"I Managed It Pretty Good": Birth Narratives of Adolescent Mothers

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Abstract:

The aim of this study was to understand adolescent mothers' childbirth experiences. Semistructured interviews were conducted with participants recruited from a community-based program for adolescent mothers. Fourteen mothers described their birth experiences. Using a narrative analytic approach, responses were reconstructed into birth stories. Stories, condensed into poetic form, were compared and contrasted. Four unique categories emerged: connected births, surreal births, disconnected births, and disempowered births. Categories differed by agency, support, and emotional tone. Positive support was found in stories that portrayed high agency and positive affect, whereas problematic support was apparent in stories that conveyed passivity, frustration, and disappointment. This study has implications for tailoring childbirth education for adolescent mothers and can inform health-care professionals working with this population.

Keywords: adolescent mothers | narrative analysis | social support

Article:

Approximately 400,000 adolescent women give birth each year in the United States (Kost & Henshaw, 2012). Although the number of teen births has been steadily dropping since the most recent peak in 1991 (Hamilton & Ventura, 2012), the dominant discourse in both research and practice constructs teen parenting as a social problem (Breheny & Stephens, 2007; Sisson, 2012). Pregnant and parenting adolescents are viewed as deviant, immature, and incapable of successful parenting. Campaigns to prevent teen pregnancy promote these attributes through visual and written representations of the lives of teenaged mothers (Sisson, 2012; Taylor, 2013). Likewise, the scientifi c literature on teen parenting primarily focuses on the defi cits of adolescent parents and consists of correlational studies that describe negative outcomes, such as low birth weight, low literacy, and problem behaviors among children as well as increased depression and stress and low educational achievement among mothers (Breheny & Stephens, 2007). However, most of these studies do not adjust for the greater likelihood that adolescent mothers come from disadvantaged backgrounds and/or have suffered trauma or abuse. More rigorous studies show that age is not a strong factor in the disadvantages of adolescent parenthood once poverty and distress are taken into account (Kearney & Levine, 2012; Sisson, 2012). This deficit model of teen parenting (Prater, 1994) has forced most of the attention and resources toward pregnancy

prevention, with fewer resources going toward the support of pregnant and parenting adolescents.

In North America, a medical model shapes the childbirth stories of women. Childbirth is seen as a painful and dangerous procedure that occurs in a hospital. Women must prepare for birth with the help of professionals through prenatal visits and childbirth education. And although pain during childbirth is a given, the management of pain through a combination of medication and interpersonal support is assumed. Feminist critiques of this discourse have centered on issues of reproductive control, choice (especially the option of a natural birth), and power but have primarily been told through the stories of White middle- and working class adult women (Dillaway & Brubaker, 2006). There is a need for a more diverse representation of women's experiences and stories of childbirth (Brubaker & Dillaway, 2008).

Positive and well-supported birth experiences are associated with better birth outcomes as well as subsequent parenting behaviors (Sauls, 2002), yet little is known about the birth experiences of teen mothers. This study uses a feminist social constructionist framework (Gergen, 2001) to examine the birth narratives of 14 adolescent mothers attending a specialized childbirth education program. A feminist social constructionist perspective posits that reality is constructed through dialogue, narratives, and discourse while maintaining a strong focus on issues of gender, power, and equality. Feminist research examines and addresses issues of power while respecting, preserving, and promoting the voices of marginalized groups (Reid, 2004). Narrative analysis, commonly used in feminist research, uses a holistic approach to interpret and understand participants' views and experiences. Stories are constructed and relayed by the participant through questions posed by the researcher. The story is then reconstructed through an analytic process and presented to an audience. In this way, the product of a narrative analysis is a story that has been co-constructed by the participants, the authors, and the readers (Reissman, 1993). This article presents the co-constructed stories of adolescent mothers' experiences of the birth of their children. With only a few exceptions (Brubaker 2007; Dillaway & Brubaker, 2006; Low, Martin, Sampselle, Guthrie, & Oakley, 2003), research on childbearing among adolescent mothers has not included the voices of the mothers themselves. In this absence, health professionals have had to rely on general knowledge of adolescent development (Broussard & Broussard, 2009; Sauls & Grassley, 2011; Tilghman & Lovette, 2008) to guide their practice and may be unduly influenced by the deficit model. Presenting the stories of adolescent mothers is important to both challenge the deficit model and to add the voices of a specific group of marginalized mothers to the current discourse on medicalized childbirth. Examining adolescent mothers' stories of childbirth can help professionals who work closely with this population provide appropriate support to young mothers. It may also provide an alternative framework to the deficit model for developing supportive campaigns, strategies, and educational programs for this marginalized population.

