Lily’s mother
had passed away 3 years earlier and Lily’s older sister with six children lived several hours away. Laura reported good relationships with Ben’s family and her own father. Lily and Ben had a large network of friends who they saw regularly and who provided regular babysitting support. Ben’s parents also provided considerable support to the family.

“Oh, they [Ben’s parents] still buy everything for Grace. Not everything, but they’ll come over every couple of days with something new they’ve bought just because she’s their granddaughter. They come over with new clothes and new stuff all the time for her” (Lily time 2)

Prior to the pregnancy, Laura had been working in hospitality after leaving school in grade 12. Shortly after Grace was discharged from hospital, Lily and Ben moved into Ben’s parent’s house in order to access more family support. By 12 months, Ben and Lily were settled in their own rental house. Ben was working in his trade, after a period of unemployment and Lily had not returned to work.

**Lisa.** I first met Lisa when she was 15 years old and still pregnant. Lisa and her partner Luke had their son Lachlan at 31 weeks and he weighed less than 1800 grams. He was discharged from the special care nursery after 4 weeks. Lisa and Luke had been in a relationship for over 12 months prior to becoming pregnant. Both Lisa and Luke lived with their respective mothers and stepfathers. Lisa’s mother also had two small children. Conflict between Luke and Lisa’s stepfather meant that Luke was not able to spend much time with Lisa at her house. However, the couple had set up nurseries at both houses to allow flexibility in the childcare arrangements. Lisa’s mother was also a main source of support.

“She’d [Lisa’s mum] take him over to play with the kids for a couple of hours or something or even overnight if we really needed a break or something… most of the times she would ring and say, “What’s Lauchy doing? Do you want to come over” and stuff.” (Lisa time 2)
At the time of first interview, Lisa was enrolled in grade 11 and Luke was unemployed. This varied over the course of the research project with Lisa initially engaging in school but disengaging after several months due to difficulties juggling school and parenting demands.

Over the course of the project, Lisa moved out of her family home and into a rented property with a friend. While this arrangement gave Lisa and Lachlan more space, it also reduced the amount of support Lisa received from her mother. By 12 months, Luke was working full-time and he and Lisa had decided to move in together so that Luke would get to spend more time with Lachlan and Lisa would have more support. They had just secured a house the time of last interview. Transport was still an issue as neither parent had a licence or a car.

**Renee.** Renee was 17 years old when I first met her and her son, Kane. Kane was born 4 ½ weeks early weighing over 3300 grams. Renee had been in the city visiting her father from a regional centre several hours away when she went into labour. This meant that she and her partner, Nigel who was not Kane’s father, had to stay in the city for two weeks while Kane was in hospital. Renee was able to secure temporary accommodation close to the hospital via a charity organisation. Kane was back transferred to the special care nursery at a regional hospital in the town where the couple lived for a further 4 weeks. Initially Kane had problems sucking and feeding and he contracted a respiratory virus in hospital delaying his discharge.

Renee and Nigel lived together in a rented house. Nigel was initially working full time; however, he lost his job around the time of Kane’s birth. Renee reported that she was close to her mother who lived nearby and that she had much extended family and friends where she lived. Prior to the pregnancy, Renee had been working in an administration position and had lived in Central Queensland. Kane’s father still lived there and had not had any contact with his son. Early in her pregnancy, Renee had moved to be near her mother and family and had met Nigel.

Shortly after Kane was discharged from hospital, Renee and Nigel moved to live with Renee’s father. Over time, Renee and Nigel ended their relationship and Renee returned to Central Queensland. Renee disclosed that Nigel had been domestically violent and very controlling. Renee began a new relationship with a man in Central Queensland. At 12 months,
Renee and Kane were living alone in a rented house but were moving into a home that Renee’s new partner, Liam had purchased. Renee and Liam were planning on becoming engaged in the near future. Neither Renee nor Kane had any contact with Kane’s biological father.

**Skye.** Skye was 19 years old when I met her and her son Zach. Zach was born at 34 weeks weighing less than 2500 grams. Skye was rooming in just prior to discharge when I first interviewed them. Skye and her partner David, Zach’s father, had been in a relationship for 4 years when Zach was born. They had also had a previous child who was stillborn 2 years earlier. This experience heavily influenced Skye’s attitude to parenting and she was primarily just happy to have her baby alive and well.

Skye and David were living with Skye’s mother and stepfather in a house with 13 people living in it. This was primarily due to financial concerns, as David had recently lost his job, but also for support.

Skye had finished school after grade 10 and had infrequent causal employment in hospitality prior to her pregnancy. Skye’s mother and stepfather were reported to be supportive. Skye also had siblings and particularly a younger sister whom she was close to and who was pregnant. Skye reported good social networks but few friends with children.

Over the course of the research, Skye and David moved several times. Skye was unable to live with either parent due to the chaotic environments and so was forced to rent privately, resulting in increased financial stress.

“We had a bit of a falling out with Dad, it wasn’t a very nice environment to… The first place we lived in was just; I couldn’t have raised him like that. It is as simple as that, I couldn’t… The abuse, the arguments that were constantly going on there, the drugs, the alcohol abuse; I didn’t want him to be brought up in the stress of a house like that” (Skye time 1)

Financial concerns were always forefront for Skye, with David remaining out of work for several months. By 12-months, Skye and David had ended their relationship but were still cohabiting. David was working full-time and this relieved much of the financial concern for Skye.
Tenielle. I first met Tenielle when she was 18 years old after having given birth to her full-term infant, Bailey. Bailey weighed over 3600 grams at birth, was 2 days old, and still in hospital when I first interviewed his mother. Tenielle was living in a boarding house in a rural town between two larger regional centres. Tenielle’s father and his girlfriend also lived in the boarding house.

Tenielle had moved interstate 2 years earlier to meet her father for the first time. Tenielle’s mother had flown in for the birth but still resided interstate. Tenielle had left school in grade 9 and had primarily been unemployed since that time.

Tenielle was unsure of paternity of her son. She was seeking DNA testing from John, the person she believed was Bailey’s father, but who had denied paternity. This changed shortly after birth and for several months, Tenielle was in a relationship with John. Tenielle had several close friends with children who provided support. Tenielle discussed an unstable history since age 14 when she engaged in illicit drug use, ran away from home. Her father was both physically abusive towards his girlfriend and Tenielle on occasion, and was unwell, spending much of his day in bed.

“[Dad] Just flogged the shit out of her…But he’s hit her before. They’ve been on and off for 5 years and he’s flogged her a couple of times…when I was living at Dad’s house and then had a big blue with my Dad, Dad had me pinned on the bed and was just in my face, “I’ll kill you.” (Tenielle time 2)

Despite this, he was Tenielle’s major source of support, which left her parenting mostly alone, unsupported.

“at the moment it’s just me. Me, me, me and me.” (Tenielle time 2)

After having Bailey, Tenielle experienced multiple interpersonal crises including a breakdown in the relationship with John, unstable housing after she moved from her father’s house to John’s and finally to a friend’s house, and a recurrence of her depression. Despite being treated pharmacologically for depression through her GP, Tenielle had trouble coping with single parenting. She eventually presented to the hospital stating that if they could not help her she
would kill her baby. This prompted treatment and a move interstate to her mother’s house for more support. During this time Tenielle’s father also passed away.

Over time, Tenielle discovered that John was not Bailey’s father and she was pursuing DNA testing of other possible fathers. Tenielle had established herself in a rental property, was in a new relationship, and was seeking casual employment. She had also become a member of a young parents’ support group.

**Becky.** I first met Becky when she was 18 years old having just given birth to her full-term daughter, Abbey. Mother and daughter had been home from the hospital for 2 days when I first interviewed them. Becky was living with her partner of 6 months, who was not the father of the baby, in his parent’s house. Becky had finished grade 12 the previous year and had been working as a childcare assistant prior to becoming pregnant. Becky did not have any contact with the father of her baby and though he knew of the pregnancy, she reported that he would never have contact with her daughter. Becky also described the circumstances of her becoming pregnant as resulting from non-consensual sex at a party under the influence of alcohol. Becky had not pressed assault charges for this or other instances of non-consensual sex acts against her. She had little contact with her adoptive parents and reported that they disapproved of her current relationship. Becky had a large number of siblings but did not report close relationships with any of them. Becky also noted a loss in friends after leaving school and cessation in partying after falling pregnant. Despite this, she did report two close friends who provided support to her and Abbey. Becky also reported a history of depression but was not currently medicated or under the care of her psychiatrist. By my interview at time 2, Becky had relapsed into depression and had begun treatment under the care of her psychiatrist.

Becky represents a particularly unique story even amongst the range of stories from my mothers as 6 months after giving birth, and after my second interview with her, Becky was in a near fatal car accident. She was hospitalised for many months and at our scheduled catch up 12 months after giving birth, Abbey was still in the care of her grandmother (Becky’s adopted mother) while Becky completed her surgeries. Despite this, Becky’s hope, optimism, and love
for her daughter shone through and I recently received a letter from Becky informing me that she was well again, was loving parenting Abbey full-time, was engaged to be married to her new partner, and that she was pregnant with her second child.

Whilst it was my intention to retain Becky’s ‘voice’ for the analysis, it became clear during early analysis that her story was significantly different to the other mothers in the sample and that she did not represent homogeneity in terms of experiences. Initially I felt that Becky’s story would provide a contrast point to themes, and that her difficulties could be conceptualised as ‘just another challenge’. However, this was not the case and factors such as the non-consensual nature of the conception and dominance of depression colouring her experiences of parenting, and the loss of custody of her daughter meant that she did not meet criteria for inclusion. It was with great regret that I had to preclude Becky’s story from my analysis.

The experiences of these young mothers form the basis of my analysis and this thesis. In many ways, they represent a homogenous sample of young mothers who were all aged between 15 and 19 when they gave birth and became mothers. Further, they represent two proposed groups of young mothers; those who had had preterm infants and those who had had full-term infants. This basic overview of these young women’s lives highlights just how inaccurate stereotypes of young mothers can be given the heterogeneity of life experiences. This diversity of experience will be explored in Chapter 6 to further help us understand just what it means to be a young mother. Table 2 provides a quick guide to the basic demographic information for each of the participants in order to promote familiarity and aid readability of the results.
Table 2.

Quick guide to participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Baby’s name</th>
<th>Birth status</th>
<th>Partners name</th>
<th>Living arrangement at time of birth</th>
<th>Length of time in hospital</th>
<th>Length of relationship</th>
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<tbody>
<tr>
<td>Bronte</td>
<td>18</td>
<td>Archie</td>
<td>Preterm</td>
<td>Joe</td>
<td>Renting with fiancé</td>
<td>3 weeks SCN</td>
<td>4 years</td>
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<tr>
<td>Claire</td>
<td>18</td>
<td>Austen</td>
<td>Full-term</td>
<td>James</td>
<td>Mortgage on fiancé’s house</td>
<td>3 days SCN</td>
<td>3 years</td>
</tr>
<tr>
<td>Danielle</td>
<td>17</td>
<td>Thomas</td>
<td>Full-term</td>
<td>Steve</td>
<td>Renting own house</td>
<td>2 days SCN</td>
<td>Recently ended</td>
</tr>
<tr>
<td>Emily</td>
<td>15</td>
<td>Lakeisha</td>
<td>Preterm</td>
<td>N/A</td>
<td>At risk of homelessness</td>
<td>11 weeks NICU and SCN</td>
<td>N/A</td>
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<tr>
<td>Holly</td>
<td>17</td>
<td>Jayelyn</td>
<td>Preterm</td>
<td>Lee</td>
<td>Rental unit with FOB</td>
<td>6 weeks NICU and SCN</td>
<td>9 months</td>
</tr>
<tr>
<td>Jade</td>
<td>17</td>
<td>James</td>
<td>Preterm</td>
<td>Michael</td>
<td>Maternal grandparents, siblings and FOB</td>
<td>4 weeks SCN</td>
<td>12 months</td>
</tr>
<tr>
<td>Jenna</td>
<td>18</td>
<td>Melissa</td>
<td>Full-term</td>
<td>Drew</td>
<td>Rental with FOB and brother</td>
<td>3 days SCN</td>
<td>10 months</td>
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<tr>
<td>Juliana</td>
<td>17</td>
<td>Kate</td>
<td>Preterm</td>
<td>Sam</td>
<td>Mortgage on FOB’s house</td>
<td>2 weeks SCN</td>
<td>12 months</td>
</tr>
<tr>
<td>Laura</td>
<td>18</td>
<td>Morgan</td>
<td>Preterm</td>
<td>Mark</td>
<td>Paternal Grandparents</td>
<td>12 weeks NICU and SCN</td>
<td>&lt;12 months</td>
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<tr>
<td>Lily</td>
<td>19</td>
<td>Grace</td>
<td>Preterm</td>
<td>Ben</td>
<td>Paternal Grandparents</td>
<td>3 weeks SCN</td>
<td>2 years</td>
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<td>Lisa</td>
<td>15</td>
<td>Lachlan</td>
<td>Preterm</td>
<td>Luke</td>
<td>Respective parents’ houses</td>
<td>4 weeks SCN</td>
<td>&gt;12 months</td>
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<td>Renee</td>
<td>17</td>
<td>Kane</td>
<td>Preterm</td>
<td>Nigel (not FOB)</td>
<td>Rental with partner</td>
<td>6 weeks SCN</td>
<td>7 months</td>
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<td>19</td>
<td>Zach</td>
<td>Preterm</td>
<td>David</td>
<td>Rental share house</td>
<td>3 weeks SCN</td>
<td>4 years</td>
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<td>Tenielle</td>
<td>18</td>
<td>Bailey</td>
<td>Full-term</td>
<td>N/A</td>
<td>Room in boarding house</td>
<td>3 days SCN</td>
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Chapter 6: Results

The purpose of the current chapter is to understand how young women experience the transition to motherhood in the context of a preterm birth. Building on the contextual and demographic information presented in the previous chapter, the current chapter presents the IPA analysis of the young women’s stories. Despite the researcher’s focus and interest in the experience of having a preterm birth, the findings highlighted many common experiences among the young women regardless of whether their infant was born preterm or full-term. The themes generated from the in-depth analysis of the women’s stories are common to all young mothers (full-term and preterm) with aspects unique to the preterm experience discussed as sub themes. The three superordinate themes were: the dual nature of motherhood (1), actual ideal incongruence (2), and transforming self (3). The first theme presents the day to day experience of being a parent as a young woman, exploring both the positives, the challenges, and the complexities. Further, the nature of the challenges are explored along with differences in the perceptions of challenge within the experience for mothers and over time. Theme 2, ideal actual incongruence, highlights the contradictions in the young women’s discourse both within and across interviews as their idealized images of the experience of being a parent do not match reality. Theme 3, transforming self, presents the ways in which becoming a parent changed the young woman both from pre-pregnancy to birth, and over the first 12 months of parenting. The ways in which the young women grew and developed are outlined. Further, this is linked to the young women’s perceptions of challenge in the experience.

All excerpts have come directly from the verbatim transcripts with changes and omissions only occurring where necessary to increase clarity and readability. Text in brackets indicates explanatory material added afterwards. For each theme, multiple example excerpts were available and were selected to ensure where possible that all mothers’ voices,
from each of their interviews, were heard throughout the various themes. In addition, excerpts were selected if they exemplified the themes or demonstrated either convergence or divergence of experiences. Appendix H provides an overview of the number of excerpts incorporated into the results by mother and time of interview.

Theme 1. The dual nature of motherhood

The dual nature of motherhood emerged as a core aspect of the experience of being a mother for all of the young women in the research. For all young women, motherhood was a mixture of enjoying and delighting in the infant and balancing the constant but changing challenges. While the moments of delight and enjoyment of the infant were universal, the challenges experienced differed across mothers and over time.

This master theme consisted of 3 sub themes: delight and enjoyment (1), acknowledging the challenges and complexities (2), and the changing nature of challenges over time and person (3). Further, subtheme two consists of 5 categories of specific areas of challenge: constancy of demands (2.1), challenging infants (2.2), external factors (2.3), appropriate support (2.4) and the challenges of having a preterm infant (2.5). These sub themes discuss what may be the universal experience for mothers: the delight that mothers feel for their infants and the challenges they face over time and the unique aspects of being a young mother. In addition, the differences in the experience of being a mother will be mapped and explored in order to understand how the experience changed and stayed the same for young women.

1.1 Delight and enjoyment. Mothers talked about the love that they felt for their infants. This love was grounded in everyday activities. For many of the women there was a loss of words to describe what parenting was like, instead the responses were:
“I don’t know how to describe how it feels; it’s good, it’s wonderful.” (Juliana time 3).

“I love it [Laugh], I love it, I absolutely love it, I enjoy it, I’m really enjoying him. It’s fun, it’s a hell of fun eh [yawn] not one minute’s boring, it’s always entertaining. God he gives me the giggles sometimes [Laugh], some of the silly things he does; keeps me fit” (Skye time 2)

The young women also commented that, despite having its challenges, the experience was not as hard as others had made out and that this experience was positive, not negative, as is often widely espoused for young women.

“It’s not to worry about. It’s a good experience. It’s a blessing to have a baby really it is… You get stressed. Everyone tells you there is so many things to worry about, you this, your whole live will disappear and yatta, yatta, yatta. No it’s excellent” (Lily time 2)

Further, their love for their infant changed over time as infants grew and became more interactive, with all mothers enjoying watching the infants achieve milestones and develop personalities over time.

“Oh just watching her grow and...Starting moving and holding her neck up and stuff so... yeah. Which has been, been good. Hey? Struggled sometimes but... that happens… I love interacting with her and like now she starts to interact back, like smile and laugh and sit up and...” (Jenna time 2)

Overall, the young women experienced being a mother in terms of enjoying their infants, rejoicing as they grew and developed. The delight the mothers felt about their infants was evident in all of their interviews and across time. Moments of positive affect that were
related to the infant characterised the experience highlighting that it was predominantly positive. At the same time mothers talked about the challenges and how these changed over time suggesting that the experience was multifaceted and sometimes contradictory.

1.2 Acknowledging the challenges and complexities. This subtheme documents the challenges associated with the experience of being a young mother. The young women described a range of challenges they faced in their daily lives during the first 12 months of being mothers. The young women talked about the struggles, challenges, and moments that were less enjoyable in their experience of being mothers. The challenges were associated with the constancy of demands, the infant, external factors (e.g. housing), and with negotiating appropriate parental support. However, also of note was the acknowledgement by the young women that it was less appropriate to discuss this side of parenting.

NS: **So are you enjoying motherhood at the moment…?**
Jenna T3: Can I say, “No” [laughs].
NS: **Yeah you can say, “No”**.
Jenna T3: That’s terrible…I love it, I wouldn’t change it, yeah… it’s just but there’s loads of things; being 19…. And it’s just all of my friends are 19 and are going out…I love motherhood, I love Melissa; I, probably going back would have just waited 5 years, I would have loved to have Melissa in 5 years from now. I love it.

The paradoxical experience is evident in this Jenna’s words.

Parenting was broken into mostly good days and some bad days and the young women described how they managed the aspects of parenting they did not enjoy with the aspects of the experience that they did enjoy.
“Oh [I like] everything. There’s heaps of likes and dislikes. And I love it when we sit there and play and all that. I hate it when he gets up in the morning…We have fun at the beach. I just love spoiling him, he’s a spoilt child.” (Tenielle time 3)

The process the women used to manage these conflicting moments was by “weighing it out” or balancing the good with the bad and creating an overall perception.

“I sound negative but, I don’t mean to be negative…it's just been a really rough time. In that, we've had lots of great times too so. And you've just got to weigh it out.” (Bronte time 2)

‘Motherhood’ and ‘parenting’ were terms evident in the narratives when the young women explained their experiences of parenting. This highlights that the challenges they perceived were not challenges associated with being ‘young mothers’ but that they perceived these experiences more generally as part of motherhood. That is, positives and challenges were seen as part of the universal experience of being a mother. However, closer examination of the types of challenges the young women experienced suggests that some may be universal to motherhood but others are age related.

1.2.1 Constancy of demands: By 3-4 months post discharge the reality of the constant nature of demands of parenting was clear and overwhelming for many (but not all) and the need for support and reassurance was high. For most mothers, the reality of parenting was more challenging than they had expected. For many, this was associated with the constancy of the demands of the infant, the lack of sleep, and the difficulty in getting day-to-day things done.

“It was hard at first because still settling in with the newborn stage where they like to cry and they’re really demanding… You’ve got to wake up, you’ve got to feed him
and burp him and change him and they always cry and stuff like that, it’s just very demanding.” (Skye time 2)

Other mothers struggled with the reduced sleep and early mornings and found it difficult to manage their own need for sleep as adolescents with the needs of their infants.

“Like I’m a big sleeper, like I love my sleep and sometimes I just don’t wake up for her and I feel so bad when I do end up waking up and she’s screaming like somebody’s killing her.” (Emily time 2)

These challenges show that young mothers struggled with the universal parenting challenges (i.e., lack of sleep, constant demands) but that this also interacted with age related needs (such as their own need for sleep).

1.2.2 Challenging infants: A challenge for some of the mothers was managing their infants when they perceived them as having a difficult temperament and having difficult behaviours. For example, Tenielle commented:

“It’s been up and down, it’s been up and down, up and down and the crying, non stop crying and getting up every five minutes to settle him down… some mornings he’ll wake up talking to me and that and some mornings he’ll wake up [screams]… and that’s when he’s just crying for no reason is when it’s aaahhhh.” (Tenielle time 2).

She perceived her baby’s temperament as difficult, a judgment based on her infant’s communication, her assessment of need, and an unstated judgement of what would be normal behaviour. Mothers also found it challenging or difficult when their infants were sick or in pain and teething was perceived as particularly hard to manage.

“Teething. ohhhh…It’s the worst thing in the world.” (Renee time 3).
These challenges were associated with difficulties managing their own frustration when the infant was crying and they did not know how to settle them. Some also experienced moments when they felt they could not continue, when managing the infant became too hard.

“Yeah, it’s been okay but I try and convince myself that I can do it, but I’ve had moments where I get really, really frustrated and then I cry” (Emily time 2).

For most young women, the prominent challenge in the later part of the first year was how to manage infant frustration and behavior described by the mothers as “tantrums”. Their infants were more active and were becoming mobile, inquisitive, and engaging in exploration, which meant mothers needed to constantly monitor their infants. Although, the demands had shifted in nature, they were still constant with some mothers ascribing meaning to the behaviours discussing the “cheekiness” and the “naughtiness” their infants ended up in if they took their eyes off them for a moment. The young mothers also struggled to find appropriate disciplinary tactics for their 1 year olds.

“Frustrating if anything it’s frustrating. Especially with him, he doesn’t listen. It’s all no and he tells you no back. You can’t smack him because he laughs and says, “Mack” and hits you anyway” (Lisa time 3).

1.2.3 External factors: Stable housing was a significant issue for several of the mothers. These young women were unable to find affordable and suitable accommodation and were often reliant on friends and new acquaintances to provide accommodation.

“And then my friends out, I have friends in [suburb], and I was meant to live with them for a while and I was meant to take over their lease and everything and then I
stayed there for a couple of nights and the real estate rang them up and complained about Bailey’s crying from the old lady next door, was complaining about his crying. So they said he has to get out… It has been. It’s just been mayhem”. (Tenielle time 2).

Lack of stable housing meant that the mother was unable to set up a nursery or to create a space for herself or her infant. Toys, clothes, and supplies were often left in several locations or were left packed in boxes making day-to-day care of the infant difficult.

Financial strain was another related challenge apparent for half of the mothers in the research. Several young mothers were reliant on government payments, and for two of these women payments were delayed for months while the paperwork was processed. These young mothers were then reliant on family members to provide financial support. Not only did this mean that at times they were unable to provide sometimes the basics for their infants, but it also meant that they were not able to indulge their infants as they felt they should.

“We’re left with nothing, no money or anything for fuel or, it just… And once after the shopping’s gone, the rent’s paid I’ve nothing. So if I need to get anything for him during the week I’m screwed so yeah…And the thing is, and the worst thing is that, the thing that upsets me at the moment is that Christmas is coming… Yeah I want to buy him heaps and heaps and I can’t afford it, I can’t” (Skye 2).

Loss of income due to the father of the baby losing his job was also an issue for two of the mothers as they attempted to manage on government payments. Unexpected changes to these payments also contributed to the financial stress.

Lack of transport was a challenge that many of the young women had to contend with. Not having a license, not having a reliable car and reliance on public transport was often reported as challenging.
“Probably not having a car would be the hardest bit…He doesn’t like the public transport. Because you have to take them out of the pram on the bus as well so he’s climbing up and trying to get over the seats and on the windows and everything else, licking the windows.” (Lisa time 3).

Importantly, the young women perceived that the challenges became easier over time. However, the nature of the challenges also changed over the first 12 months meaning that the young women were constantly having to grow and develop in order to manage, with some adjusting better than others. Most women were reporting stability in terms of housing by 12 months. All but one young mother were living out of their parents homes at by the time their infant was a year old and this one mother was only temporarily living with her family while she and her partner looked to purchase a new house. Most were living with their partners in rental properties and the move into their own house was considered extremely positive for most of the young couples. Having their own house afforded them more space and freedom. However, this often led to a reduction in support from family and decreased time out from the infant. In addition, living alone was often associated with an increase in financial strain and raised new concerns about finding appropriate flatmates.

“It’ll help with the money ‘cause it’s expensive staying here. Yeah but with all that and the baby stuff as well. But my friend, she’s moving in in a few weeks…Even if she was my best friend or whatever, I’d think that, because she’s good with him that’s why I said she can move in. I just need to find someone who’s good with him, because if he’s not comfortable with someone around then that’s not gonna be a good thing” (Jade time 3).
Thus, there were compromises for the young women who moved out of the family home: increased autonomy and freedom but an increased cost, reduction in support, and increased concern about the infant.

1.2.4 Appropriate support: Negotiating appropriate support from family, partners and friends was a constant struggle as the young women managed their need for support with their need for autonomy in the parenting role. Negotiating the ‘right’ kind of support from parents was difficult for many as the young women received unwanted advice instead of help with little things or time out. The young women reported that they did not require constant or intrusive support and advice. Instead, it was about knowing that there was someone else there who could take over for short periods of time or help out with little things like dishes, washing or helping with cooking: Just knowing that they were not doing it alone.

“You kind of really needed help but you didn’t know how to ask them. Then if you feel like you’re asking them, then they take it on too much. It’s asking for the right amount of help. You don’t want them to come in and parent fully, which our mums are likely to do [laughs], just because they love us. You just need sometimes a bit of freedom, which now we’ve got, which is good.” (Bronte time 3).

Bronte continued

“…being a young parent thing, if you look like you’re doing okay, then they’ll leave you alone, which is good. But if you ask for help from them, they think it’s because of your youngness that you need the help. So then they take over and you don’t really want them to take over, you just really want them to just help.” (Bronte time 3).

Support was perceived negatively when a parent or a professional told them, lectured them, took over, challenged them, bossed them around, or interfered. Alternatively, support
was perceived positively when it honoured the young woman’s autonomy in the parenting role by providing guidance and advice as and when requested. This need for autonomy was also seen in the young mothers’ accounts of finding ‘my way’ of parenting; a way of parenting that suited the mother and baby’s temperament and needs.

Accessing support from others also put the young women at an increased risk of becoming subjected to negative judgment and interference rather than guidance, and this made the young women feel as though they did not know what they were doing. However, this will be further discussed in the subsequent theme ‘ideal and actual incongruence’, as the role of others in emphasizing the discrepancy in how the young women see themselves is discussed. For young mothers of preterm infants, having an infant in hospital and under the care of nurses challenged their notions of autonomous parenting.

1.2.5 The challenges of having a preterm infant. Differences in the narratives of the young women who had preterm and full-term infants were only evident early in the parenting experience. Specifically, there were differences in the reported challenges for young mothers of preterm infants, when they were navigating the hospital system prior to taking their infants home. These challenges fell into 3 categories which are discussed below. Further, the young women employed a number of coping strategies to manage these challenges and these are also outlined. However, idealizing home was the primary coping strategy used by the young women and this will be discussed in the next theme.

The first group of challenges was related to difficulties inherent in the hospital system. These included negotiating the care of their infants with staff who they perceived as not supporting their attempts to be autonomous parents, and restrictions in the care they could provide to the infant.
“… and like some of their ways of doing things kind of…were not really my way…she just basically did it all so how was I supposed to learn…but I want to have a turn myself”. (Jade time 1).

“There are a lot of nice nurses but there has been some nurses that have been really nasty. They tell you that you can’t pick up your baby at the moment and stuff like that when you can… I was a bit intimidated by that… I just let it go. That’s all you can do. You can’t argue back or otherwise they’ll put a little note on your file” (Emily time 1).

“Yeah it is a bit harder because you go in there and it feels like the baby is not even yours you know because you’ve got to ask the nurse, “Can I change her nappy and can I do this and that,” and then she was in the isolette thing” (Holly time 1).

The young mothers struggled to negotiate this environment, as nurses changed each shift, and the participants perceived that with changing staff came new rules about the nursery and care for the infant. Also challenging was the unpredictability associated with the SCN.

“And the fact that cause the nurses are never there for long enough there is always someone else there the next day you go back and they’re telling you something different then you go back the next day and the first lady is there and you’re doing what the other lady told you and then she’s like why you doing this you should be doing this what I told you the other day. It’s like youse are all telling me different things. They were all telling me different things and then it’s like oh well”. (Lily time 1).
“Some of them were a little bit more lenient I found than others. That was also something I found really hard because we’d go in there and some would be like “No, just feed him”. And we’d be like, “we’ve already feed him once today”. And she’d be like “No go go”. And then we’d come in another day and be like “can we feed him? “And they’d go, “Don’t you touch him”. (Bronte time 1).

The changing nature of the environment was often managed through creating a sense of predictability and control by creating milestones and indicators of progression in their infants.

“seeing all those other mothers going up there too kind of made it easier seeing them there every day feeding their babies and doing what I was doing and also I could kind of see the steps she was taking as she was going to go home like I could almost tell… One day closer every day it was good” (Lily time 1).

Other young women defined their roles and the roles of the nurses into parenting versus caretaking (i.e., feeding, bathing, changing versus medical care) in order to have distinct responsibilities in the co-parenting relationship.

“I basically do everything for her while she is here… they do her temperature and stuff like that when they need” (Juliana time 1).

Another way of stabilising the situation and unpredictability was by using social comparison process to assess progress and normality.

“ … I didn’t expect to have a preterm baby but it’s been alright. I mean I have seen some other mums in there with the sicker babies and I think that would be really
hard…and going home, I can’t even imagine what it would be like for the mums with the 25 weekers.” (Juliana time 1).

The young women perceived high levels of negative judgment from hospital staff and felt that they were treated differently in the nursery due to their age.

“At the time being I was a young Mum and some of the looks I’d get… I think there is a big difference because I had three older ladies in the room… and they got treated with a lot of respect, more respect than what I did; I picked up on that straight away so. Just disappointing because every Mum should get treated, doesn’t matter how old you are, every Mum should get treated the same way.” (Skye time 2).

“I didn’t have a very nice midwife…she told mum I wasn’t maternal…and [said] to mum, you know make sure she doesn’t dump the baby” (Lisa time 1).

The second category of challenges was related to situational difficulties such as lack of access to transport. Nearly all mothers mentioned that transport and travel to and from the hospital were difficult to arrange and sustain. Most were reliant on friends and family members to drop them off and pick them up. Several mothers also lived rurally, with limited access to public transport and long travel times to get to the hospital.

“I’ve got to get someone to take me, give me a lift up or I’ve got to sit on public transport… It’s just so draining because if it was like 5 minutes down the road for me, I would be here all day every day… It’s a 45-minute drive, I think. And on the train and bus, it’s just like oohhh. ‘Cause you’ve got to wait for the train, get on the train, go to the next stop and get off and wait for the bus and that takes you through all the traffic." (Laura time 1).
Concerns such as these meant that the young mothers could not devote as much time or effort to their infants as they would have liked and made managing the hospital situation considerably more difficult.

“I try and get here whenever I’ve got money or whenever I’m able to, somebody can give me a lift down here. But I’m looking at just to try and do my best” (Emily time 1).

This also interacted negatively with the mothers’ attempts to parent through small tasks such as feeding, as they would often miss feeding times. This created frustration as the young women could not devote as much time or effort to their infants as they would have liked and made managing the hospital situation considerably more difficult.

“It’s just frustration, anger with a lot of the nurses because yesterday I was in the hospital and one of the nurses, I said, because they’d already started to tube feed when I got there, and I was only 5 minutes late. I’m like, we could have waited or you could have called me” (Laura time 1).

A third challenge for the young women who had preterm infants was managing the emotional side of the experience. For most mothers the time of their infant’s hospitalisation was described as an emotional rollercoaster. All mothers of preterm infants described how challenging it was to be separated from their infants. Most mothers had little more than a quick hold after the birth before their infant was removed to either the ICU or the SCN.

“Yeah he got taken straight away. We didn’t get to cut the cord or anything. They just took him straight away. He was gone”… Very, very hard. I didn’t get to see him. I saw a blue foot and that was it.” (Renee time 1).
For most, the next sighting of their infant was hours later when they saw their infant in an isolette, and the next touch of the infant was usually days later. Mothers were removed to the maternity ward, where other mothers had their infants. They were left without their infants but with constant physical and external reminders that they had indeed become mothers.

“They took me back to the ward and all the other ladies had their babies next to them and I didn’t have my baby”. (Jade time 1).

Further complicating the attaching and bonding process was the mother’s discharge from hospital, usually a couple of days after birth. From here we see the challenges associated with the situation (i.e., transport) interplaying with the bonding process. However, we also see the difficulties for the young mothers in not having the infant around them and having to leave the infant at the hospital each day and separation was keenly felt.

“it was just a lost feeling, like something was missing…I just spent 9 months carrying her and pushing her around and now I don’t even have her near me. It was like they’d almost taken her away from me” (Lily time 1).

“[I left the hospital after] three days and that broke my heart when I had to leave there without her” (Holly time 1).

In order to cope with the lack of embodied interaction with their infants the women invoked an image of the ‘absent baby’ by interacting with photos of their infants. This then allowed the process of bonding and attachment between mother and infant to continue in the absence of the physical presence of the baby. When touch was not available, other senses such as sight were used and bonding by watching occurred.
“I had the camera. The camera’s what saved me. The hundreds of thousands of photos I had of her. Every couple of hours we’d look at her photos again… If I didn’t have those photos I don’t think it would have I would have coped much easier… It’s been really hard” (Lily time 1).

“I’ve been trying to get into the routine without her being there. I try and we’ll get the photos out and we go to her bedroom and her little bassinet” (Holly time 1).

The young women also tended to turn to their partners for support while in the hospital, relying on them for emotional support as well as practical support.

“he helps me cause he supplies everything and when we’re at home I’m like when I all sad like I want to go see baby and he’ll make me happy like shows me a picture or he’ll just try and make me laugh and stuff like that. I’ll be l like I can’t be laughing this is crying time it’s emotional” (Jade time 1).

The young women’s narratives around their experiences in hospital highlighted a number of challenges that they had to contend with. Many of these were practical challenges associated with not having access to transport. However, these challenges in turn had impacted their perceptions of their ability to be parents within the hospital setting, adding to a situation that was already perceived to be out of their control and challenged their perceptions of being an autonomous parent. Despite this detailed exploration of the challenges inherent in the experience of a preterm birth, the young women’s narratives suggested that the experience of being a mother and the positives associated with this outweighed the slight increase in challenge. The challenges were just seen as something to contend with in their journeys of being mothers to their infants.
“Ohh well I didn’t expect to have a preterm baby but it’s been alright… Yeah it has pretty well its been a little bit hard – the hardest time is leaving the hospital and leaving her here but other than that it has been pretty good” (Juliana time 1).

In this vein, there were few reported concerns about their infant’s health and development, few reports that having a preterm birth was contrary to their expectations, and no directly stated concerns that the bond between infant and mother was affected by the separation. Instead, the young women reported that they had good bonds with their infants and replaced the natural bonding process with other interactions (such as looking at photos) but struggled being apart. However, over time this changed.

When reflecting on their experiences at 12-months post discharge, an additional category of challenge emerged with some young women noticing that they had had increased difficulties in bonding with their infants while in the SCN and the experience in the SCN not being as it ‘should’ be when you have a baby.

“It was a bit more different at the start when we weren’t allowed to hold him or anything, so we didn't get to bond as much as other Mums get to... I didn't feel as bonded with him. It’s like I couldn’t really touch him at all really…, when he came home It’d be like, “Can I hold the baby?” “No.” [laughs].” (Lisa time 2).

“…It didn’t stop us bonding but it really slowed the process a bit I think. Just having them take care of her, not me take care of her…I cried for the first couple of nights ‘cause you have a baby for the first time and you expect it to be like that huge bonding experience…They always were like “Take her out and hold her, you need to bond with her, give her cuddles,” but it’s not enough, it’s not like it should be.” (Lily time 3).
This suggests that it is only after the mothers have full time care of their infants at home, that they fully realize the impact that the SCN environment has had on their ability to bond with their infants. However, it is also possible that their ideas of what parenting ‘should’ be have developed over the first year of being a parent and a retrospective appraisal fell short when it did not at the time. This interpretation supports the assumption that one reason the SCN may not be as stressful for young mothers at the time is because of less differentiated expectations of what parenting should be.

At the same time, mothers noted that the time in hospital provided them with the opportunity to grow stronger, that it taught them appreciation of their infants, and also helped their infant be more content and less demanding.

“I don’t take him for advantage now and I appreciate him a lot more.” (Skye time 2).

“I think that, I think that having that hard time with her being in hospital for so long made me a stronger person.” (Emily time 3).

When the mothers were asked to reflect on the experience, the challenges experienced at the time their infant was hospitalized were recalled with clarity months on. However, the experience of having a preterm infant was not something that the young women thought of often and there were few ongoing challenges related specifically to preterm birth. Instead, the experiences of young mothers of preterm and full-term infants (in terms of enjoyment and challenge) converged post infant discharge regardless of completed gestation at time of birth.

1.3 The changing nature of challenges over time and person: At a group level, parenting was perceived as both challenging and as enjoyable and the nature of the challenges changed overtime. However, the young women varied in both the challenges they experienced and their sense of enjoyment in parenting. It is possible to conceptualize these as independent orthogonal dimensions: one of enjoyment of the infant and parenting and the
second the perception of challenge in the parenting experience. Due to the differences in experiences between young mothers of preterm and full-term infants at time 1 (discussed above), it is not possible to provide global and meaningful representations. However, by 3-months post-discharge the two groups of mothers had converged in terms of how they experienced parenting with each mother perceiving the joys and challenges slightly differently, but each mother experiencing both to some extent. Graphically, this is represented below and is based on the global perception of their descriptions within interviews at time 2 and 3. While no mother discussed actively disliking being a parent in their narratives, some admitted to times when there was less enjoyment. Similarly, consistent with those outlined above, each young woman faced unique and divergent challenges. These have been grossly combined to present graphically and examples are provided and discussed in greater detail below. Gross mapping also allowed comparisons over time by visually demonstrating how experiences for some young women changed quite drastically while also demonstrating the heterogeneity of experiences for young women.

- **No Challenges**
  - Juliana
  - Claire
  - positive enjoyment of motherhood
  - Lily
  - Danielle

- **Lack of enjoyment of motherhood**
  - Skye
  - Jenna
  - Jade
  - Bronte
  - Holly
  - Emily
  - Tenielle
  - lots of challenges

*Figure 1. Dimensional map of adjustment at time 2*

In this conceptual map, Emily and Tenielle, who both had unstable housing, little support and financial difficulties can be positioned at the very challenging end of the
continuum. Also represented at this end is Bronte, who had a number of ongoing difficulties with her infant’s health and inability to settle. Tenielle was also lower on her enjoyment of parenting, visually representing her struggles with post natal depression and difficulty managing the constancy of demands. On the other side of the struggling continuum are Juliana and Claire, who both lived with their partners in homes that they owned. They had good family support and loved being parents. Their perceptions of challenges were much lower than those of other mothers in the study and their enjoyment of the experience was great. For Juliana, transport was the only perceived challenge. Similarly, Danielle and Lily perceived parenting to be a gratifying experience but reported minor challenges with uncertainty about feeding their infant/baby, negotiating support, and partner relationships.

“It’s really hard [to think of challenges] because I’ve got a good baby. There's nothing really because he doesn’t cry, he doesn’t do anything… Just a happy little man.” (Danielle time 2).

For other mothers (i.e. Laura, Lisa, Skye) parenting was not particularly challenging but also not overwhelmingly positive and these mothers discussed the range of positive and challenging aspects of parenting.

**Figure 2**: Dimensional map of adjustment at time 3
Comparison of the conceptual maps above shows that stability characterises the experience of some of the young mothers while for others instability or change mark the experience of being a mother. By time 3, the positioning on the axes is different for several of the mothers. Notably, Tenielle was no longer experiencing being a parent as an overwhelming challenging experience. After receiving help for her depression and support with managing her infant, she moved interstate where she had more family support and was linked in with a young parents program. At this time, her narrative was about stability, enjoyment, and being able to manage.

“I ended up in hospital for two weeks. Bailey was with me though. If I didn’t go to hospital and get help, I would have done something that I regret and just changed everything to now… Yeah, things are going really good at the moment.” (Tenielle time 3).

However, for Lisa, parenting had become more challenging as her infant became increasingly demanding and her support had decreased. Her interview had fewer instances of enjoyment and more discussion and examples of when she had been overwhelmed by her infant.

“[Parenting] it’s a lot of things. Pretty stressful actually...Kind of hard running after him now he’s up and going.” (Lisa time 3).

Subtle changes are evident in the positioning for most of the other mothers, which reflects either an increase in their perceived challenges (i.e., increased financial pressure and decreased support from moving out of home) or a decrease in enjoyment of parenting as they lamented being stuck at home.
“Like being in the house and all cooped up and stuff, that’s what it feels like; I’m at home every day by myself so I look for things to do. And it’s just like, “Yeah come on, chuck something at me I want to do it.” (Jade time 3).