Methods

This exploratory and descriptive study was conducted as part of a process evaluation designed to assess services provided by a community-based organization (CBO) in the southeastern United States. The CBO provides a comprehensive adolescent parenting support program that includes childbirth education classes, doulas, mentors, literacy, and leadership programs as well as case management. Adolescent mothers were recruited from childbirth classes offered between December 2010 and December 2011. Participants were told the purpose of the study was to learn more about supporting teens during their pregnancies, childbirth, and in caring for their babies. Fourteen mothers volunteered and provided birth stories. Participants included primarily lower

income teens (ages 15– 19 years) receiving Medicaid and other social services (see Table 1). Most (n = 9) were African American, and all but two participants were experiencing their first pregnancy. Participants attended an average of six childbirth education classes.
Trained research assistants conducted interviews at the CBO or in participants' homes, depending on participant preference. Participants were asked to describe their birth experiences by taking the interviewer "through it step-by-step." Interviewers probed for details on the start of labor, pain management, social support, hospital support, as well as positive and challenging experiences during labor and birth. Interviews took between 30 and 90 min, with an average of 42 min. Interviews were audiotaped and transcribed verbatim. Each participant received a $20 gift card to a local retailer after completing the interview. The study was approved by the fi rst author's institutional review board, and informed consent was obtained from all participants who were 18 years of age or older. For younger participants, informed consent was obtained from their parent or legal guardian, and underaged participants provided their assent.

Analysis

Birth stories were reconstructed from verbatim transcripts and read aloud during group meetings. The original transcripts were used as a reference for all discrepancies. Throughout the process, the authors identified and discussed individual and collective reactions to the mothers' stories to bracket personal perceptions and biases (Creswell, 2012). Extreme care was taken to maintain the voices of and language used by participants, but words or phrases (such as parts of the interviewer's questions) were inserted where further clarification was needed. The fi rst author then read all of the narratives in their entirety and crystallized the stories into poetic form. Condensing transcripts into poetic form has been found to be "a practical and powerful method for analyzing social worlds" (Richardson, 2000, p. 12) and aids in the researchers' ability to recognize the complexity of the phenomenon (Tracy, 2010).
The aim of the poetic transformation was to focus the analysis on how each participant experienced the birth instead of the logistics of the birth. By converting the stories into poetic narratives, the tone and imagery of the story became more apparent and the plot was less prominent. The other authors reviewed all poems and compared them to the birth stories. Disagreements were resolved through discussion. The poems were then examined for language use and tone. Examples included examining the use of "I" statements and adjectives used to describe events. Issues that came to the forefront through this process included reactions to support, sense of agency, and emotionality. A final level of analysis occurred when each story was compared and contrasted with all other stories on levels of agency and support. From this analysis, a typology of birth narratives consisting of four separate categories was identified. A final review of all materials (poems, stories, transcripts, and corresponding memos) was conducted within each category to verify the soundness of each category.

Findings

A common narrative of medicalized and supported birth was found across all stories. It is important to note that all births took place in the same hospital and therefore hospital protocol was consistent across all stories. The common plot line included the mother identifying that labor has begun (which may or may not be corroborated by others), transitioning to the hospital (usually taken by support people), coping with pain (primarily through the use of an epidural), birthing vaginally (most perceived a quick birth), and holding her baby before he or she is cleaned. In addition to this common narrative, important distinctions separated the stories into

four types: connected births, surreal births, disconnected births, and disempowered births. A full description of each category is provided in the following sections, exemplified by a birth story, and connections between the types are depicted in Figure 1.

Pseudonyms	Age (years)	Race/Ethnicity	# of Classes	# of Children	Typology
Kalina	16	African American	8	1	Connected
Abrianna	16	African American	4	1	Connected
Miranda	18	Latina	6	1	Connected
Destiny	17	African American	4	1	Connected
Reina	17	African American	10	1	Connected
Heather	15	White	6	1	Surreal
Danielle	18	White	8	1	Surreal
Tonya	17	Biracial	7	1	Surreal
Cyiarra	17	African American	2	1	Disconnected
Charmaine	17	African American	2	2	Disconnected
Yolanda	17	African American	6	1	Disconnected
Jeri	18	African American	8	2	Disconnected
Josephine	19	White	7	1	Disempowered
Stephanie	15	African American	4	1	Disempowered

Connected Birth

Abrianna was alone in her room on a Sunday afternoon when labor started. She managed the pain by getting on her knees and "doing [the] pelvic rock about 3 hr." Eventually, she called her mother upstairs to go to the hospital. Her mother told her they should wait until the contractions were closer together. About an hour later, she went to the hospital, accompanied by her mother, her friend's mother, and her sister. Her aunt, her cousin and his girlfriend, and her brothers met her in the hospital room.

I think I was more relaxed than anything. I was calm. At first I didn't even know I was in labor. So I was real calm. I could just feel the contractions were easy and smooth.

Later when the pain increased, she used breathing and rocking to control them. She also reported "massages, talking about things, eating ice cubes, walking" as pain relief measures. Although she was not able to have a doula like she wanted, she felt her mother "was basically [her] doula." A nurse told her when she was ready to push and then the doctor came in and got ready. He came over to her just as the head was visible and "just pulled the whole body out." He then cleaned the baby and Abrianna's mother cut the umbilical cord. The doctor wrapped up her daughter and handed her to Abrianna. Holding her baby was an emotional and tearful moment for her. When asked to describe the best part of her labor, she responded, "When I first saw her, knowing that she was mine and I actually had her, had a baby. And tears, that's it."