In contrast, Juliana, Claire, Danielle, and Lily displayed stability in their parenting experience, reporting few challenges and considerable enjoyment over time. Further consideration of why these mothers may have had a more stable, positive experience of being a mother will be offered below.

The positioning of the young women on these trajectories can also be demonstrated by a basic valencing of the individual themes generated during analysis of the individual transcripts. Accordingly, Juliana’s experience of parenting at time 3 fell mostly into themes that were positively valenced. In contrast, Holly’s experience can be split between negative challenging aspects and positive enjoyable aspects of parenting.

Juliana (time 3)

+ Trip to see extended family – showing off baby
  Easy baby
  It’s wonderful – being a mum
  Family support with baby
  Little contact with friends – mainly family
  Time of infant learning
  Comparison – assessing development of infant
  We – partner relationship
  Move to live with family
  Savings plan for new house purchase
  Equal parenting – mother and father
  Ignoring unwanted advice and judgment from others
  Not about being young
  Lack of desire to go out
  Life = looking after Kate
  Changing future plans for work
  Future plans for another child
  Caught up from preterm
  Only sick once – no health concerns
  Preterm = teaches appreciation
  Developing infant personality
  Milestones – teeth, talking, and food

- Constant surveillance
  Parenting = unpredictable
  Challenge = no license
  Nice to meet others -should go out more
  Disrupted routine – hard living back at home
  Daddy developing bad infant habits
  Baby needing more interaction with other babies
  Hard part of preterm = hospital/separated
**Holly (time 3)**

+ Delighting in giving infant treats
+ Close supportive relationship with sister
+ Confidence in managing
+ Supporting sister through DoCS involvement
+ Taking opportunities provided by government
+ No delays – preterm
+ Good baby
+ Promoting milestone achievement

- Desiring grand parent attention of grand daughter
- Parenting = hectic
- Chaotic family
- Limited support from Grand Mother
- Reliance on others for transport
- Chaotic life = late for appointments
- Financially harder – reduction in payments
- Unstable living arrangements
- Self identified need to improve parenting

A second crude categorization with Lily and Lisa demonstrates both the duality of the experiences as well as the convergence and divergence in experiences for the young mothers and suggests that we may be able to explicate the young women’s experience of being a mother by investigating factors that differ between the young women.

**Lily (time 2)**

+ Accessing information on the internet
+ As women you learn to parent – not about age.
+ Associating with people own age
+ Baby = blessing – nothing to worry about autonomous
+ By the book – as expected and on time
+ Grandparents spoiling
+ I don’t want to leave her – plans to work in future
+ Importance of help from family
+ Mother’s pride – enjoyment of baby’s development
+ No health problems – no impact of preterm
+ Normal baby
+ Regimenting baby’s patterns – routine
+ Waiting for her to play – loving increased baby interaction
+ Waness – coparenting

- A little too much support
- Hard but enjoyable
- Managing father baby time
- Managing need for support with parenting
- Need for baby’s own room
- Uncertainty about food

**Lisa (time 2)**

+ Accessing health support regularly
+ Baby interacting more
+ Following traditions
+ Future plans for children

- Advice from others
- Baby setting the rules
- Challenges living at home
- Don't trust daycare
No effects of preterm
Parenting support from others
School for future goals - hairdressing
SCN = chance to get to know him better

Hard - reliance on public transport
Harder than expected
Lack of sleep hard – tiring
Looking forward to more infant independence.

Shared parenting - father of baby.
Sleeping with baby
Struggling financially

Managing baby's health concerns
Managing changing infant demands
Managing school
No time for hanging out with friends
Poor relationship with grandfather
Problems with feeding
SCN= difficult lack of touch
Supporting grandmother while sick

For those that are stable on the dimensions of enjoyment of parenting and perceived challenges (such as Lily and Juliana), we can see far more positively valenced themes than negatively valenced themes. This is similar for Claire and Danielle. For these mothers, parenting still had its challenging moments but the positives of the experiences were far more prominent in their narratives. Alternatively, Holly described parenting as chaotic and hectic and was dealing with challenges such as the father of the baby being in jail. These were similar to some of the challenges that Emily and Tenielle had to overcome. Finally, Lisa’s valenced themes highlight the subtlety of some of the challenges and the lack of positive descriptors reveal less enjoyment in the experience. Skye, Jade, Jenna and Renee’s narratives were in many ways similar to Lily’s but with more subtly changing challenges. A review of the young women’s self-reports of general wellbeing (as measured by the GHQ) provided further information about the young women’s functioning over time. Table 3 demonstrates changes over time in the women’s psychological functioning, in terms of perceived distress, with time 2 (3-4 months post-discharge) the most challenging time for most. Again we see relative stability for some mothers and variability for others.
Table 3.  
*Changes in psychological distress over time (as measured by the General Health Questionnaire-12)*

<table>
<thead>
<tr>
<th>Mother</th>
<th>Time 1</th>
<th>Time 2</th>
<th>Time 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronte</td>
<td>8</td>
<td>21*</td>
<td>5</td>
</tr>
<tr>
<td>Claire</td>
<td>10</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Danielle</td>
<td>7</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Emily</td>
<td>20*</td>
<td>16</td>
<td>5</td>
</tr>
<tr>
<td>Holly</td>
<td>6</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Jade</td>
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<td>Jenna</td>
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<tr>
<td>Juliana</td>
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<tr>
<td>Laura</td>
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<td>Renee</td>
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<td>Tenielle</td>
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Note: Higher scores indicate increased distress (score range 0-36)

* scores above 18/19 represent significant levels of distress based on Australian adolescent normative data

The possible mechanisms which may underpin both the stability of some mothers and the shift towards stability for most mothers over time will be discussed in the theme ‘changing self’ when the role of parenting in transforming the self and developing internal and external resources is explored. However, one additional factor that may contribute to the perception of challenge, particularly at 3-4 months post discharge, is the incongruence between the mother’s idealized image of the parenting experience and the actual experience.

**Theme 2: Actual/ideal incongruence**

The theme actual/ideal incongruence captures the incongruity between how the mothers perceived the experience of being a mother would be and how it was. In most cases incongruence was identified by the researcher with only a few of the mothers able to identify the differences between what was espoused as expected at one point and what the experience was like at another. In this theme, the term idealized is used to portray that the mothers had
an image of how things were going to be, an ideal of what, who, or how things would be. Further, the young women discussed the incongruities in different domains. Some mothers experienced an incongruity between their idealized view of the parenting experience and their actual experience. For others, there was incongruence between the idealized father and actual behaviours of the father of the baby. Other young mothers of preterm infants noted incongruence between what they thought it would be like to take their infants home from hospital and what the actual experience of parenting was like once home. Finally, some young mothers discussed incongruities between how they felt they should be as mothers and their actual capacity as mothers. Thus, not all mothers experienced incongruence in the same way, but most experienced and needed to reconcile the incongruence to some degree. Each of these areas will be discussed and examples provided. As with the continuum of struggle, there was also a continuum of incongruence. Interestingly, the narratives revealed that for mothers who reported parenting as very challenging there appears to be a more incongruent view of the ideal of parenting versus their experience, suggesting the two are related. Further, criticism and advice from others tended to emphasize the incongruence between the mother’s ideal image of self and actual performance as a mother, and this often led to a reduction in help seeking behaviours. These ideas are explored in more depth below.

2.1 Idealized home. For most of the mothers of preterm infants, the hospital experience was not as they had hoped; for them, the idealized image was of being the mother in terms of the caretaking tasks, of not being separated from their infants, of not having an empty cot at home, of not leaving their infant behind each day, and of not having to share care of their infants with nurses. As such, ‘home’ became idealized. Home was the place where the young woman would get to be her infant’s mother, to do things her way, and principally, where things would be easier. This notion of home being easier was idealized in that the young mothers were not considering or reflecting on possible challenges of going
home – of being primary carers to their infants and the ensuing exhaustion that often follows. This notion of the idealized home was borne out in the young women’s stories at time 2 where they discussed how hard it was when they came home, often laughing about how they should have made the most of when the infant was in the hospital to sleep. So while the researcher could see what could be described as a ‘rose coloured’ view of home prior to the infants discharge, the young women only saw this on reflection after living the experience. Laura at time 1 highlights the incongruent view of what home will be like when describing her response to mothering in the SCN:

“So once she’s home she’ll be able to cry when she wants something to eat. She’ll be able to cry when she’s got a dirty nappy. So I’ll be able to go, alright I know that cry, I know this cry. Ca-chink. It all just falls into place. But at the moment it’s, “Okay, what’s she crying about now? She’s just been fed, I’ve just cleaned her bottom, what is it?” (Laura time 1).

In this excerpt, Laura demonstrates the idealized view of home. She associates home with being the mother and with ‘knowing’ her infant whereas currently the environment (i.e., SCN) is seen responsible for her not knowing rather than what may be natural uncertainty about meeting her infant’s needs. Renee also talked in a way that idealized home in the first instance and was able to reflect later on the realities

“I just want to play with him now. It will be so much better when he’s home…, just feeling like being a family instead of sort of having to run back and forwards to the hospital and its hard to get to sleep at night because I don’t know what he’s doing and So when I go home with him I think it will be easier with no driving. I’ll be able to just sit down and sleep when he is asleep and just relax” (Renee time 1).
“I couldn’t wait to get him home and when I got him home it was like, “Can we go back to the nursery?”. Because at least I could sleep [laughter]… Yep and oh, I was so tired.” (Renee time 2).

Once again the environment (i.e., the SCN) was used as the explanation the tiredness rather than it being attributed to a natural challenge associated with mothering. For some of the young women the focus was on the current difficulties associated with the situation (i.e., SCN) and there was little acknowledgement that home could or would be harder than their experience while their babies were in hospital.

“And it felt kind of better, everything was done and finished when I came home with him like. But that’s when it just began like did I know that? Here I am thinking it was so like over all the days going up to the hospital and walking there with my um my scar and my stitches and stuff like that and I thought yes when I brought him home but that’s when it really started so I was like “oh my gosh”…And then oh my gosh it hit me with a real like, yeah like a reality check kind of thing.”(Jade time 2).

Jade’s words suggest a ‘reality check’, that is the realisation that going home was different to the anticipated experience. Further, the idealisation of home may serve as a coping mechanism in that young women idealise home in order to cope with the difficulties of the having an infant in the SCN. Believing that things will get easier at home gave them hope that they would manage. However, Jade’s excerpt also highlights how parenting began ("really started") once both mother and infant were home suggesting that a) the challenges of having the infant in hospital differed from the challenges of being a day-to-day parent; and b) that parenting in hospital was different from parenting at home, as explored in the theme above. Idealizing the father of the baby, his role and relationships was another aspect of the
young women’s accounts which give evidence to the experience of an ideal – actual incongruence.

2.2 The idealized father. For several of the mothers, a misfit or incongruence between the idealization and the reality of experience was evident in their descriptions of their relationships with the father of the baby and, also, in their expectations of how a father should behave and their experience with the fathers of their infants. This was particularly notable for the young mothers who were not in stable ongoing relationships with the father of their infant. Tenielle described her desires and expectations for Bailey, her son.

“I want to stay over here [in Queensland] because Bailey’s dad’s over here and I know if he’s given the chance to do the right thing, he’ll do the right thing... I want Bailey to have his father and I don’t want, I know his father, he’ll do the right thing and he will want his son around...he’s nearly 32 and he needs to settle down as well. Like he’s a real party person and yeah and I think having Bailey will settle him down...” (Tenielle time 1).

Despite her unwavering expectation of the role a father should take and thus those of her baby’s father, John after 4 months had not become the father she expected him to be.

“I let him [John] have him [baby Bailey] a couple of days ago and he drove past me without Bailey in the car, and I saw red as soon as he drove past without my son in the car...Just the fact that he could leave him, leave him with people that are drug addicts...” (Tenielle time 2).

Emily also idealised the role of a father for her baby, ignoring the biological father’s history of abuse.
“I don’t want Lakeisha to grow up without that male income… I just wanted to know if he was like going to participate in paying child support and stuff like that …, He’s come in to the [name of] Hospital and seen her a couple of times and he’s come in here twice… ‘cause he’s got a child already. He’s got a very bad history. He tortured the baby and he threatened to tie bricks to its feet and throw it in the dam” (Emily time 1).

Emily continued to be attached to the idea that Nathan should do more despite describing his lack of interest.

“And then people say to me “You can’t do it on your own” and like I tried to tell Nathan that I needed help and like “You’re her father so you’re supposed to step in and be the father. You wanted to be a father, so” but he doesn’t listen… I was downtown and I asked “Did you want to come see Lakeisha while I’m in town?” and he goes “No, I’m at home, I’ve got more important things to do.” (Emily time 2).

These expressions highlight these young women’s deep seated belief that these men would do ‘the right thing’ and become ‘fathers’ and their desire for this to be the case. They ignored evidence that contradicted this need in order to preserve the belief that the idealized father would come to fruition.

In addition, the struggle of ‘doing it on my own’ came through suggesting that any father is better than no father. This provides further support for the proposition that idealized views may serve as a coping mechanism, in that the belief that the father will step up and provide support to the mother is needed so that the mother feels she can be a successful parent. This was also evident in the discourse of the young women who were in stable
relationships. In these cases the young women had idealized notions about the father of the baby’s involvement in caretaking duties, which was often shattered after going home.

“Yeah and I know that he's going to let me sleep in in the mornings because her feeds at 6.30 and that what time he goes to work so I reckon he's going to sit there feeding her and that before he goes to work. Because he only works one minute away…I reckon he's going tell his boss, I won’t be at work until 7 o’clock because he starts at 6.30.” (Holly time 1).

“Yeah but he don’t be a man he just, he won’t be man?... He just goes to work and drinks and that’s all. He don’t show me love or nothing you know… and he wouldn’t even give her a kiss and that…Yeah he won’t – like he wasn’t being dad, he wasn’t, no he just didn’t show her heaps of love like” (Holly time 2).

We see that Holly was expecting the father of the baby to prioritise her need to sleep over his work, also expecting that the father would negotiate a new start time with his boss. Instead, she was confronted with a father who did not show his child love and would not be a ‘dad’. Interestingly, being a dad was also linked to the concept of masculinity with Holly believing that being a good dad was part of being a man (as opposed to working and drinking).

Early in the experience of being a mother, the young women desired and looked forward to how having their infant would be a shared experience between mother and father. The father of the baby was idealised with sometimes unreal expectations espoused, and from there, the father may have had little chance of meeting the mother’s the expectations. Further, the young women ignored contrary information from past experience, perhaps expecting that the birth of the infant would have as dramatic effect on the father as it had for
them as mothers. However, incongruence in their idealised view of themselves as mothers and their practice was also evident in some of the young women’s accounts.

**2.3 Idealised view of self as a mother.** Virtually all mothers noted that they had experience in caregiving to children either through caring for siblings or as babysitters. This previous experience was offered as though justifying their suitability for being a mother. Early in the parenting experience and particularly for mothers of preterm infants, this previous experience was deemed to be enough, and the young women lamented the lack of acknowledgement for their perceived pre-existing skills by nurses at the hospital. However, over their course of the first year of parenting many of the young women came to openly acknowledge that these skills were not enough to prepare them for parenting.

“Being your own mum is, I don’t know. I think because you’re responsible for your actions with that baby. Whereas if you’re actually babysitting them, it’s not the same thing. It’s completely different. You go home at the end of the day. Whereas you’re stuck with your baby 24/7 [laughs]. No, I really had a complete turnaround once I had my own kid. I was like, “Wow, this is nothing like that.” [Laughs].” (Bronte time 3).

Similarly, many of the young women noted that parenting was not as expected, though were rarely able to articulate why and how things were different to what was expected. Similarly, though mothers often voiced that they knew parenting would be difficult, the actual experience still appeared to be far more difficult than their image.

“It’s going to be a rollercoaster ride. I know not every kid is perfect at all. I know I’m not perfect and I can see me going, “Why did I have you, why did I get you?” And the next day it’ll be like, “Oh I love you so much.” It’s going to be a rollercoaster ride.” (Tenielle time 1).
Despite acknowledging the experience as a rollercoaster ride, Tenielle’s experience of being on the rollercoaster and who she is expected to be shocks her.

“I have a baby now.” I wanted to go to the shops because I was hungry. And I was laying there and I was like, “I have a baby now. I can’t do anything. What am I doing? Why did I do this to myself?” I was full on questioning myself, “What have you done? What have you gotten yourself into? You have a baby now, you can’t do nothing. You have a baby now, you have to do everything for this baby.” And I woke up the next morning and he was crying and crying and crying and I was just like, “I have to make you a bottle, why can’t you do it yourself? I have to change your nappy, why can’t he do it himself?” And it was a big shock to me that I had to be not only independent for myself, be dependent for him.” (Tenielle time 2).

From these comments it is clear that these young women do not have clearly developed expectations of what parenting will be despite their early assertions and justifications of suitability for the role. In addition, there was incongruence between what they state they know (i.e., parenting will be a rollercoaster) and the actual experience of being on the rollercoaster. In addition, having skills in caretaking babies (i.e., babysitting, siblings) does not necessarily translate to being prepared to be a mother. Believing that they are prepared and have the skills necessary to mother may also serve a self-protective role, helping them to manage the uncertainty of becoming a parent. However, this incongruence was not true for all of the mothers with approximately half of the mothers stating that parenting was as expected. Reasons for why some mothers may be better prepared will be explored in the subsequent theme ‘transforming self’.

2.4 Idealised view of self. The young women also held themselves to an idealised internal standard. Of note, the benchmark for this internalised/idealised standard was
primarily to not be a ‘stereotypical’ teenage mother. Therefore, the standards were of what not to do, rather than of how they should act. Further, the young women presented images of themselves as someone who was coping and managing. Part of the idealisation of self was about maintaining an impression in line with their ideal of a parent – or conversely not acting a) in line with a stereotypical young mother who dumps their baby or b) as they had been parented. At times, this ideal was held quite rigidly often resulting in the young women not asking for help or time out from others.

“I’ve got a cousin who has a baby and her child goes to her mother every second day and she goes out clubbing and drinking …And so, I don’t like leaving her with my mum, which is not good because my mum loves her to pieces but I don’t like leaving her over there because I feel that then my mum’s like “well, you’re just a party animal”…So it gets a little bit full on then ‘cause sometimes I’m just at the point where I’m like I just want to drop you to your grandmother’s but I don’t, I can’t. Like, I just feel like I can’t” (Jenna time 2).

Keeping up the appearance of being a mother who was coping was also a central part of Tenielle’s story, where her inability to admit that she was struggling, and the risk of being perceived negatively, was so great that she jeopardised her relationship with the people who may have be able to help.

“Because I’m hopeless at showing my emotions. I won’t show, if I’m upset I’ll pretend to be happy when I’m around people. If I’m around people I don’t like to show them that I’m upset. I don’t like people to think that I’m weak. And every time she [midwife] came around I was happy, jokeful, happy, doing everything. The way that she approved me and she thought, she said, “Well you’re doing pretty good as a mother.” And because I have my own doctor as well for Bailey, she said, “Well you’re
obviously you have your own GP, you’re doing really well as a single mother, so you
don’t need my help anymore…They probably think because my being me, I smile and
that and hide everything, hide my emotions, they probably think the same thing. She’s
good, she’s happy.” (Tenielle time 2).

This suggests that the young women experienced incongruities between their own
ideal of what a parent ‘should’ be and that they would often not admit that they were falling
below this internal standard. This need to impression manage often meant that they were not
honest or open in admitting that they needed help. For some, not being truthful was about
impression management, managing how others saw them, while for others it was about
avoiding the internally discomfort experienced.

“It sort of makes me uncomfortable, being around other people and their babies
because like I’m on show. I’m trying to impress them sort of thing. See who can be a
better mum than the other” (Renee time 3).

These words expressed a fear or discomfort at being compared to other mothers and
taken together these excerpts suggested young women both worried that they were not good
enough parents (not living up to their ideal and instead being typical teenage parents) and
feared that this would be recognised and pointed out by others. This then resulted in avoiding
those people, friends and family who may best have been able to help. This process may also
have shaped how attitudes and opinions towards service providers were formed.

“my old Community Health Child Nurse, I didn’t like her, but the new one I really
like her. Because the old nurse, she really criticised me. She’s like “Morgan really
needs to be eating more” this and that, blah, blah, blah. I’m like “Well I can’t force
her to eat, she eats what she wants to eat. I can’t shove a tube down her throat and
say “Eat this”… Whereas now [the new nurse] she’s going “Well she’s done very well, it’s okay if she doesn’t eat, like she’ll eat what she wants to eat when she wants to eat it”, this and that, which is good because that’s what I want to hear. I don’t want to hear someone saying “Well she needs to eat more.” (Laura time 2).

Laura’s statement ‘that’s what I want to hear’ may highlight her need for praise which lines up with her ideal image of herself as a mother rather than a perceived criticism of her inferred in comments about what the baby might need. It is unclear if the second nurse also talked about the baby’s needs but the message communicated to Laura was about her as a mother, emphasising the incongruence. Judgment about being a mother was closely connected to judgment about their knowledge and actions of caretaking their infants. Bronte for example, had this to say about her encounter with a doctor,

“[The paediatrician] was an older man but he basically looked me in the eye when I explained to him that we couldn’t figure out why Archie was screaming…he looked at me and said, “Are you telling me that by now you still don’t know what your baby’s screams are?” He was doing it in a mocking way, and I actually remember sitting there and I looked up at him and I was just like, “I can’t believe you just said that to me!” (Bronte time 3).

She continued “I felt like I was being judged as a mother and not knowing why he was crying, and then I felt that I wasn’t succeeding at being a mum, at one point, because of that” (Bronte time 3).

Thus, these young women protected against their own fears that they were not good enough parents by avoiding people who may reinforce the incongruence between their ideal of themselves as parents and their actual performance as parents. The idealization/avoidance
process here fulfills a self-protective function in directing blame away from the self; protecting against a threat to self-esteem.

The incongruence between the actual experience of becoming a mother and the ideal was less evident for a few mothers than for the majority. Skye reflected with insight on her own understandings of motherhood and herself in the role.

“Yeah, a lot more mature as you are when you get older. But I have more patience now too. Like even when he’s crying and screaming I would have just been like, I would have put him down and walked away if I was younger; I wouldn’t have coped very well at all. It’s as simple as that, I just wouldn’t have coped but now I find it easier, I just have more patience, more willing, I don’t think I was quite ready with my first one; I don’t think I was willing to give up the party life. You know, the parties and drinking and stuff. I didn’t quit smoking; I was smoking with my first child. With him I’ve quit smoking with the other. I’ve quit drinking and smoking.” (Skye time 1).

Skye verbalised the incongruence as she reflected on her own attitude to what a baby is.

“I wouldn’t even think of that when I was younger; I would have just been like, “Ew, a baby.” The first thing I would have thought of, “Oh, walking, talking baby” you know, I wouldn’t have even looked at the gap of before that and afterwards. I would have just been looking at the bit that I wanted to and it would have been like, okay, hey…I can tell you now, I wasn’t thinking of changing nappies back then, I wasn’t thinking of breastfeeding or being up at 2 o’clock in the morning to give him a feed or him crying or anything like that. I was just thinking of having a baby and carrying
around a quiet baby that doesn’t do anything, that doesn’t need anything like that.”
(Skye time 1).

The congruence and insight that Skye developed may well explain her lack of perceived challenges in parenting and overall enjoyment of the experience. Claire, Juliana and Danielle’s experiences were also consistent with this position. It is important to note that even for these mothers there was still some degree of shock and adjustment to the realities of parenting.

“It's more demanding than I realised. Well it's not so much now but in the beginning you don’t realise, like you don’t realise when you're going through it and you look back to now, to what I have to do now to what I had to do then, you don’t realise how demanding it really was.” (Claire time 2).

In summary, young mothers appeared to experience an incongruence between their idealised images of what parenting would be like and how parenting was. Where this occurred the young mothers struggled to reconcile the incongruence. The young mothers who held on to these idealised images or deep seated beliefs that contradicted the reality of their situation and everyday life also seemed to find parenting the most challenging and vice versa. Further, the young mothers who reported a less challenging transition also had a combination of internal and external resources that enabled them to better manage the transition to motherhood and preceded a process involving acceptance and change to self.
Theme 3: Transforming Self

Figure 3: Motherhood as transforming the self

The theme transforming the self, discusses how being a parent changed the young women and how they grew and developed. At the time of pregnancy (and as discussed in chapter 5) the young women were a heterogeneous group, with some women planning to become young parents and others having unplanned pregnancies. For some of the young women there was a sudden and dramatic disjuncture between who they were as young women and who they became as mothers. Associated with this was a sometimes drastic shift in trajectory away from drug and alcohol use and other risky behaviours, towards behavioural choices that centralised being a mother. After birth, there was immersion in the maternal identity for all young women, often to the exclusion or reduced salience of other identities such as young woman, teenager, girlfriend, student, employee and daughter. This was associated with self-sacrificing behaviours, where the needs of the infant were prioritised above all and the infant was central to decision making. There was a progression in how the young women framed and defined themselves from who they were as young women, to who
they became as mothers. Over time there was also a shift or return to considering who they were as young women and mothers. For many there was also a shift away from identifying as ‘teenagers’ and this was associated with a lack of identification with the ‘teenage mother’ label and a greater identification with the ‘mother’ label.

The transformational change discussed in this theme refers to the character of the changing experience of half of the participants during pregnancy and the more subtle growth and development that occurred as a result of being a mother for other participants. This is followed by a discussion of how the young women’s internal resources developed throughout the process of being a mother. Further, relationships among the concepts of internal resources, ideal actual incongruence and perceived challenge in the parenting role are explored. Finally, the identification with the label teenage is addressed.

3.1 Who I was and who I became. Many of the participants described a self-perception of who they were pre-pregnancy that was in stark contrast to who they became following the birth of their infants. The young women described the process as ‘going the other way’ indicating the way pregnancy and becoming a mother altered the trajectory for the young woman.

“Not as many people talk to me as to what they used because of like I used to go out and have fun and everything and these people still are going out and having fun and I’ve now had a kid and gone the other way. I think it’s because I’m trying to be a responsible person now like not going out and being silly and doing stupid things. I don’t think they like that at all [laughs]… But that doesn’t faze me. As long as I’ve got her”. (Emily time 1).

‘Going the other way’ was associated with personal characteristics such as responsibility, not going out, not engaging in silly acts, but also with not having fun and a
loss of friends. Further, pregnancy was seen as presenting a reason or purpose in the young women’s lives; that is, pregnancy’s role was to prevent the young women from continuing in a life trajectory that they reflected on as ‘wrong’.

“Things happen for a reason and I think having her happened for a reason. God had a reason for her. Because I think I was heading right down the wrong track. If I didn't have her I think I would be in a very sad situation.” (Emily time 3).

This perception was particularly interesting as it differs from society’s perception of teen pregnancy being the ‘wrong track’. For the young women, having a baby provided them with alternatives to going out to parties and engaging in high risk behaviours, such as drinking and drug use.

“Okay, you know how you at night time you see all the little young kids, not young but 14, 15, 16 year olds running around drunk; that’s a gribbly. So, yeah, I was one of those. I used to run around drunk all the time. I wouldn't go home sort of thing…I was on Centrelink all the time. So I was working in Youth Allowance ... not working, going to school and getting Youth Allowance. Not that I ever went to fuckin’ school” (Laura time 3).

These young women reported a dramatic change in trajectory from pre to post pregnancy, and this was still echoed in their stories 12 months later suggesting that changes made during pregnancy were maintained overtime. As such, pregnancy resulted in a long term change in trajectory and movement away from high risk behaviours.

“I’ve been a lot more quieter. I don’t drink as much. I used to drink heaps before I fell pregnant, now I’ll be lucky to even go to the pub, or go to the bottlo to even buy any drinks and anything and…I just don’t want to. Because that means I have to find,
if I want to drink that means I have to find the money to drink. And then it means I have to find a babysitter. Then it means I have to make sure get him all organised. And then it means while I’m drinking I have to sit there and wonder what he’s doing, whether he’s awake, whether he’s asleep, or whether… It’s just not worth the effort.” (Tenielle time 3).

Tenielle’s narrative also highlights the centrality of the infant in decision making and in the thought processes of the young women. Further, becoming a mother changed the way young women lived their lives day to day in practical terms as they shifted from being students or employees to stay at home mothers.

“It’s great, I love it. It’s certainly different to what I’m used to because I’m used to just going to school and coming home and doing everything how I want to do it. But now there’s a bit of variation where I have to go to attend to her and I have to put her to sleep and I have to bath her and I have to take her for a walk if she’s not settled. It’s got me out of place and I’m like, wow, I like this, I’m not on a regular routine now. But I’m starting to get back into a regular routine but it’s with her, not my old regular routine.” (Laura time 2).

Not every participant experienced a major trajectory shift as a result of becoming a mother. For some, the shift away from the ‘typical’ teenager had already occurred. A number were in long term relationships and two had planned their pregnancies. For these mothers there was not the same dramatic shift in trajectory. Instead, becoming a mother fulfilled an existential need. It was the fulfilment of their plans to create a family. Claire and her fiancé had planned to become parents and also had structured plans for 3 more children.
The discourse around pregnancy and parenting for Claire was centred on the premise that this was her path in life.

“We did plan it because, yeah, we’re not – I’m not the type of person who likes to go out and party. I’m more of a family oriented person... we’ll have another one just after we get married...We plan to have 4 kids so. Yeah, so we’re happy with that”. (Claire time 1).

Being a mother changed the way the young women viewed themselves and many of the young mothers talked of how having a baby gave them meaning, gave them a role they could fulfil, and a sense of purpose in their lives: That, in essence, it created who they were and fulfilled their life dreams. For several of the mothers becoming a parent had been a planned action designed to ease the sense of emptiness and loss caused by previous miscarriage, and to fulfil a perceived life purpose.

“That’s the reason why I wanted him cause I had nothing else, I had no career, nothing you know, and I’m not like, I’m not one of these teenagers who want to go our clubbing and do the whole drinking; I did that, I’ve done that. It’s not that and I wanted something just to do with my life… Cause there was nothing there and now my day’s not going to be empty, I’m not going to be lonely and I’m not going to be bored”. (Skye time 1).

Overwhelmingly, becoming a mother was positive and though often indescribable, always “good”. As such, we see that becoming a mother provided the young women’s self-concept with positive attributes often filling what was previously a predominantly negative view of self.
“You know I look at him and it feels like I finally did something right., it’s good” (Renee 2).

“I am important now I have to do it… they’re not going to be looking after him for the rest of his life, I’m going to be looking after him” (Jade time 1).

The infant was also perceived as an extension of the self - a part of themselves out in the world.

“It’s just a really really good feeling being able to hold her something that you’ve made. Its good” (Juliana time 1).

“It’s positive because I’ve got a part of me out in the world now” (Emily time 1).

This suggests that being a mother filled an important purpose in the young woman’s lives, creating meaning and giving direction. It was also, for some participants, an opportunity to do things differently from their own childhood experience and to provide their children with opportunities that they had not thereby filling needs that may not have been met in their own parent-child experiences.

“In a way when I first fell pregnant I was happy that I fell pregnant but then I wasn’t because I was just scared that she couldn’t have, I just want to give her a life that I never had… I cried all the time. Only because I was scared that I was like I wasn’t going to be able to give her a good life and that but I've just got to keep trying my hardest to do that for her.” (Holly time 1).
This developing sense of maternal identity was also enacted through identifying with the ‘mothers instinct’. All of the young women discussed the sense of mothering coming naturally and how they just instantly had a place for it. This mother’s instinct provided reassurance and self-confidence to the young mothers demonstrating inwardly that they would be successful in this role. This role, as different from other previous roles, was something that they were ‘instinctually’ able to do. Further, it bonded them to all women and mothers as it was something inherently associated with being female.

“Female instinct, mothering instinct kicks in. Yeah, like breastfeeding... I just started doing it and mothering instinct just kicked in.” (Skye time 1).

Associated with the development of the maternal identity was a sense sacrificing the development of other aspects of self, at least for a while. Perceptions were that life is long and parenting shorter, that there would be time later for ‘things’ or for the mother to become who they wanted to be through education, work, or social life. The predominance of the developing maternal identity meant that mothers suspended the development of their individual and other social identities, perceiving that there was time in the future for this to happen.

“Got the rest of my life ahead of me so it doesn’t really matter for the time being… can’t do as much but I’m pretty fine with it.” (Juliana time 1).

This sacrificing of the self continued in the months after giving birth with the sole focus and priority placed on the infant’s needs. Often, this meant that mothers did not even do relatively small things for themselves.
“I have double eyebrows…I haven't had time to do anything. My main focus is him, as long as he's happy and healthy, that's all I want. That seems to be the thing with me.” (Bronte time 2).

The needs of the infant were prioritised above all else.

“…she always comes first before, before relationship stuff, before household stuff, before bills, before anything...” (Emily time 3).

“…it’s not, she works round our plans, we work around her plans and so...” (Jenna time 3).

All the women experienced a shift in focus as their individual self moved out of focus and the maternal identity came to the fore. The infant became prioritised with the young women working around the infant rather than themselves.

Over time, the priority shifted back to considering who they were outside of the parenting role. By time 3, most mothers were beginning to think about a return to work, training, or other self-focussed activities. Bronte highlights this transition over time.

“…I think finding myself as a person again was another issue too, because you change…I have started to find myself again. We’re on a long road here [laughs]... “Then I think it’s just the change in general, such a massive thing. You think you've lost yourself but you really haven’t. We’re back on the road. We’re getting there. I feel more like the old Bronte” (Bronte time 3).

Bronte continued, explaining how she perceived changes in her sense of self – her identity during the process of being a mother.
“You’re a teenager and to put on that role as a mother, you do change. Now I’ve got both sides. At one point I didn’t have me. I had the mother in me, but now I’m getting the old Bronte back and I’m a mum as well. So it’s just really learning to take on that role and being comfortable with it, I think…I think you have to be a mum but you also have to show them that you have, you’re your own person…” (Bronte time 3).

The goal then became about developing those aspects of self unrelated to their parenting role. However, feelings of guilt and selfishness were experienced when young women did not put their infant first, when they did things for themselves, took time out or bought things for themselves.

“I hate making people babysit her or I hate leaving her because it makes me feel like I'm a bad person. Mum used to just leave us with somebody or alone and I don't want to follow in her footsteps. I don't want to look like a bad person and I don't want to feel like a bad person.” (Emily time 3).

The young women experienced negative affect when they perceived that they were not fulfilling their roles as mothers suggesting that the management of negative affect is another skill young women need to contend with.

Becoming mothers provided the young women with opportunities to grow and develop. They described themselves as becoming more mature, less self-focussed (egocentric), and more other-focussed as a result of becoming mothers.

“Just making me wake up and grow up and see the world in a different way. Rather than all about me, it’s not all about me it’s all about her now. It’s different. As like being a young mum instead of an older mother you’ve got all your stuff set out and you’re mature and you already know everything. Whereas with me I was young and
just wanted my life, I wanted to have fun and wanted to run amuck, and then she turned up and everything changed. But that’s why I’m saying it’s good. It’s made me stop and think and grow up a bit. (Lily time 3).

Prior to becoming parents, most of the young mothers had not had opportunities to crystallize who they were or to develop a sense of confidence and competence in who they were. For these young women the lack of confidence carried across when contemplating being a mother. For Laura, this meant looking to external sources, including a psychic, to provide reassurance that she would indeed be a good mother.

“Well, um, apparently the psychic said that apparently I’m going to be a really good mother, and I’m going to give her a different life to what I have, had, and I’ll be like a good mum apparently.” (Laura time 1).

This suggests an initial lack of internal belief in the ability to parent. Instead, the sense of confidence in parenting emerged over time as the young women became more familiar with their infants’ needs and settled into routines. The belief then was that they would be able to cope no matter what the challenges were ahead.

“Sometimes it gets a bit hectic but you know but I pull through…It has been a bit over the place but I am I know how to get through it” (Holly time 3).

Some mothers also reported the development of positive characteristics associated with becoming a mother such as becoming more cautious, more organized, more prepared, and more responsible. This in turn was associated with this was the notion of being grown up and making responsible choices, choices that now prioritized the infant rather than the mother.
“I was out about six months, seven months [pregnant] when I got this house... I thought my baby needed his own room. Needed to start doing things on my own. Like having a baby you need to be independent and wanted to be able to do it. So I didn’t want to rely on my Mum too much.” (Danielle time 1).

One mother also reported that she saw good and bad differently as a consequence of her experience, often standing up for things she believed in. For others, the infant became the drive to succeed and to push on, suggesting a motivational role.

“I did not care what I did, but, ‘cause now I do care…You’re cautious with everything really.” (Danielle time 3).

“you have morals when you have a baby… we kind of want to make the world a better place for them. But yeah it’s just insane how things change” (Jenna time 3).

However, it also became apparent to the researcher that the development of internal resources such as developing confidence and competence, becoming more organized and patient, and developing more resilience to negative judgments and increased assertiveness, was a process over time. That is, for most mothers self-growth, development, and change continued throughout the process of doing mothering. Most of the young mothers experienced a growth in their confidence as parents and alongside this was more trust in themselves and belief in their ability to do the best for their infants.

“You don’t have to listen to everything they say. Sometimes you just know best. Sometimes just as a mother you can just listen to yourself. Listen to yourself before you listen to anyone else…Sometimes I know better than anyone. A lot of times I know better than anyone.” (Lily time 3).
Further, the young women described how over the course of the year they perceived that they had become strong minded. This enabled them to stand up to criticism or unwanted advice from others.

“Before when people could tell me things sometimes, like to bring me down and whatever. Before ‘cause I was so, I don’t know, just the fact of being a new mum, the stress, the emotions that you go through it’s like, “Oh okay, they’re right.” But now it’s like, “Whatever. Not listening to you.” ‘Cause you kind of get more strong minded.” (Jade time 3).

This increased confidence and competence in parenting also meant that most mothers perceived a reduced need for support from others over time.

“[the need for support has] gone right down. I don’t need as much help anymore. it’s not really challenging; I know pretty much everything now.” (Danielle time 3).

The young mothers also reported becoming more organised, utilising various strategies in order to achieve this.

“This year I’ve got myself a diary and I’ve been writing everything to do with Bailey in it. Yeah. Everything, all of his appointments, Mum’s groups, his days he goes to day care, his days that he’s due for a new tin of formula and days that he’s due for nappies, everything. [Laughs] (Tenielle time 3).

As parents the young women were able to derive a sense of pride and their infants’ achievements.
“No matter whether it's like, it could be cleaning every day or whatever but at least you can look back and be proud of yourself... I'm very proud of myself... Yeah, and you look at your responsibilities and once you take care of your responsibilities you can be proud of yourself, and I'm proud of how Lakeisha is.” (Emily time 3).

One domain where significant shift and change occurred was with plans for the future. Prior to having their infants the young mothers reported plans for their future that were usually abstract and grandiose, with little thought given to how the goals would be achieved. In addition, early goals tended to be self-focussed with little consideration of how having an infant would alter them.

“I have yes I have heaps of plans for the future. I want to be a horse trainer and ummm all that. I can still do it, I can still study and that just it’s going to take longer than what I originally planned to do. I was going to, before I fell pregnant. I was going to work to save up and um so I could study and then I was going to get all of the certificates I needed and then work again and save up and get my own property and then I was, what I want to do is get, have a station and get like, have two houses on the property and have enough horses and equipment and stuff so I can like all the youth students, all the youth kids and that that are out on the streets and that having like having a program where they can stay out and work with horses and learn how to do like farm work and that. They’ll probably realise there is more to life than like drugs and all that.” (Tenielle time 1).

However, over time the young women tended to shift to less egocentric, abstract goals.
“Hopefully a new job… And that’s pretty much, yeah. And today I have a job interview at 2.00… It’s a service station with a car wash down the road, about ten houses down. It’s about a 10, 15- minute walk away from my house.” (Tenielle time 3).

We can suggest that a grounding process occurred whereby the young mothers shifted their goals and plans to ones that were more concrete and achievable. This may be related to normative cognitive changes and/or it may be related to the universal process of being a mother wherein, regardless of age, the mothers became more aware that the parameters for goal attainment have changed. Either way it suggests that part of the growth and development that occurs for teenage mothers is in planning and setting of achievable goals.

Overall, the young women developed many internal resources as they adjusted to and became, mothers. Some of these, such as becoming more organized and patient, occurred out of necessity as they struggled through the adjustment process. Others included becoming committed or strong minded, which lessened the impact of negative judgments. Mothers reported becoming increasingly resistant to negative judgement as they rose in confidence and understanding of what was right for their infants. This often translated into increased assertiveness as they stood up for their decisions and parenting practices in the face of negative judgment. One thing that appeared to aid young mothers in their development of parental efficacy was realising that others, including professionals, were not always right.

“[The doctors were saying] you know, there’s nothing wrong with him.” And I kept looking at his doctors and go, “I know he does.” I could hear him cough. And then they got a doctor to fly in from Sydney who walked straight in and went, “Oh, he’s got whooping cough,” and I went, “Wow, congratulations.” (Renee time 3).
The more the young women were shown to be correct in trusting their instincts, the more confident they became in their parenting ability. In addition, they described the process of learning through accessing advice from multiple others, using trial and error, and eventually moving to an integration of their best guess and trial and error. The ambiguity surrounding parenting and what may or may not be best for their infants, while initially causing distress and high levels of uncertainty, eventually became the catalyst for trusting their own instincts and developing their confidence.

Also notable was that some young women had had previous opportunities to develop these internal resources and it was those young women who experienced the least amount of challenge and most enjoyment from parenting. Two young women’s narratives reflect a contrary experience: Claire and Julianne. Both mothers appeared to be confident and competent in their parenting ability from the outset and did not express uncertainty nor a lack of confidence in their role. This influenced their experience in many and varied ways. For example, both Claire and Juliana had atypical hospital experiences, with Claire staying in hospital for 3 days (normal stay is 24-48 hours) in order to access as much support from midwives as possible and Juliana reporting positive relationships with the midwives and other parents in the SCN.

“I reckon – like people go home early but I would never. I stayed the whole three days or whatever you are supposed to be there but yeah so it was really handy because you just press a button and then you ask questions. Ring the nurse, ring the nurse…So yeah I liked the support yeah. Yeah and if he was upset or something or you know like little questions. I had no idea what was wrong with him and they would help out and then you know you can go away and I’m happy again to take care of him and they helped heaps while I was there.” (Claire time 1).
In addition, both young mothers presented as assertive in their parenting roles, able to stand up to grandparents in order to assert their own rules for their infants.

Claire (T3): “see they have different views on parenting, he’s throwing things on the ground and I pick it up a couple of times and he does it again I say, “No, that’s enough, you’re not having it anymore,” where Jim will go, “I’ll keep doing it for you, Austen,” and I say, “No.”

NS: So does that cause any problems or how do you …

Claire (T3): No.

NS: … manage that, like …

Claire (T3): Well, I just tell him.

NS: Oh, okay.

Claire (T3): I just say, “No Jim I said, no,” and he goes, “Okay.”

Further, Claire noted that she had had a vision and had been saving money for her future plans, making her financially secure. In addition, the desire to become a mother, though strong, did not overrun the practical considerations of becoming a mother.

“I just always wanted to have a family, I always wanted to make sure that I had – like I wouldn’t have had Austen if I didn’t have a home to live in.” (Claire time 3).

Of potential importance, Claire had completed high school, begun university, and had worked in a semi-professional role in a financial company prior to becoming pregnant. Similarly, Juliana, despite leaving school in grade ten had completed a TAFE course and was working as a beautician prior to her pregnancy. Both women were in stable relationships with men who owned their own homes and had secure employment. These factors suggest that both women had opportunities to solidify who they were prior to the pregnancy, and had developed a range of internal resources, which may have added to their sense of confidence.
in parenting. Danielle and Lily also shared some of these characteristics but had not fully
developed professional identities prior to their pregnancies. Further, these women had
external resources in terms of family support and were able to access this support.

In contrast to these four women’s experience, most of the other young women in the
research developed internal resources as a result of parenting - the development of these
internal resources occurred via the process of being a mother over time. Further support for
this proposition is seen in the young women’s self-reports of their parental self-efficacy (as
measured by the parental efficacy scale; Reece, 1992). Two important trends can be seen.
First, self-reported efficacy increased over time. Second, some mothers reported higher
efficacy early in the parenting experience than others. Those mothers who had developed a
sense of competence prior to being parents reported early efficacy in the parenting role. For
others efficacy increased over time as they came to know their infants and their infant’s
needs. For all mothers, the increase in efficacy was associated with parenting becoming
easier overall. Thus, the development of internal resources is related to the perception of
challenge in the parenting role and changes in these perceptions over time.

Table 4.
*Changes in perceived self-efficacy in the parental role over time*

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<thead>
<tr>
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<th>Time 1</th>
<th>Time 2</th>
<th>Time 3</th>
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<tbody>
<tr>
<td>Bronte</td>
<td>87</td>
<td>79</td>
<td>90</td>
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<tr>
<td>Claire</td>
<td>74</td>
<td>90</td>
<td>86</td>
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<td>Danielle</td>
<td>62</td>
<td>60</td>
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<td>Emily</td>
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<td>Holly</td>
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<td>Jade</td>
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<tr>
<td>Jenna</td>
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<tr>
<td>Juliana</td>
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<td>Laura</td>
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<td>Lily</td>
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<tr>
<td>Lisa</td>
<td>68</td>
<td>84</td>
<td>82</td>
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<tr>
<td>Renee</td>
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<td>89</td>
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<tr>
<td>Tenielle</td>
<td>63</td>
<td>73</td>
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</tr>
<tr>
<td>Skye</td>
<td>64</td>
<td>-</td>
<td>88</td>
</tr>
<tr>
<td><strong>MEAN</strong></td>
<td>69.93</td>
<td>78.07</td>
<td>86.57</td>
</tr>
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Note: high scores indicate increased self-efficacy in the parental role. (maximum score = 100)
3.2 The inter-relationships between internal resources, incongruence and perception of challenge. As previously discussed, the young women faced an incongruence between the ideal and actual self and other. However, after parenting for 12 months much of this incongruence appeared to have been resolved. Interestingly, the mothers appeared to have shifted from a focus on external solutions to their problems to an internal focus. Renee’s narrative exemplifies this. She began with an idealized view of home, of her partner, and of her infant. Early statements from Renee highlighted that things would be easier when her infant was transferred back to a closer hospital, when her infant was home from hospital, when her infant was more independent, or when her infant was older. There was a real sense of her blaming the infant when things were not easy or when things went wrong.

“If he didn’t drink a bottle I’d get the shits it took me so long to get the milk and everything. I blamed him for everything pretty much.” (Renee time 3).

However, in reality things became easier when Renee herself adapted and changed to the demands of the infant. Accordingly, Renee noted that becoming organized, prepared, patient, and confident made the experience of parenting her infant much easier. She then resisted disruptions to her established routine.

“Just to be prepared, I think. Preparation is definitely the key to being a good mother. I think I like to wake up earlier than him now and have everything ready, so when he wakes up he can be fed straight away… So if you have a nappy there ready and have everything in the shower ready, so everything is done and you’ve got to get yourself into a routine. It would be boring as, doing the same thing every day but you get the break you need when they’re happy.” (Renee time 3).
Here Renee was able to identify several key internal resources that she developed over time such as being prepared and organized and these echoed those that were seen in Claire and Juliana’s narratives. The paradoxical effect of prioritizing the infant’s needs over the mother’s needs is that it made things easier for the mother.

In sum, the development of internal resources during the experience of mothering inevitably reduced the perceived challenges associated with parenting. Some mothers had the internal resources prior to pregnancy and for these mothers the transition to parenthood appeared to be less challenging. However, for most young mothers the process of being a mother shaped their confidence and competence and provided an avenue for them to develop and grow over time. As they grew they became better able to manage the demands of the infant.

The relationships among ideal/actual incongruence, development of internal resources and perceived challenge can be visually represented by returning to the visual maps previously presented. In theme 1 the young women were mapped on ‘enjoyment in the parenting role’ and ‘perceived challenge’ dimensions in order to demonstrate the dual nature of parenting. To demonstrate the inter relatedness of these concepts young women are now mapped on ‘degree of incongruence’ and whether they are ‘highly or poorly resourced’. The stability of some of the mothers over time then can be seen to be a result of pre-existing internal resources and little idealisation of the parenting role. In contrast, change over time can be seen to be a function of increasing confidence, competence, growth and development as well as a reduction in the incongruence.
External factors such as support from others also played a role in a young woman’s experience of being a mother. As outlined in chapter 5, the young women came from a range of backgrounds and had different access to appropriate support from friends and family. Young women such as Tenielle, Emily, and Holly came from chaotic family systems involving drugs, alcohol, violence and child safety interventions. Their family systems were
often highly stressed and less able to provide support when needed than some of the other young women’s families. Most of the other young women came from fairly stable family systems that could help support the young women to varying degrees. In this way, support or family systems could represent a third independent dimension in the concept maps above. However, it is argued here that mediating the relationship between accessing available support (external resources) and perceived challenge in parenting were the incongruence between actual and ideal images of parenting and the young woman’s internal resources.

Much has been made of the role of support for successful parenting as a young woman. However, if a young woman perceives a discrepancy between her own ideal of a parent and her actual experience of herself as a parent, she is unlikely to access help or admit that she needs help. Similarly, young women with internal resources had both a reduced perceived need for support and were better able to negotiate autonomous support. This suggests that despite having available support, internal factors contribute to the young woman’s willingness to access that support.

In summary, the time pre-pregnancy was a time of typical adolescence for most of the young women where egocentrism predominated and little thought was given to concrete plans for the future. For some young women becoming mothers altered their trajectory away from high-risk activities, and refocused their attention on a separate entity, their infant. In the interviews these young women tended to make self evaluations comparing and contrasting themselves with who they were and who they had become. The parenting domain became focal for developing a sense of competence and confidence in the self, as well as for developing a range of resources. In turn, this allowed the women to better manage, reducing perceived challenges. For other young women the shift in trajectory was more subtle as their pre-motherhood lifestyles were more compatible with parenting. However, changes to the self were similar for all as the maternal identity came to the fore and other aspects of self
were sacrificed for several months. Over time, the young women began to consider who they were as women and mothers. However, noticeably absent in their conceptualisations of self was identification with teenage mothers.

3.3 Lack of identification with teenage mother label. As highlighted in the themes above, when talking about their experiences of being a mother the young women would use terms such as ‘mother’, ‘mum’ or else drew on the global label ‘female’ to describe the normality of their experiences rather than designating themselves as ‘teen mums’. When asked what differences they felt there were between adult mothers and young mothers all of the young women either stated none, or else noted practical considerations such as having a car and house. No young mother perceived that they had less ability or competency to parent than an adult mother.

“I was perfectly comfortable [at adult antenatal classes], I was just like “I’m pregnant just like you there’s nothing different apart from our age... I think a lot of them were like, you guys are really young to be having a baby’, but it’s not their business”.
(Jenna time 1).

This suggested that the experience of being a mother was one more closely related to being a woman than being an adolescent; but the young women needed to find arguments for why they were not typical teenage mothers.

“I guess it’s harder because if you love being a mum you just love – you’re just good at it, I guess, but I think I’m a different kind of young mum to what most young mums – I think a lot of young mum’s I know are – there are probably a lot of mum’s like me, but I think there’s a lot of young mum’s that don’t plan on being a young mum where we planned Austen. So I think that’s a little different, as well. I don’t know, I
think – I think a lot of people probably judge me in a way, they probably don’t know who I am, they probably think, maybe – I don’t know. I think a lot of people think that Austen was an accident, which it does happen to a lot of people. Like I feel – I get that impression, people look at me, think, oh, well, she’s only a young mum, they think that I probably am not a really good mum.” (Claire time 3).

For some there was a complete denial and separation from the teenage label and identity, especially in relation to being a teenage mother. There was an active differentiation from other teen mothers and a focus on traits they had that the stereotypical teen mother did not (i.e., responsibility) regardless of whether they had planned on unintended pregnancies.

“It is, it’s a massive responsibility. Sadly, some teenage mums take that, they don’t take that responsibility importantly [laughs].” (Bronte time 3).

Several of the young women did not want to actively associate with other teen mothers. This often meant the young women resisted joining young parents programs or other programs targeting teenage mothers.

“although there are lots of young mothers around, I don’t want to associate with them [laughing].” (Jenna time 3).

Despite their age being within the range of ‘teen’ age, some mothers clearly felt that their teen years were in the past. Being in a committed relationship and being a mother moved the young women out of the teenage domain. ‘Teenage’ was a mentality or attitude rather than an age.

“…we’ve just hung out as teenagers and then we sort of started dating and then got engaged last year in September.” (Claire time 1).
Temporal consideration of what Claire said implies that her sense of being a teenager was in the past. This indicated a lack of identification with ‘teenage’ identity. Instead, we see identification with and salience of the relational self.

For one young mother, there was a growing realisation that she was no longer the child in her family system.

Jade: “I took him [the baby] to Dreamworld…it was the day before Mothers’ day and I said, “I really want to go to Dreamworld.” ‘Cause I’ve been there before but I’m still a kid a heart though. I’ve grown up, I do responsible things, I think I can choose wisely but when I’m at a theme park I go crazy. It’s like, “Oh my gosh!” Like you’re a little kid again.”

NS: **Wanting to go on everything?**

Jade: Bright lights attracted me and stuff. But then I had to realise I had a baby with me that couldn’t go on any rides, that couldn’t do anything at all, and I was like, “D’ah.” When I got there I realised I was not the kid anymore. (Jade time 3).

Taken together, these narratives suggest a moving away from or at least a separation between being a mother and being a teenager. Importantly, young mothers did not see themselves as different to older mothers, they did not categorise themselves in terms of age in relation to mothering. As such, being a parent appeared to change the way the young women categorized themselves. For some of the mothers, ‘preterm’ became a salient identity for their infants suggesting that a premature birth may create a salient identity category.
Summary

To conclude, the experience of being a mother as a young woman and in the context of a preterm birth has been explicated by the three themes presented in this chapter. First, being a mother can be described in terms of polarities – good moments and challenging moments – highlighting the dual nature of parenting. The day to day existence was experienced by young women as both full of pleasurable moments spent with their infants combined with challenging moments as they managed the sometimes chaotic worlds around them and the needs of the infant. The young women contended with instability and uncertainty about what was best and right for their infants as well as situational challenges related to housing and transport. However, there was considerable variability in the perception of the challenges faced by young women.

Preterm birth compounded these everyday challenges of motherhood for young women by emphasising transportation difficulties and placing women in more frequent contact with people who they perceived negatively judged them. Further, the young mothers of preterm infants contended with the separation from their infants. However, while preterm birth did lead to more challenges, it did not detract from the enjoyment and knowledge that they were mothers and this was the predominant focus of the women’s stories.

The second theme demonstrated how young women idealised the experience of being mothers and how reality of the lived experience did not marry with the idealised image. It was proposed that idealisation served a self protective role for some of the young women, to help them defend against fears of not being good enough or not being able to cope and/or idealisation served as a coping strategy for others as they wished for an easier future. This was particularly pertinent for young mothers of preterm infants who idealised home as the place where things would be easier. The greater the degree of discrepancy between the idealised image and the actual experience of being a mother, the more challenges the young
women perceived with parenting. Further, young women with large discrepancies between their ideal and actual images of self were less likely to ask for help for fear that others would label them as inadequate mothers and thus emphasise the discrepancy between their idealised and actual views of self.

The final theme highlighted that becoming a mother transformed the way the young women viewed themselves. Despite the heterogeneity of the young women’s pre-pregnancy experiences, becoming a mother resulted in the young women defining themselves primarily as mothers. Alternative identities, such as teenager, daughter, sister, student, employee etc, initially became less salient as the women devoted themselves to the infant. This was often accompanied by sometimes drastic behavioural changes and the women saw motherhood as altering their trajectories away from delinquent behaviour, instead giving them meaning and purpose in life. Over time, the young women’s identities became more defuse and more time was devoted to developing other areas of self. Also important in this process was that, for most, motherhood provided the vehicle for the development of internal resources such as organization, patience, reduced egocentrism, confidence in self and competence in their ability to succeed.

The interrelationships between these themes also suggested important factors that contribute to a positive transition to motherhood. Those mothers who had previous opportunities to develop confidence, competence, and self efficacy, perceived fewer internal challenges in the parenting experience. These women appeared to be able to generalize efficacy to parenting and had less self-doubt in their ability to parent. This meant they were less likely to idealize self or other as there was little need to defend against fear and uncertainty about whether they could parent.

For others, motherhood was the vehicle for change. Being a mother resulted in behavioural changes as they reduced drug and alcohol use, cognitive changes as they thought
more concretely about the future and less egocentrically, and changes to self as they
developed internal resources and a positive self image. Early in the parenting experience
these women were more likely to idealize themselves and others in order to cope and to
defend against fears that they would not be good enough mothers. Parenting was more likely
to be perceived as challenging. However, over time these young women relied more on
themselves and less on idealization and, in turn, perceived parenting as less challenging.

As a final note, external support and family background factors, reviewed in chapter
5, also interacted with the core themes explicated in chapter 6 but were not central to the
experience of being a mother. Young women differed in their willingness and capacity to
access support. Those young women with discrepancies between their idealized and actual
view of self as parent were less likely to access support or admit that they needed support for
fear that this discrepancy would be emphasized and reinforced. Similarly, young women
from chaotic family backgrounds were less able to access support as others in their networks
were often contending with multiple challenges and instability themselves. Some young
women had few problems in accessing support and used support effectively to manage
parenting. These young women were more likely to have stable family systems and were
more likely to have confidence in their parenting ability. So while support was important, it
was internal factors that influenced the young women’s ability to access it.

The next chapter will discuss how these findings answer the research questions
proposed at the start of the thesis and expand our understanding of what the experience of
being a mother is like for young women who experience a preterm birth.
Chapter 7: Discussion

The current research project explored the experience of being a young mother in the context of a preterm birth. Although a significant body of literature exists on having an infant as a young woman and a second body of literature exists on having a preterm infant, little is known about the experience of being a young woman who had a preterm infant. The current chapter will review the findings of the current research by firstly addressing the research questions and discussing how the key findings add to what is known about a) the experience of preterm birth and b) parenting as an adolescent. Theoretical and practical implications will then be discussed and limitations of the research, along with suggestions for future research, will be proposed.

The aim of the current research was to explore the complexities of being a mother for young women by developing our understanding of how young women experience the transition to motherhood in the context of a preterm birth. As such, the questions this research sought to answer were:

- How do young women experience being a mother in the context of a preterm birth?
- How does having a preterm infant change the experience of being a mother for young women as compared to young mothers of full-term infants?
- How does having a preterm infant alter the experience of being a mother over the first year of the infants life?

In answer to the research question, “how do young women experience being a mother in the context of a preterm birth?” the current findings suggest that the experience is characterised by polarities in that being a mother is comprised of both positives and challenges. This was reflected in the first theme ‘the dual nature of motherhood’, which discussed the day-to-day joys of motherhood along with the challenges. While there were few
differences overall between the experience of mothers of full-term and preterm infants the findings did suggest that the birth of a preterm infant did bring additional challenges for the young women, but only at time of infant hospitalisation. These included difficulties inherent in the hospital system, situational difficulties, and managing the emotional side of the experience. These challenges signify both similarities and differences in the experience of having a preterm birth for young women and what has been previously reported by older mothers of preterm infants.

Consistent with the experience of preterm birth in the adult literature, the young women in the current research reported distress associated with the separation from their infant and the relinquishment of control for care of their infant to nursing staff (Affleck & Tennen, 1991; Miles, Burchinal, Holditch-Davis, Brunssen, & Wilson, 2002). This was often managed through creating a sense of predictability and control, by creating milestones and indicators of progress of their infants. Some mothers also coped by allocating tasks and roles to themselves and nurses in terms of feeding, bathing, changing versus medical care. Others engaged in social comparative processes, specifically downward comparisons were used to assess progress, normality, and to reassure the young women that others were worse off. These ways of coping have also been commonly reported by older mothers, suggesting a similar response for all to a preterm birth or hospitalisation of a child (Affleck et al., 1991; May, 1997; Yetman, 1999). In particular, downward comparisons are a common and adaptive way of coping in response to a preterm birth (Affleck et al., 1991). As such, age does not appear to be an important categorisation for defining experience in this context.

The current findings highlighted the difficulties the young mothers experienced in leaving their infants behind and the notion of the absent baby. This is also similar to experiences of older mothers suggesting it is a common stressor for most who have a preterm infant (Cleveland, 2008). The young women in the current research reported that they sought
to develop the connection to their infants outside of the hospital environment and outside of physical proximity to their infant through the use of photos and establishing routines at home. This suggests that the young women enact motherhood in the absence of the physical baby. While bonding in the absence of the physical baby has been reported by older mothers (Affleck et al., 1991), the current findings highlight the specific ways that young women engage in mothering. This has implications for staff in nurseries working with young women, who may be able to assist the young women (discussed more below).

The young women also reported that the experience of a preterm birth was one of emotional upheaval compared to young mothers of full-term infants. That the event is more emotionally challenging than full-term birth is consistent with research conducted with older mothers of preterm infants. In particular, Pederson et al. (1987), found that the majority of parents whose preterm infants were classified as well still reported that the event was emotionally distressing. However, overall, the young women in the current research did not appear to be experiencing high levels of distress. This is in contrast to the findings with older mothers, that a preterm birth is highly stressful and the worst life event they have experienced (Doering et al., 1999; Whitfield, 2003). However, the lack of distress is in keeping with the lack of differences in anxiety, self-esteem and stress reported between older mothers and adolescent mothers of term and preterm infants in Field et al.’s 1980 and follow up (Stone et al., 1988) study.

In contrast to older mothers of preterm infants, the young women in the current study did not report concern about the infant’s outcome, the infant’s appearance or the sense of loss associated with the expectation of giving birth to a healthy infant. These are factors associated with distress for older mothers (Affleck & Tennen, 1991; Affleck et al., 1991; Miles, 1989). The differences in these results, particularly concerning the worry about outcome, may be a reflection of the sample, in that most mothers in the study had infants with
no major health concerns. However, the fact the young women were not reporting a sense of loss associated with not having a healthy infant suggests that this event did not violate their expectations about becoming a mother. That is, older mothers may well have more defined expectations of what becoming a mother ‘should’ be like, and this is violated when they have a preterm infant (Whitfield, 2003). Alternatively, young women have been shown to have less well defined knowledge and expectations of motherhood (Condon, Donovan, & Corkindale, 2000; Delmore-Ko, 2000; Parks & Arndt, 1990) and in the context of a preterm birth, this may be a protective factor. Further, the young women relished the fact that they were now mothers and a preterm birth did not detract from this.

Young women of preterm infants in the current study had to contend with a number of challenges that were more common for young women than for older mothers by virtue of age and experience. These included lack of stable housing, limited access to transport, and limited access to money. Many of the young women were not old enough to have obtained their driver’s licences and those under 16 years of age could not sign rental leases on properties. Further, factors that many older mothers may take for granted, such as having a bank account, were a challenge for younger mothers who were unable to receive government parenting payments without appropriate documentation and bank accounts. As such, lack of their own means of transport, reliance on others or public transport for pick-ups and drop offs, or limited money to purchase fuel or public transport tickets interacted with the experience of being a mother to make the experience of having a preterm infant more difficult. Time spent arranging things like parenting payments and housing and an inability to get to or from the hospital meant that the young women were often unable to spend as much time at the hospital as they would have liked. This in turn increased frustration and influenced their ability to connect with and care for their infants, and may have contributed to poorer relationships between the young women and nursing staff. The young women then perceived lack of
understanding and increased negative judgement from hospital staff. Previous research suggests that older mothers watch and learn in both the NICU and SCN not only about the system but about their baby and mothering (Affleck et al., 1991). The ability to watch was hampered for young mothers in the current study both because of the logistical issues that they faced in terms of transport and because they felt they were being judged. This may have created reasons to stay away from the nursery with ongoing repercussions for mother and infant.

Despite the challenges discussed above, the predominant focus of the women’s narratives was on how becoming a mother had transformed the way they saw themselves and the enjoyment they now experienced as a result of becoming a mother. Theme 3, transforming self, discussed the way becoming a parent led to sometimes transformational change for these young women. Having an infant in the special care nursery did not change or take away from this fact. Instead, the young women saw themselves as ‘mum’ suggesting that the experience was one of being a ‘mother’ not of being ‘preterm’ and not of being ‘teenage’. Preterm birth appeared to have little impact on identity development as the transformation of self was related to becoming a mother (discussed in more detail below) rather than being linked to the preterm label. This is in contrast to previous findings with older mothers, which suggested the development of maternal identity may be delayed for older mothers of preterm infants (Mercer, 1995).

The lack of identification with the teenage label may also have contributed to difficulties between young women and hospital staff. The young women did not see themselves as ‘teenage mothers’. Instead, they viewed themselves as being mothers and becoming a mother was associated with being female and being a woman. However, they perceived that others (i.e., nurses) defined them primarily in terms of age or being a ‘teenage mother’. Perceived differential treatment by staff towards older mothers was attributed to
their age and by comparison their own care was perceived negatively. Consistent with this finding, Peterson, Sword, Charles, and DiCenso (2007) found that young women inpatients perceived nursing care as more positive when they were treated the same as older mothers. Alternatively, being treated differentially due to age often hindered the development of an effective nurse/patient relationship (Peterson et al., 2007). This has important implications for working with young mothers, as many may resist being labelled as a teenage mother and may expect to be treated primarily as a mother/woman with age a secondary consideration.

Further, many negative experiences with staff in the hospital were reported and the young women did not discuss hospital staff as a main source of support. This differs from the experience of older women, who name hospital staff as an essential source of support during their infants’ hospitalisation (Affleck et al., 1986; Affleck et al., 1991; Fenwick et al., 2000; Jones, Rowe, & Becker, 2009; Yetman, 1999). In particular, Yetman (1999) found that staff were vital in meeting both the physical and emotional needs of the older mother. Often nurses would schedule core activities (i.e., bath time) around times when they knew the parent would be there and this was much appreciated by the mothers, as it provided a sense of caretaking and involvement (Yetman, 1999). In contrast, the current study found that the young women were experiencing frustration, confusion, and sometimes anger that was directed towards staff for not involving them in care. Although there is a large body of literature exploring the difficulties that older parents have negotiating care of their infants with staff (for a review see Cleveland, 2008), it appears that young women have the further complication of contending with age as a perceived barrier. It also raises the question of whether there are differences in how staff interact with younger mothers or whether young women perceive the actions of staff differently to older mothers. A further possible explanation is that the difficulties with transport and competing demands outside of the hospital may mean that young women are not able to establish a routine that is easily
recognised by staff. Further research on the dynamic interplay between hospital staff and young mothers is warranted to explicate the differences in experiences between older and younger mothers.

In order to manage the challenges of having their infants in hospital the young women idealised what home would be like. The incongruence between idealised home and the actual experience of taking their infants home was explicated in the second theme “actual/ideal incongruence”. Home was perceived as a time when they would become mothers, where they would do things their own way, and where life would become easier. There was little consideration of the challenges of going home, possibly consistent with their cognitive developmental stage (Crone, 2009; Fischhoff, 2008; Sadler, 1983). This resulted in an idealised image of home that was shattered once the infant was home. Being a mother once home was not as easy as the young women perceived it would be. So while for older mothers, the distress associated with preterm birth often dissipated quickly after the infant has been released from hospital (Affleck & Tennen, 1991; Rowe & Jones, 2008) the reverse may be true for young women, as they contend with the realities of motherhood. However, perceiving increased challenges over the first few months of parenting was not unique to young mothers of preterm infants, with some young mothers of full-term infants also struggling at this time (discussed below).

In summary, the three core themes explicated in the current research suggest some clear differences in the experience of having a preterm infants for young mothers compared to findings with older mothers. The positive aspects of becoming a mother pervade perceptions of the situation, while coping mechanisms such as idealisation served a protective role and minimised the impact of the increased challenges that resulted from having a preterm infant
The second research question asked “how does having a preterm infant change the experience of being a mother for young women as compared to young mothers of full-term infants?” The findings reviewed above suggest that, overall, preterm birth, though increasing the challenges faced, was not a significant stressor in the young women’s lives. Further, and in answer to the third research question “how does having a preterm infant alter the experience of being a mother over the first year of the infant’s life?”, the findings suggested few differences in the experience of being a mother over the first 12 months. As discussed above and as found in theme 1 ‘the dual nature of motherhood’, the experience for young women was very similar over time regardless of whether they had a full-term or preterm infant. For all young women in the study the experience of being a mother was associated with a duality of managing the challenges but also delighting in the infant. For most young women the joyous moments outweighed the challenging moments. However, there was variability on where the women fell on these dimensions. This finding is consistent with Wilkinson and Walford’s (1998) proposition that wellbeing and challenges in parenting for young women were separate independent dimensions and not polarities on a single dimension. Further, the current research suggests that this conceptualization is true for both young mothers of preterm infants and full-term infants. This finding supports a need for researchers to move away from the dominant conceptualization of adolescent mothering/adjustment on a one-dimensional scale and, instead, supports the need to explore the positive impact of being a mother on the young women as independent to the challenges, in the same way it is conceptualized for older mothers (Wilkinson & Walford, 1998).

Being a mother as a young woman was about managing the day-to-day joys and challenges. It was an experience filled with polarities – good and bad, joyous and challenging. Further, the women defined themselves as either good enough parents or not, as coping or not. One of the core ways of managing these polarities and fears early in the
parenting experience was through idealisation. As explicated in theme 2, the young women engaged in a process of idealising, sometimes themselves and their parenting ability, sometimes other people such as the father of the baby or the infant, and other times the future. However, the incongruence between the idealised images of how things would be was often highly incongruent with the actual experience. The young women displayed limited insight into what the future would bring and/or ignored evidence that the idealised image was unlikely. The interpretation here is that the process of idealisation is needed; that the young women engaged in this process in order to cope with either the fears that they held about their own ability to be a good enough parents or to manage the challenges of the environment.

It can also be argued that most of the young women did not hold realistic attitudes of what parenting would be like. Early in the parenting experience many of the young women were drawing on their previous experiences of babysitting and childcare. The way they presented their previous experience was reminiscent of presenting a resume for a job suggesting a checklist approach to being qualified for parenting. However, the previous babysitting was not adequate and most mothers experienced an incongruence between their idealised image or view of parenting and the actual experience. That is, their ‘resumes’ were not sufficient to qualify them for the position and they struggled to adopt the skills necessary. However, 12-months on the young women had developed realistic attitudes towards parenting, including asking for help when needed and appraising their abilities and the role more accurately (with less idealisation). Seamark and Ling (2004) demonstrated that young women in their study had developed very realistic attitudes to parenthood within several years of giving birth and this was in contrast to much of the previous research on adolescent mothering. However, the current research suggests that these attitudes develop for most within the first year of parenting.
All of the young women perceived that motherhood had transformed them and given them meaning in life, and this was at the forefront of the experience of being a mother. As highlighted in theme 3, all of the mothers converged on a salient maternal identity following the birth of their infants and the infant was prioritised above almost everything else, including themselves at times. For most young women parenting provided a positive view of self and gave meaning to their lives; a finding that adds to a growing body of qualitative research (Arai, 2003; Barrett et al, 1996; Hunt Morse, 2002; Spear &Lock, 2004; Williams & Vines, 1999; Hanna, 2001). Over time, the young women began to reinvest in the development of other facets of their identities, enacted through a return to work/study or taking time out for relationships. However, despite rejoining the trajectories they may have been on pre-pregnancy, they returned with a different view of both themselves and the world. Despite this return of focus to individual self development, the women were transformed by becoming mothers and, similarly to older women, they could not return to being a single unit (Bibring, 1961; Sadler, 1983). This meant that priorities had changed, the scope of plans for the future had changed (often becoming more grounded and practical), and the young women themselves had a more stable sense of who they were. Age, however, can be seen to play a role, as the individual identities that the women returned to were less developed than for older mothers. Whereas older mothers often have achieved and defined themselves with motherhood requiring a reorganisation of family roles (Sadler, 1983), the young women returned to identity development and role experimentation.

The current study also found that part of the transformation of self that occurred over the first 12-months of being parents was in the development of much more grounded and less abstract goals for employment and study. This is consistent with Seamark and Ling’s (1992) findings that the young mothers they interviewed were developing or carrying out plans for future careers, including completing their education. Together these findings provide further
challenge to the assumption that an adolescent pregnancy ruins young women’s lives and suggests that motherhood can be the turning point to maturity.

The findings further suggested that the experience of being a young mother was not simply about the three core themes but about the interactions between these core components of experience. Not only did the women fall along a continuum in terms of the dual nature of parenting (enjoyment and perceived challenge), the young women also differed along continuums of their ideal and actual incongruence and perception of transformation to self. Further, when plotted along the various dimensions the young mothers could, to some extent, be categorised into two groups.

One group included those young women who had previous experiences or opportunities to develop confidence and competence (self-efficacy) and to establish a sense of who they were. These young women had already begun to develop skills such as being organised and prepared (i.e., internal resources). When motherhood was overlaid on to this the sense of efficacy was more likely to generalise to parenting and the young women perceived fewer challenges in the mothering role. This is consistent with research on role acquisition, which found that current or new role acquisition was facilitated by past experience in role acquisition (Sarbin & Allen, 1968, as cited in Mercer, 1980). Further, research by Delmore Ko et al (2000) found that young mothers with realistic expectations of parenting and a sense of mastery over their situation were able to contend with their life stresses more effectively and felt more self-efficacious, and suggested that expectations were predictive of a more positive transition to parenthood. Consistent with these findings, the current research also found that expectations in the form of idealised views of self and other and a sense of self-efficacy were important in positive adjustment. Those mothers who held less idealised views of parenting and who had a congruent view of self and other, reported fewer challenges and greater enjoyment with parenting. Further, for some of these young
women motherhood was perceived as the fulfilment of an existential need and attainment of a life goal. Half of the women in this group were in stable long term relationships and had planned their pregnancies.

A second group of young women had not had as many opportunities to develop efficacy or a competent sense of who they were. For these young women being a mother was associated with often dramatic changes to their perceptions of self, as they compared and contrasted who they were with who they had become. Consistent with research from a growing body of qualitative research (Spear & Lock, 2003), the current study found that being a mother resulted in sometimes significant changes in trajectory away from delinquent behaviour (i.e., drug and alcohol use) and towards responsibility and maturity, where the infants needs were prioritised. Moreover, it was in the context of being a mother that many of the young women in this group experienced growth and development in terms of their internal resources. That is, through parenting and experiencing a sense of pride and achievement, many of the women developed a sense of competence and confidence in who they were, feeling that they had done something right with their lives. By successfully managing the demands and challenges of being a mother, the young women developed patience, organisation, confidence, and competence.

These young women also often held idealised images of themselves and/or others, particularly early in the parenting experience, which differed from their actual experiences. However, the development of internal resources also served to help the mothers reconcile the incongruence between their idealised images and their actual experiences. This in turn reduced their perception of the challenges they faced. In contrast to early strategies of looking for external solutions to challenges (i.e., if he/she/they would only do …) and expecting others to change, developing a sense of competence and confidence in their roles as mothers, shifting from an egocentric view, and becoming more organised also reduced the
incongruence between their idealised and actual experiences. For example, there was a reduced reliance on the idealised image of the father of the baby once the mother gained confidence in being able to parent alone. Similarly, there was a reduction in blaming the baby for being difficult once the mother became more organised and prepared. These skills and familiarity with the role of mother lead to fewer challenges and greater mastery as mothers. By 12 months most of these mothers on this end of the continuum were in stable, though fragile, situations.

The fragility of the situation for most of the young mothers does need to be emphasised. Although most young women felt that they were managing well and were in stable situations by the time the infant was 12-months of age, there was a sense that if anything should go wrong within the system in which mother and baby were embedded that stability could be shattered. Research on adolescent pregnancy has suggested that second pregnancies can be a risk factor for poorer outcomes for mother and her infants (Kalmuss & Namerow, 1994). Further, the risk of relationship breakdown for young women remains high (Bunting & McAuley, 2004b; Quinlivan et al., 2004). Infants can become increasingly demanding as they enter into toddlerhood (Gross & Conrad, 1995) and cognitive delays for preterm infants may continue and become apparent over time and when schooling commences (Short et al., 2006). In addition, contextual factors such as the difficulty of finding affordable housing and increasing costs of living could create further challenges in maintaining stable housing. Most of the young women in the current study could be susceptible to several of these risk factors and this could contribute to altering the current state of equilibrium. As such, in-depth longitudinal research with young women is warranted to investigate whether the experience of motherhood becomes more or less challenging over the longer term.
In summary, the findings of the current research provide a framework for understanding which of the young women had trouble adjusting to parenting, how this played out in terms of day-to-day life for the young mother, and why this may be so. The women were a heterogeneous group pre-pregnancy with some young women being highly resourced and others not. However, given the time and opportunity most of the mothers developed the skills necessary to parent. The first few months were a time of adjustment as the young women came to terms with the realities of parenting and managed their own fears of not being good enough parents. However, this resolved over time as efficacy developed and the young women felt competent as parents. Thus far, little has been discussed about the role of other people in the young women’s experience of being parents but this was another important area that interplayed with each of the three core themes.

People in their support networks also influenced the young women’s experience of parenting despite this not emerging as a core theme in the analysis. Instead, the role of support emerged as an important factor in both actual/ideal incongruence and transforming the self and as a sub theme of the challenges of parenting. Support people were found to both hinder and help the young women as they adjusted to motherhood and it was proposed that this could be conceptualised as a third dimension or continuum. Significant others such as the woman’s partner/father of the baby and both maternal and paternal grandparents fulfilled essential support roles. However, the type of support provided could either help, by developing the young woman’s sense of autonomy and being ‘good enough’ in the parent role, or hinder, by emphasising that the young woman was not parenting in line with her ideal of how she should be. Similarly, family of origin factors reviewed in chapter five played a significant role with women from chaotic backgrounds disadvantaged in terms of access to support and stability, often because their families did not have secure housing themselves.
This often meant they had additional challenges to manage above and beyond adjusting to parenthood.

Much has been written about the importance of support for young women who are mothers. However, the current findings suggested that for all young mothers there was a sense of needing the ‘right kind’ of support from others. This right kind of support was described as support that facilitated the young woman’s need for autonomy in the parenting role, while recognising that the young mothers needed help with little things and time out. Support that was intrusive or that undermined the young woman’s ability to parent autonomously negatively influenced the young woman consistent with previous research (Bunting & McAuley, 2004a; SmithBattle, 1997). In addition, support that emphasised the view of self as not living up to their ideal (i.e., not being good enough) was perceived negatively. The young women did not want people to take over and parent for them or to tell them what to do. Rather they wanted help with providing time out in the form of short breaks and with the little things (i.e., washing, cooking). Time out was probably the most vital aspect of support that the young women discussed. Unfortunately, many of the young women felt unable to ask for time out for fear or being associated with the ‘stereotypical teenage mother’ who dumps her baby. Early in the experience of being a parent this prevented the young women from accessing support. However, the young women overcame this resistance to seeking help over time as their idealised view of themselves and fear of not being a ‘good enough mother’ decreased and their confidence in the parenting role increased. This suggests that people in support roles for young women need to consider the type of support they provide and should be aware that young women struggle to ask for help when they feel that they are performing poorly as mothers or that others may judge them.

Previous research has found that the relationship between grandmother and daughter is not straightforward, with the grandmother often perceived as a source of conflict for the
young woman (Bunting & McAuley, 2004a). Similarly, SmithBattle (1997) proposed that the experience of parenting is embedded in ongoing social relationships. The current findings suggesting that it is about receiving the right type of autonomy promoting support, may help explain why support from grandmothers is associated with poorer parenting experiences for the young mother (Clemmens, 2001; Voight et al., 1996). Clemmens also found that at the same time support from grandparents was associated with better outcomes for the infant. This suggests that though feedback from grandparents may be perceived negatively by the young woman and may emphasise that she is not parenting in line with her ideal, this guidance may be necessary for improving the outcomes for the infant. Accordingly, service providers, family and relatives may need to balance feedback to the young mother on the needs of the infant with her own need to be praised and encouraged as a parent.

Previous literature suggested that there were variations in how involved the father of the baby was in the care of their infant and noted that often relationships were unstable (Bunting & McAuley, 2004b; Unger & Wandersman, 1988). However, the current research found that fathers who were involved with the mother during pregnancy and at 3-4 months post-discharge were still involved and co-parenting 12-months post discharge. Relationships with the father of the baby remained remarkably stable over time with only one relationship breaking down. However, this may be related to the sample of the current study, with stable young women opting to continue with the project over time. Proportionately, the current study had fewer single mothers than rates reported in previous research (Quinlivan et al., 1999). Despite this, the current findings on father involvement help to challenge the perception that all young fathers are uninvolved in the care of their infants and that all young relationships are unstable. Future research on the nature the nature of the relationships between young mothers and the father of their babies is warranted, particularly from the father’s perspective, in order to understand their experiences and needs.
Two themes have been repeatedly raised throughout the discussion above and warrant further explication as they have direct implications for practice. First, the experience of being a mother was related to the negative judgment that the young women perceived from multiple sources including, family, friends, health professionals, and the general community. All of the young women reported being stopped in the street and berated or criticised by strangers. Perceived negative judgment from health professionals was particularly troubling as this usually led to a reduction in help seeking behaviour, which may have had ongoing ramifications for both mother and infant. In addition, the negative judgment from others also served to emphasise the incongruence between the mothers’ ideal and actual images of self. Accordingly, the women minimised contact with people who challenged their view of self as a competent mother or a mother who was managing. Similarly, support that provided reassurance that they were ‘good enough’ mothers was perceived positively, though mothers noted receiving reassurance was one area where they did not receive enough support. The current finding that the young women in the study were exposed to negative attitudes from others, including health professionals and general members of the community is consistent with other Australian research by Hanna (2000), which found that the young women were exposed to high levels of stigma. Stigma and negative judgement can also translate into discrimination and can have a major impact on the experience of parenting and the mother’s willingness to engage in help seeking (Fessler, 2008).

Second, the findings outlined throughout chapters 5 and 6 highlight the heterogeneity of the group of young women who become mothers, cautioning against stereotyping and labelling. Despite a growing body of research demonstrating the heterogeneity of young mothers as a group, dominant discourses both in public and scientific forums reinforce the ‘problem’ of teenage parenting (Breheny & Stephens, 2007, 2010; Cherrington & Breheny, 2005) as though it applies to all, thus perpetuating the stigma (Fessler, 2008). This suggests
that professionals and researchers have a responsibility for acknowledging the heterogeneity of the group and should be wary of categorising young women primarily by age and applying group membership labels that may not be salient to their view of themselves. Implications for practice are discussed below. First, the implications of the current findings for theory are outlined.

**Theoretical Implications**

The current research explored whether young women’s experiences of having a preterm infant fit with the posited double risk in the extant literature (Thurman & Gonsalves, 1993). The current research found little support for the position that young mothers of preterm infants were are double risk for poor adjustment. However, the time of hospitalisation of their infants did emerge as a time of increased challenge. Despite this, the enjoyment of being a mother and the perceived positive transformation to self counterbalanced these experiences. There was little difference between the young women’s experiences of parenting over time. In addition, there did not appear to be ongoing health concerns for most of the infants and the infants exhibited few delays in their milestones as reported by the young women. Self reported symptoms of distress suggested that the period post discharge was a difficult time for the young women but this was not particular to young mothers of preterm infants. These findings support those reported by Farnell et al., (in press), which found that older mothers of preterm infants were reporting significantly more distress than adolescent mothers of full-term infants. No significant differences were found between adolescent mothers of preterm infants and adolescent mothers of full-term infants (Farnell et al., in press). As such, the double risk proposition does not appear to be supported, at least for mothers. Further research is needed to test if there is a double risk for infants.

Knaak (2008) proposed a model of adolescent parenting which outlined a range of tasks that when achieved would lead young women to feel adjusted. Knaak described
variations in wellbeing in terms of how well the young women were adapting to the challenges of parenting. Consistent with this, the current study found that the perception of challenge was a core component in the experience of being a mother and that this was balanced with the enjoyment of the infant. For the women in Knaak’s study feeling adjusted was accomplished by establishing an integrated maternal identity – related to accomplishing tasks. These tasks included connecting with the baby, developing competence and confidence in their ability as a mother, rebuilding day-to-day life, overcoming social isolation, integrating work, and reconciling expectations and reality. Variability in how well the mothers felt they were adjusting was related to resources, including prioritising self-care, having low situational stress, having enough help, feeling understood, feeling emotionally and physically ready for parenting, and having realistic ‘core’ expectations and beliefs about parenting (Knaak, 2008). This maps directly onto the findings of the current study providing further support for Knaak’s model and supporting its applicability to mothers of both full-term and preterm infants.

According to Knaak’s model reconciling expectations and reality was a core aspect of the experience of being a mother and prioritising self-care occurred as the young women began to re-establish their own identities. Similarly, the development of confidence and competence was core to the experience of being a mother. However, the current study also suggested that the development of internal resources, including competence and confidence, occurred over the course of parenting and was influenced by others in the young women’s support networks. In addition, the current study furthers adds to this conceptual model by highlighting the ways young mothers with preterm infants connect with their infants in the absence of a physical baby. Further, preterm birth contributes to the discrepancy between expectations and reality by providing a further avenue for an idealised image to be created; that is the image of ‘home’ and what it will mean to have their infants home.
The current research is also consistent with aspects of Schellenbach’s (1992) model of adolescent parenting, supporting the propositions that the adolescent parenting is different to older parenting in that factors interact differentially to influence outcomes for the young woman. Specifically, young women are contending with factors such as lack of access to transport and stable housing, which increases the challenges associated with parenting. Further, the current research also suggests that situational variables made the experience of parenting particularly difficult for young mothers of preterm infants. This finding is consistent with previous research that demonstrates the role of resources in accounting for poor educational outcomes for young parents (Mollborn, 2007). However, it further explicates the additional role that these variables play for mothers of preterm infants.

A number of studies investigate maturity as a variable that contributes to positive outcomes for mother and infant. These studies often use age as a proxy of maturity (Hess et al., 2002). However, the current study, while suggesting that internal resources are important for positive experiences, did not find that age was necessarily related to the development of these internal resources. Instead, it was opportunity to develop competence in an avenue other than motherhood, for example, by completing a TAFE course or gaining fulltime employment in a job. This is more in line with Schellenbach et al.’s (1992) conceptualisation of a key attribute for young mothers being cognitive readiness for parenting, which is influenced by but independent of age. Further, the lack of relationship between age and internal resource development is consistent with research that found no correlation between age and developmental complexity (Flanagan, McGrath, Meyer, & Garcia Coll, 1995). However, further research is warranted to explore the relationship between age and the development of internal resources as the current study included only a few mothers below the age of 17. The inclusion of more younger mothers, and particularly young mothers under the age of 15, in the current study may have yielded different findings.
The current findings also add to understanding of the transition to motherhood more generally. Consistent with the model of becoming a mother proposed by Mercer (2004), the young mothers in the current study can be seen to have achieved a maternal identity, by establishing and trusting in her intimate knowledge of the infant resulting in feelings of competence and confidence. This occurred for most over the first 12 months of being a parent. Similarly, the new ‘normal’ in terms of lifestyle had been reached as she and her partner had created a sense of family together with the infant (Mercer, 1984). Importantly, this process described by Mercer for older mothers, did not differ in any noticeable way for the young mothers in the current study nor for the young mothers of preterm infants (Mercer, 1995). The young mothers in the current study also followed the pattern of formal and informal development of competence. That is, the young women initially copied expert’s behaviour, following advice (formal stage) before shifting to using her own judgment and no longer rigidly following the direction of others (informal stage; Mercer, 2004). Further, most of the young women had progressed to the stage of integrated maternal identity characterized by confidence and satisfaction in the maternal role. Though no time frames were explicated directly by Mercer (1984, 1995), and she describes the process of achieving a maternal identity as a gradual process, for some of the young women in the current study, this process was still continuing 12 months post birth, with proficiency still being developed and expert role models still being accessed regularly. That is, some young women were still relying on the direction of others rather than trusting themselves.

Mercer (2004) also posited that progression from the formal to the informal stage of becoming a mother involved a shift from rigidly following the directions of others (i.e., nurses and doctors) to using their own judgment. Research exploring the effects of preterm birth on maternal identity development has found that older mothers remained trapped in the formal stage, dependent on directives from experts and unable to move into the informal
stage, as she is still gathering cognitive information and making acquaintance with her infant (Mercer, 1995). The current study found that one of the challenges associated with a preterm birth was the young mother’s inability to make the transition from the formal to informal stage. However, unlike older mothers, who struggled to move from relying on the expert opinion, possibly due to the health concerns of the infant (Mercer, 1995), the young women in fact desired the shift, but other people were resistant to let the young mother use her own judgement. So, what may look like a similar process for both older and young mothers of preterm infants (not progressing from formal stage) in fact has different psychological mechanisms underpinning it. In the case of young women, the shift to the informal stage is prevented by others who may not allow the young mother to become autonomous parents rather than by fear or concern about taking responsibility for decisions. It is possibly the fear of others rather than the fear within self that prevents the shift, though further research is required to understand the motivations of others.

The current research can also be seen to be adding to the body of literature of adolescent parenting in Australia. Much has been documented in the literature about differences in the experiences of being a mother for young women in the US based on race characteristics and state government policies (Furstenberg et al., 1989). However, much less is known about the meaning of motherhood in the Australian context where there is good government support in the form of parenting welfare payments. Further, Australia currently has low rates of unemployment and high employment in mining and trade sectors, which may mean that young women’s partners have an increased chance of being in stable high paid employment. The current research found that most of the partners to the young women in the study were employed, and that when they were, there was less financial strain. However, many of the young women did still discuss how they were financially struggling with the high costs of rent and utilities. Similarly, finding appropriate and affordable housing was an
issue for several of the mothers, often meaning they were reliant on the kindness of acquaintances for somewhere to live. This highlights a particular social problem in Australia, whose importance has been growing in recent times, as the impact of unaffordable housing has been seen in increased rates of homelessness, particularly in youth (Chamberlain & MacKenzie, 2008), and in the impact that unstable housing has on mental health (St. Vincent’s Mental Health Service (Melbourne) & Craze Lateral Solutions Bungendore NSW, 2005).

**Implications for Practice**

The findings of the current research have important implications for practice and intervention. First, for those working in the NICU or SCN with young mothers, the findings highlight the importance of photos in promoting bonding between young mothers and their infants in the absence of their physical infant. Photos were regularly used to help manage the separation and distress at not being with their infants but young women in the current study also discussed using photos as a proxy of their infant when practicing a sleep/feed routine. One way staff may help promote adaptation to motherhood is by ensuring young women have access to photos and promoting the use of technology to assist young women (e.g., checking if they have mobile phones and/or a means to produce the pictures, helping download photos from mobile phones so that they can store and share the photos with others).

Second, young women feared that if they asserted their own opinions of how they would like to parent, or what they felt their infant might have preferred, they would be judged negatively. They also feared that there may have been repercussions such as notations made on their charts. Further, the current findings suggest that in order to develop parenting efficacy the young women need to become autonomous parents. Staff are in a position where they can promote autonomy by eliciting the young women’s opinions about parenting practices. However, they may need to openly address the fears felt by young women.
regarding perceived negative judgment. An attitude of openness, and consideration that these young women may have some parenting skills, could help develop relationships with young women allowing them to express their opinions and to question practices. This may also allow staff to make a more accurate assessment of gaps in knowledge. In contrast, assuming that young women do not have parenting skills or knowledge could damage the relationship between staff and young mothers. This is more likely to reduce the young women’s openness to new information.

One implication of the finding that young women categorize themselves as women and mothers first and as teenage second is that people involved in the care of young women or their infants need to be aware of the labels that they use and the way that they categorize young women. Labeling young mothers as a mother first and acting in accordance with this is likely to reduce their perceptions of being judged negatively based on age. Similarly, staff may need to ensure that their practices are similar for all mothers regardless of age and to become aware of their preconceptions. The current focus on providing family centred care tailored individually to the needs of the family (Franck & Callery, 2004) may help to counteract this challenge for young women. However, staff may need to be aware of, and actively address, young women’s appraisal of differential treatment as being age based.

People working with young mothers should also have an awareness of the degree of prejudice and discrimination that young women face. The current findings have added to a growing body of literature highlighting both the prevalence of perceived negative judgment directed at young mothers (Hanna, 2000) and the impact that being a member of this stigmatized group has on the young women’s adjustment (Fessler, 2008). Actively acknowledging the heterogeneity of the group and appraising young women as individuals could help to counteract the stigma experienced by the young mothers. Again, increased understanding of the heterogeneity of the group can also help to challenge preconceptions
about young mothers. Additionally, staff working with young women, particularly in the nursery environment should be aware of the practical limitations the young women faced in terms of lack of access to transport. The young women in this study faced significant challenges getting to and from the hospital. Thus, despite the having the desire to be at the hospital to care for their infants several young women could not attend regularly. This information may be useful in challenging the interpretations made for non-attending behaviours.

Further to this, staff working with young women should be aware that some young women may hold idealized images of themselves as mothers. In defending against fears that they may not be good enough parents or may be stereotypical teenage mothers, young women are likely to minimize contact with people who may reinforce this belief. Thus, young women may either not ask for help or else may present as well (i.e., as not struggling). Providing reassurance and building a trusting relationship may be integral in engaging young women. Further, presenting information on infant needs that so that it is not perceived as criticism of the young women, while presenting its own challenges, is a further suggested way of engaging young mothers. The current research further suggests that young women become more open to intervention as they develop confidence and competence in the parenting role. The implications for practice are that maintaining regular contact with young women over time may be necessary a) to facilitate a trusting relationship, b) to help young women build confidence in the parenting role, and c) to ascertain need and openness to intervention. In many ways working successfully with young women is about dialectics. That is, reassuring the young women that who they are and what they are doing is good, while moving the young women towards change and developing new skills.

Similarly, providing support also requires managing the dialectic. That is, both the helpfulness of support and the desired amount of support are subjective and for young women
who are struggling, often no amount of support is perceived as being ‘enough’.

Simultaneously, support is often perceived as too intrusive. Honouring the young women’s need for autonomy and appreciating that the process of being a mother is often the mechanism for self-development, including the development of confidence and competence as a woman, may help those in support roles to target their support more effectively. Given the heterogeneity of the group and the differing support needs, staff should avoid a standardized care approach instead targeting interventions for those who have not previously had opportunities to develop confidence and competence in the parenting role perhaps assessed using a parenting or self efficacy measure.

**Limitations and future directions**

The current research investigated the phenomenon of becoming a mother of a preterm infant from the perspective of a small number of young women. This approach allowed a deep exploration of the issues for these young women and was able to explicate aspects of being a mother in the context of a preterm infant that had not previously been explored.

However, as with all research, there were limitations inherent in the design and implementation of the research.

One limitation of the current study was the heterogeneity of the current sample. Ideally, for IPA studies, the sample should be as homogenous as possible in order to explicate the psychological variability within participants matched on social or theoretical factors (Smith et al., 2009). The current participants were homogenous in that they were all first time mothers, within a select age range, who had either experienced a preterm birth or full-term birth. Further, the sample had limited variability in terms of education, ethnicity, and geography, which are important broader social variables that influence experience. However, the sample also differed on a number of other social variables. Some research suggests that the experience for younger teens <15 is different than for those who are >17 (Mercer, 1980);
therefore, it may have been useful to separate the group further matching participants on age. Further, most of participants were 17 years old or more with only a few of the mothers in the younger age range. The current study, while being useful for highlighting the divergence and convergence of experiences, could also have benefited from selection of participants matched on SES, marital status, or education. This would allow a deeper analysis of the meaning of being mothers within specific social contexts and among young women with more equal internal resources.

The current study also included mothers whose infants differed on gestational age at birth, length of hospitalisation, birth weight, and degree of difficulties post birth. Literature with older mothers suggests that the experience for mothers differs based on these factors (Cronin et al., 1995; Davis, Edwards, Mohay et al., 2003). As such, it is possible that distress and perceived challenges associated with having a preterm infant would differ for the young women depending on these factors and this should be explored in future research.

The majority of the young women in this study were in stable relationships with their partners. This is at odds with other Australian research that found up to 47% of fathers were not involved with the mother or infant (Quinlivan et al., 1999). While the Quinlivan study did appear to have very high rates of uninvolved fathers compared to rates for the UK and USA (Bunting & McAuley, 2004b), it still highlights that the current sample may be overly representative of partnered young women. Given the differences in experiences and challenges faced by the single young women compared to the young women in committed relationships in the current study, it is suggested that future research is warranted to explore the experiences and differences of these two groups of young women in more depth.

Of note was the number of young women in the current study who had previously miscarried an infant. Three of the 14 mothers had previously miscarried an unplanned pregnancy. This experience was significant in the current experience of being a mother, with
all three of the mothers noting how having this miscarriage had changed how they prepared for the current infant. Little has been noted in the literature about the role of previous miscarriage on young women’s experiences of parenting. However, the current study found that those mothers who had experienced a previous miscarriage were more likely to describe themselves as mature, responsible, and ready to be mothers. These women were also more likely to have planned their current pregnancies and, hence, were more prepared. This suggests that a previous miscarriage may have a facilitative role in the young woman’s experience of parenting, with the event possibly being a catalyst for change and growth. This proposition is consistent with research that found miscarriage was a pivotal point in the lives of women, with both past and future experiences reassessed as a result (Maker & Ogden, 2003). Future research should assess the role of miscarriage both in precipitating planned pregnancies and in developing attitudes and resources that may facilitate parenting preparedness in young mothers.

Only a small body of literature exists on communication and relationships between young women and nurses in hospital settings (Petersen et al., 2007). However, previous research with older mothers has found that ineffective communication is usually under-accommodative and intergroup (Jones et al., 2007), which, based on the young women’s perceptions, may characterise communication between young women and nurses in the SCN. Further, the current research suggests that a dynamic interplay between hospital staff and young mothers occurs. Future research is needed to a) explicate perceptions of young mothers held by nursing staff and implications for care, b) ascertain whether there are actual differences in communication and interactions between staff and older and younger mothers or whether it is a matter of perception, and c) how young women influence interactions between themselves and staff.
Very little research exists on the experience of being a father as a young man (Frewin, Tuffin, & Rouch, 2007) nor from the perspective of men more generally who conceive with young women (Bunting & McAuley, 2004b; Larson et al., 1996). At the current time there does not appear to be any research looking at the experiences of young fathers of preterm infants. Given the role that fathers play both in supporting older mothers of preterm infants (Sloan, Rowe, & Jones, 2008) and in supporting young mothers (Roye & Balk, 1996), this research is both warranted and necessary. Research on the father’s experience is also needed to understand their needs and the variability in their stories.

**Conclusion**

The current research explored the experience of being a mother for young women of preterm infants and found few differences in the experience compared to young mothers of full-term infants. The findings of the current research suggest that the experience of being a mother, regardless of infant birth status, is primarily about change to self. The young women construct themselves differently as a result of being mothers both in positive ways, as they move away from delinquent behaviours, develop internal resources associated with maturity, gain a positive view of self, and gain meaning for their lives, and in negative ways as they idealise motherhood and fight against the social construction of teenage motherhood. The ramifications initially are a reduced likelihood of accessing supports, an increased perception of challenge in the parenting role as the experience falls short of their expectations, and increased fear that they are not ‘good enough’ parents.

Over time, the young women resolve their fears and reduce their incongruent views as they develop confidence and competence in the parenting role. Familiarity with their infants leads to an increased sense of mastery in their maternal roles. Parenting becomes the vehicle for positive self growth.
The importance of this research is twofold: First, it has explicated the differences in the experience of preterm birth for older and young mothers, drawing attention to the unique challenges that young women face in their attempts to mother in the context of a preterm birth. Second, it has demonstrated the similarities in the experience of being a mother for young mothers of preterm and full-term infants. Explicating the experience and discovering these differences and similarities means we are no longer making assumptions about the needs of this group of women. Finally, the current research methodology allowed the nuances of the experience to come to the fore demonstrating both the heterogeneity of the group of young women who become parents and how young women manage the polemics of enjoyment and challenge on a day-to-day basis. This research provides a further challenge to the dominant conception that early motherhood is detrimental to young women.
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### Appendix A: Distribution of quotes included in results by mother and theme

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Note: - indicates that theme was not relevant for those mothers (i.e., full-term mothers).
Appendix B: Sample analysis of transcript

S1: So when you got home and you say “I did it my own way” like how did you know your way?

Because it felt comfortable. Like when I was in the doctors or the nurses in the hospital the ways that they showed me was kind of difficult, like especially with the bathing I felt him slipping a lot and yeah I just didn’t feel comfortable like that but I had to do it their way or else they would get real mad like I’m the mother and so I was the one getting real mad so at the same time and yeah when I came home I tried different ways and found out the best way so for me to do it anyway.

Yeah. So how are you feeling with doing all those things now that you are doing it your own way?

S1: I feel way better like heaps better and like I said there is no-one to boss me around as well.

S1: Yeah.

JADE: So it kind of feels good. Because I felt like someone else was telling me how to be his Mum and I didn’t really like that.

S1: Yeah.

JADE: Yeah so it feels better for me.

S1: So that time when you first got home from hospital was it like, how was it?

JADE: Oh it was good like it was good to finally get home as well and there was no nurses coming in checking on me and like. Okay I understand that they are checking for our safety to see if we are alright and stuff but when I was in there they came like every hour, like on the hour and it was really annoying.

S1: Even when you were roaming in?

JADE: Oh yeah they came into to check quite a lot of times but not as much as when I was in there.

S1: Okay. So it wasn’t hard having to take full responsibility for him or anything like that?

JADE: Yeah. Well you can’t say it was easy like yeah like I’m sure everybody else would say the same thing. But it kind of just felt better because like – because when he was in hospital and I was here at home like it felt that there was like something missing like.

S1: Yeah.

JADE: And it felt kind of better, everything was done and finished when I came home with him like. But that’s when it just began like did I know that? Here I am thinking it was so like over all the days going up to the hospital and walking there with my um my scar and my stitches and stuff like that and I thought yes...
S1: Yeah.
JADE: And he is just trying to reach his toys on the mat, the playing mat as well.
S1: So it sounds like he is quite active and he is doing a lot of the talking.
JADE: And yeah the doctors told me that he wouldn't be doing that for a while because he was behind but I think that was wrong because like he is doing everything that he is supposed to be doing like for his age.
S1: Yeah.
JADE: And a lot of doctors told me that he wouldn't be doing a lot of things until later on.
S1: Yeah.
JADE: Yeah they told me like he would like be smiling as much or talking as much and I had like one of the visitors a midwives, I think it was, or a nurse or something come round and told me that he would be behind and she was asking me if he could smile yet and I said "yeah" and she's like didn't believe me kind of thing. But then he was smiling so she kind of "yeah" like.
S1: So it sounds like they are saying that usually with pre-terms they don't do all the achievements on time.
JADE: Yeah.
S1: But he has been.
JADE: I don't really like it -- but when they tell me things like that because they are trying to tell me that I don't know anything. That's what I feel like.
S1: Okay.
JADE: And well I must seeing a bit of a baby when he is not doing any of those things so they say.
S1: Yeah. Because I know when we spoke last we were talking about how the midwives as well like they were telling you how to do it and you said I just can't wait to get home to do it my way.
JADE: My way, yeah, and it feels way better. I have no-one to boss me around and say you are doing it wrong and all that, when how to do this, how to do that, like especially changing him, like they showed me different ways and stuff and there were a lot of people that showed different ways in the hospital and I was thinking if there is one way why is everyone doing it all different ways in the hospital? And like the bathing as well was the one thing that I really didn't like when I was in there because like there was a lot of people who showed me how to hold him different ways and stuff so I just do it my own way.
## Appendix C: Recruitment rate estimates

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<th>Site 2: SCN/ Antenatal</th>
<th>Site 3: SCN only</th>
<th>Site 4: Antenatal</th>
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### Total number of mothers available for recruitment

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<td>1 SCN/3 Ante</td>
<td>7</td>
<td>22</td>
</tr>
</tbody>
</table>

### Participant number | Reason for exclusion in current study | Participant number | Reason for exclusion in current study
---|--------------------------------------|-------------------|--------------------------------------
1  | Juliana                             | 21                | Skye                                 |
2  | Jade                                | 22                | Time 1 and 2 only                    |
3  | Lily                                | 23                | Laura                                |
4  | Intellectual impairment             | 24                | Multiparous                          |
5  | Becky                               | 25                | Holly                                |
6  | Multiparous                         | 26                | Multiparous                          |
7  | Claire                                             | 27                | Time 1 only                          |
8  | Time 1 only                         | 28                | Time 1 only                          |
9  | Renee                                | 29                | Time 1 only                          |
10 | Time 1 only                         | 30                | Time 1 only                          |
11 | Time 1 only                         | 31                | Time 1 and 2                         |
12 | Danielle                            | 32                | Eligible                             |
13 | Time 1 only                         | 33                | Time 1 only                          |
14 | Time 1 only                         | 34                | Time 1 and 2                         |
15 | Emily                               | 35                | Time 1 only                          |
16 | Tenielle                             | 36                | Eligible                             |
17 | Jenna                               | 37                | Time 1 only                          |
18 | Lisa                                | 38                | Time 1 only                          |
19 | Time 1 and 2 only                   | 39                | Time 1 and 2                         |
20 | Bronte                              | 40                | Time 1 only                          |
Appendix D: Interview protocols

Time 1 guided interview protocol
1) Could you tell me a little about your baby?
   - Baby’s name? How did they choose the name – where it came from?
   - Age of baby?
   - Was baby born premature – if so how many weeks?
     - Was your baby expected to arrive early?
   - What was weight?
   - Current weight?
   - How many weeks/days has your baby been in the NICU and/or SCN?
   - What is the thing you like/enjoy most about your baby at the moment?
   - How is baby progressing? (Prompts - health, wellbeing, development)
   - How was labour – who was with during?

2) I would like to ask you a little about your own experience during this time
   - Can you tell me about how the experience has been for you over the past few weeks/months (whatever is appropriate)?
   - What are the things that you believe have helped you most as a parent during this time?
   - Can you tell me a little about how you think having ______ (use the baby’s name) has impacted on your life? (Prompts – work/school, interests, relationships) – examples

3) Can you tell me a bit about the pregnancy and how it was for you?
   - supports
   - family reactions
   - partner
   - antenatal care
   - intendedness (whether you had planned to have a baby at this time)
   - expectations of becoming a mum

4) Can you tell me a bit about your feelings about taking your baby home and what you think the experience will be like?

5) What things do you think are important when you think about becoming a mother?

Interview Protocol Time 2
1) Could you tell me little about how your baby has been going since coming home from the hospital?
   - Can you tell me about how your baby is progressing? (health, wellbeing development might need prompts or not)
   - What is the thing you like/enjoy most about your baby at the moment?

2) Could you tell me a little about your own experience since coming home from hospital?
   - Can you tell me about the experience has been for you over the past few months?
   - What are the things that you believe have helped you most as a parent during this time?
   - Can you tell me a little about how you think having ______ (use the baby’s name) has impacted on your life?
   - What types of things would you say you have done to cope or manage during the last 4 months?
   - Is parenting what you expected it would be – can you tell me about this (if yes or no)?
What would you say are some of the challenges of the past 4 months?
What do you think are your strengths as a parent?
3) If another young woman who was expecting a baby came to you what would you tell her to prepare her that you may not have known or that might have helped.
4) Do you think being a young mother is different to being an older mother – in what ways?

**Time 3 protocol**
1) First I would like to ask you a little about how your baby has been going since I last spoke to you when your baby had been home for 4 months
   - Can you tell me about how your baby is progressing? (Health, wellbeing development might need prompts or not)
   - What is the thing you like/enjoy most about your baby at the moment?
2) I would like to ask you a little about your own experience since we last spoke.
   - Can you tell me about the experience has been for you over the past eight months?
   - What are the things that you believe have helped you most as a parent during this time?
   - Can you tell me a little about how you think having ______ (use the baby’s name) has impacted on your life?
   - What types of things would you say you have done to cope or manage during the last 8 months?
   - Is parenting what you expected it would be – can you tell me about this (if yes or no)?
   - What would you say are some of the challenges of the past 8 months?
   - What do you think are your strengths as a parent?
3) How do you think having a preterm infant has influenced your experience of being a mother? (Preterm mothers only)
Appendix E: Demographics questionnaire

Participant Number: ___________

Thanks for agreeing to take part in our project. Could you please answer the following questions about yourself?

Thanks 😊

❖ Age: ___________ (years)

❖ Marital Status: (please circle) Single Married Defacto (living with partner)

❖ What year of school have you completed? (please circle)

   Grade 7    Grade 8    Grade 9    Grade 10    Grade 11    Grade 12

❖ Are you still enrolled in school or are you planning on going back to school?

   Yes       No

❖ Who do you live with? (please circle one)

   mum       dad       mum and dad       father of the baby
   boyfriend (not baby’s father)       alone       friends       with family

Other: ____________________________________________________________

❖ Is this your first child? (please circle) Yes No

❖ If you answered no – how many children do you have and how old are they?

   ____________________________________________________________
Appendix F: Quantitative materials.

All participants completed a questionnaire booklet as part of data collection for the larger study. The following measures were administered and descriptive information for these measures is provided as an appendix as it provides further descriptive information about the young women’s perceptions of parenting over time.

1) **Stress Appraisal Measure** (Rowley, Roesch, Jurica, & Vaughn, 2005). The Stress Appraisal Measure is a 24 item measure that has seven sub-scales measuring cognitive appraisal: stress, threat, centrality, challenge, which measure primary appraisal, and controllable by self, controllable by others and uncontrollable, which measure secondary appraisal processes. Each sub-scale is comprised of 4 items, which participants respond to using a 5-point likert scale (1 = strongly disagree to 5 = strongly agree). The scale has good internal reliability (alphas ranging from .65 to .90 across three studies), and convergent validity (Ayers, Sandler, West, & Roosa, 1996). This measure has also been validated for use with adolescents (Dunst et al., 1994).

2) **Children’s Coping Strategies Checklist** (GHQ, Goldberg & Williams, 1988). This 45-item measure provides four subscales: active strategies, distraction strategies, avoidance strategies, and support seeking strategies and can be used with both children and teenagers. The measure has good internal reliability (alphas ranging from .89 to .73 across two studies) and the factor structure was invariant across sex, age, sample and stressor. Participants responded to each item on a 4-point scale according to how
often they used the strategy ranging from never to most of the time.
Construct validity had also been demonstrated by superior fit to the hypothesised model than either problem versus emotion coping or active versus passive coping.

3) Family Support Scale (Tait, French, & Hulse, 2003). Participants indicated the helpfulness of various sources of social support on a 5-point likert scale, from zero (not helpful at all) to five (extremely helpful). Participants indicated “not available” if the source was not available to them. The 20 items form five subscales: ‘informal kinship’, ‘spouse/partner support’, ‘social organizations, ‘formal kinship’, and ‘professional services’. This measure has good reliability, with an alpha of .79, and test-retest correlation of .91 for the total score and .75 for individual items (Dunst et al., 1994). The measure also has demonstrable content, convergent, discriminant, and criterion validity. The Family Support Scale was designed specifically for use with families with young children experiencing difficulties (Dunst et al., 1994) and has been used with mothers of infants currently hospitalized in neonatal intensive care units (Feldman-Reichman et al., 2000).

4) Parent Expectations Survey (Reece, 1992). The scale asked parents how much they agree that they can perform a range of parenting tasks e.g., feeding of the baby, dealing with baby crying, meeting demands placed on me now baby is here. Participants responded to each item using a 4-point scale 1 = strongly disagree to 4 = strongly agree. The scale also included a not applicable response, as parents may not have been undertaking some tasks while their infant was still hospitalised. The 20-item scale has good
internal reliability (alpha .86-.91) and good concurrent and predictive validity.

5) Psychological distress was measured using the 12 item General Health Questionnaire (Tait et al., 2003). This measure is used extensively in research on stress and coping and has been validated with Australian teenagers with previous research finding it to be a valid measure of general distress. Participants are asked to describe how often they experience 12 different psychological health symptoms on a 4-point scale (e.g., “Felt constantly under strain” 1 = not at all to 4 = much more than usual) giving a possible total score range of 0-36. The measure has good internal reliability (alpha .80-.91), construct validity, and discriminant validity. Higher scores on the GHQ indicate greater levels of distress with cut-off scores of 18/19 being indicative of high psychological distress.
Appendix G: Participant flyer

A special invitation

Thank you for taking the time to read this leaflet. We would like to invite you to take part in a project that is looking at young mums who have low birth weight or preterm babies.

What is this study about?
The young mums and their preterm/low birth weight babies project is looking at teenage mothers' experiences following the birth of a low birth weight or preterm baby. We are interested in finding out how teenage mums cope with this stressful experience and what support they require. We are also interested to find out how teenage mums adjust when their baby goes home.

What is involved for me if I decide to participate?
The study is designed to use a minimum of your time, because we know your time is precious.

If you would like to participate please let any of the nursing staff know, who will then pass your details on to Nicola. You can also call or text Nicola directly on 0416 286 104.

We would like to catch up with you 3 times...
- About 1 week before your baby goes home from hospital
- Three months after your baby is discharged from hospital
- When your baby is 1 year old

We will ask you to...
- Have a talk with a researcher about your experiences as a mother
- Fill out some questionnaires
- Complete an activity about who helps support you and your baby.

This should take about 1 hour of your time.

What are the benefits or risks if I decide to participate?
Each mum will be given the chance to give feedback about your experiences at the hospital and how you feel when you and your baby go home. You may find it good to talk to someone about your experiences.

We also hope that the results of this study will help support young mums in the future.

You are free to decide whether or not you want to participate in this study and it will not affect the care of your baby. You can also withdraw from this study at any time and it will not affect the care of you or your baby in any way. Anything you tell the researchers will be confidential.

About the research team

You will mainly have contact with Nicola Sheeran. Nicola is a postgraduate psychologist who is completing her PhD in Clinical Psychology at Griffith University.

Nicola's mum was a young mum herself and Nicola is interested in what can be done to help out young mums when they need it.

How can I find out more about the Study?
The study is due to be completed in 2010. If you are interested in finding out more about what we discovered from talking to young mums we can send you a summary of what we found.

If you have any questions or concerns about the study please do not hesitate to contact a member of the research team.

Nicola Sheeran can be contacted on 07 3735 3903 or 0416 286 104 or you can email on N.Sheeran@griffith.edu.au.
Liz Jones can be contacted on 3735 3365.

Young mums and their preterm/low birth weight babies.
From hospital to home

Study Team
Griffith University
Dr Liz Jones
Dr Jennifer Rowe
Nicola Sheeran
Anita Hocking
The Royal Brisbane Women's Hospital
Jane Powell
Aandrea Plint
Redcliffe Caloundra Hospital
Melinda O'Sullivan
Helen Jackson
Child and Family Health Service (Yeppoon Hospital)
Helen Walker
Kathy Prior

Young mums and their preterm/low birth weight babies.
From hospital to home

Griffith University

[Image]
Appendix H: Information Sheet

Participant Information Form

Participant information form (Version 4 February 6th 2009)

Project Title: Young mums and their special babies. From hospital to home.

Who is conducting the research?
Principal Researchers:
Dr Liz Jones
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Associate Researcher: Nicola Sheeran
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School of Psychology, Griffith University
Mt Gravatt Qld 4111 Australia

Lisa Farnell
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Lisa.Farnell@student.griffith.edu.au
School of Psychology, Griffith University
Mt Gravatt Qld 4111 Australia

Your Consent

You are invited to take part in this research project.

This participant information sheet contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this information sheet carefully. Feel free to ask questions about any information in the document. You may also wish to discuss this project with a relative, friend, your local GP/doctor or your local health worker. Feel free to do this.

Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the consent form, you indicate that you give your consent to participate in the research project.

You will be given a copy of the participant information and consent form to keep as a record.
Why is the research being conducted?

The purpose of this project is to examine aspects of your experience of teenage mothering. We want to examine the stressors and coping responses after the birth of your baby, general wellbeing and feelings and experiences about parenting. We are particularly interested in how supported you feel following the birth of your baby and who provides you with support as you and your baby go home. In particular we are interested in finding out whether mothers who have preterm or low birth weight babies have similar or different experiences to mothers who have full-term babies. There is a great deal of information about older mothers’ experience from previous research but little is known about how teenage mothers of low-birth weight or preterm babies feel about the experience both during their baby’s hospitalization or once they get home from hospital.

You are invited to participate in this research project because of the valuable information you may be able to tell us about your personal experience.

This research is the basis of a PhD thesis in the degree of clinical PhD in Psychology at the Griffith University, and will be conducted by Dr Liz Jones, Dr Jennifer Rowe and Nicola Sheeran.

What you will be asked to do

You will be asked to do a number of things if you agree to take part in the research:

- You will be asked to fill in a booklet of questionnaires while your baby is still in the hospital. It is expected that this part of your participation will take no longer that 20-30 minutes.
- In addition, you will be asked to take part in a short interview with one of the researchers at this time. This interview is expected to take no longer than 20 minutes and will be digitally recorded.
- Once you and your baby have been home for about 3-4 months we would like to meet up with you again and ask you to complete the same booklet of questionnaires.
- In addition, we would like to hear about what your experiences at home have been like since leaving hospital. This interview is expected to take 40 minutes of your time and will also be digitally recorded. During this interview we will also do an activity where you will be asked to identify who provides you with support.
- Once your baby is 1-year old we would like to meet up with you again to ask about your experiences during the past year. During this interview we will also do an activity where you will be asked to identify who provides you with support.
- At this time we will also ask you to complete another survey. The Interview and survey will take about 1 hour to complete.

You do not have to take part in all of these things if you do not want to and you can choose to not be involved at any point.
Selection and Screening of Participants

All teenage mothers between the ages of 15 and 19 years of age, who give birth to a baby at XX hospital, and who do not have ongoing maternal health issues or child alert notifications regarding cognitive impairment, will be invited to participate in the young mums and their special babies project. Other teenage mothers who give birth to a preterm/LBW baby are also being recruited from other hospitals. Participants will need to be young mothers who are either being discharged from the XX, XX, XX, or XX hospitals or back transferred to the central health services area to enable follow up interviews to be conducted.

Possible Benefits

It may be helpful to you to have the chance to express your feelings, thoughts and ideas about your experience of being a teenage mother. Talking to the researcher may help you to share some of the good things you are feeling and it may also help to ease some of the stress, anxiety, and distress that you may be feeling in your current situation. In addition, your participation will help future young mums who have a low-birth weight or preterm baby. This research will help the development of future support services and care for teenage mums.

Possible Risks

It is possible that while you are answering questions in the survey or during the interview you may become upset, due to talking about an emotional issue. If you experience distress of any kind we can first stop the process, and continue only when you feel comfortable. If you are distressed we can put you in touch with support or counselling services. Specifically, the services of Lifeline and/or the Neonatal units’ Social worker will be made available to you if you choose. We will also call you after each interview to check to see how you are feeling.

Your confidentiality and privacy

Any information that we collect in connection with this project and that can identify you, will remain confidential. We will need to keep your contact details so that we can contact you in 3-4 months and again after 1 year to discuss your experiences during that time. However, this will be stored separate to the questionnaires and interview recordings so that you cannot be identified. The research team will use a code so that we can keep track of the information you provide. The digital recordings will be kept until we have transcribed and analysed them and then they will be deleted.

Any information obtained in connection with this project will be stored in a locked filing cabinet, or on a secure computer system. Information will be stored for 7 years. You may access the data you provided at any time during these 7 years by contacting Dr Liz Jones. At the end of the 7-year period the data will be destroyed by shredding and burning. Identifying information will not be available to any individual outside the research team.

Limits to confidentiality

Although the current research is interested in who supports you (such as friends, family and the father of the baby), information about how you became pregnant is not relevant to the
study. We would ask that if you would like to talk about these events that you do not use real
names, specific dates or details about specific locations so that we can protect your
confidentiality.

If you disclose information that leads our researchers to believe that you or your child or
anyone else is at risk of physical or psychological harm, they will be obligated to report this
to the Police or Department of Child Safety or other authority. If this is the case they will first
discuss with you who would best provide advice and support. If you have any questions about
this please talk to a member of the research team.

**Your participation is voluntary**

Participation in any research project is voluntary. This means that if you do not wish to take
part you are not obliged to. If you decide to take part and later change your mind, you are
free to withdraw from the project at any stage.

Your decision to take part or not to take part, or to take part and then withdraw, will not
affect your routine treatment, your relationship with those treating you or your relationship
with the hospital or Griffith University. Researchers will not inform hospital staff of whether
you have decided to participate or not.

Before you make your decision, a member of the research team will be available to answer
any questions that you have about the research project. Then you can ask for any information
you want. We would also encourage you to talk to a friend, relative, or local health worker
about participating. You can also ask to talk to an independent person at the hospital who is
not part of the research team if you would like. Sign the Consent Form only after you have
had a chance to ask any questions you have and have received a satisfactory answer.

**Results of the Project**

If you give us permission by signing the Consent Form, we plan to publish the results in
Nicola Sheeran’s PhD thesis. The results of the study may also be published in a Nursing or
Psychology academic journal. The results will also be published in two reports to the
Queensland Government’s Department of Communities. In addition, the results of this study
will be shared with the staff of the hospitals involved in the study and the psychology staff of
Griffith University. In any publication or presentation information will be provided in such a
way that you cannot be identified.

At the end of the research project a one-page summary of the results of the study will be
mailed to you.

**Aboriginal and/or Torres Strait Islander Peoples**

The researchers on this project have meet with Indigenous Liaison Officers who work at the
hospital to check that the project is respectful to Aboriginal and Torres Strait Islander people.
The researchers will not be recording whether you are Aboriginal or Torres Strait Islander.
Further information or any problems

If you require further information or if you have any problems concerning this project (for example, any side effects), you can contact the principal researchers:

- Dr Liz Jones (Ph: 3735 3365. email: L.Jones@griffith.edu.au); Dr Jennifer Rowe (Ph: 5456 5160 Email: JRowe1@usc.edu.au). Or Nicola Sheeran (ph: 3735 3303 or 0414 286 104. email: N.Sheeran@griffith.edu.au)

Other Issues

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact the Griffith University Research Ethics Officer.

Details: Griffith University Research Ethics Officer
Office of Research, Bray Centre, Griffith University, Kessels Rd, Nathan, QLD, 4111
Ph: 07) 3735 5585

Alternatively, you can contact the XX ethics committee directly.
XX Health Service District HREC Administrator on 07 (email: @health.qld.gov.au)

Financial Issues

This project is being partly funded through the Queensland Government Department of Communities and partly funded through Griffith University. Participating in this project will not cost you any money and we will not be paying any participants for their participation in the project.

Ethical Guidelines

This project will be carried out in accordance with the National Statement on Ethical Conduct in Human Research (March 2007) produced by the National and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in research studies.

The ethical aspects of this research project have been approved by the Human Research Ethics Committees of the hospital and Griffith University.

Privacy Statement

The conduct of this research involves the collection, access and / or use of your identified personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. A de-identified copy of this data may be used for other research purposes. However, your anonymity will at all times be safeguarded. For further information consult the University’s Privacy Plan at www.griffith.edu.au/ua/aa/vc/pp or telephone (07) 3735 5585.
“This study has been reviewed and approved by the XX Hospital Health Service District Human Research Ethics Committee. Should you wish to discuss the study with someone not directly involved, in particular in relation to matters concerning policies, information about the conduct of the study or your rights as a participant, or should you wish to make a independent complaint, you can contact the Coordinator or Chairperson, Human Research Ethics Committee.
Appendix I: Consent form

Consent Form: Young mums and their special babies. From hospital to home.

Research team:
Principal Researcher: Dr Liz Jones (Ph: 3735 3365), Dr Jennifer Rowe (Ph: 3735 7389)
Associate Researcher: Nicola Sheeran (Ph: 3735 3303)

By signing below, I confirm that I have read and understood the information package and in particular that:

- I understand that my involvement in this research will include an intial interview and completion of a questionnaire booklet, a second interview and completion of a questionnaire booklet 3-4 months after my baby and I return home, and a final questionnaire booklet and interview when my baby is 1-year old.
- I have had any questions answered to my satisfaction and had the chance to discuss my participation with a support person
- I understand the risks involved
- I understand that there may be no direct benefit to me from my participation in this research.
- I understand that each interview will be digitally recorded; and I understand that only the research team will have access to recordings. I understand that the recordings will be erased following transcription and analysis.
- I understand that my participation in this research is voluntary. My decision to take part or not to take part, or to take part and then withdraw, will not affect my routine treatment, my relationship with those treating me or my relationship with the hospital or Griffith University
- I understand that if I have any additional questions I can contact the research team
- I understand that I am free to withdraw at any time, without comment or penalty
- I understand that I can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee on 3735 5585 (or research-ethics@griffith.edu.au) or _______ Health Service District HREC Administrator on 07 (email: @health.qld.gov.au) if I have any concerns about the ethical conduct of the project; and
- I agree to participate in the project.
Participants Name (please print) .................................................................

Signature ........................................ Date: .........................

______________________________________________________________

“I confirm that, to the best of my knowledge, the participant has understood the information provided to him/her, the implications of this information and that the participant will be provided with a copy of this document.

Researchers Name (please print) .............................................................

Signature ........................................ Date: .........................

______________________________________________________________

Note: All parties signing the form must date their own signatures.