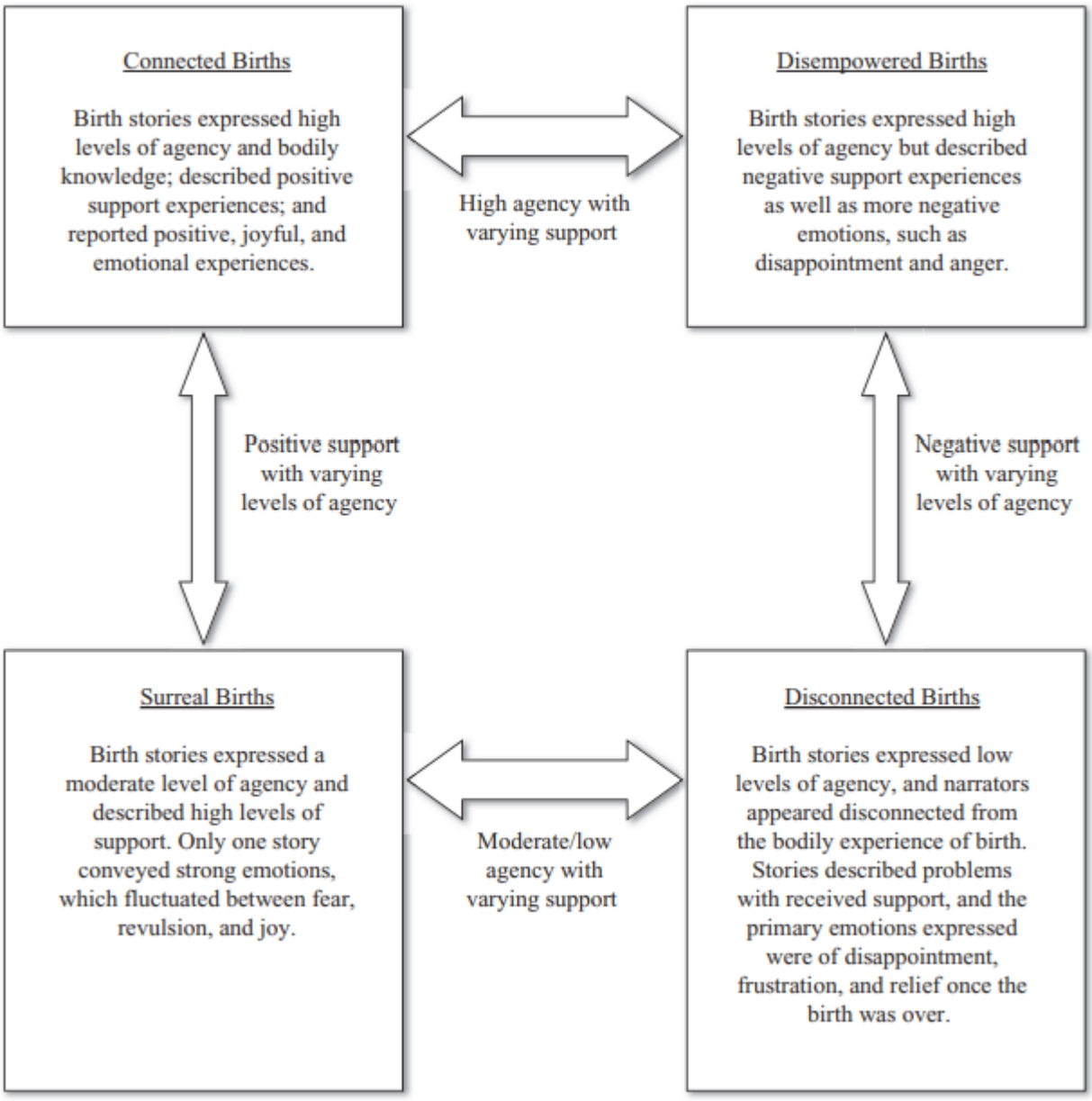

Figure 1. Categories of birth narratives by agency and support.

Five participants fi t into the connected birth category. In these stories, the mother portrayed her birth as supported and described herself as a present and active agent in the birth. As seen in the story earlier, Abrianna labors on her own for 3 hr, using a “pelvic rock” technique, before calling for her mother. Other examples include making the decision for an epidural and rejecting other people’s breathing technique for their own. Many adjectives used by the mothers were positive. For example, Kalina described almost everything as “good” while diminishing negative aspects (“It was like a little pain. It wasn’t as bad as people say.”). This does not mean these stories were without negative events or feelings. Nor does it mean these mothers necessarily felt less pain than the other mothers but rather that the story they chose to tell included more positive than negative phrasing.

The presence of continuous support is an essential feature in this group. Support comes in various ways and did not depend on the size of the support group. However, the support was steady, primarily came from family and friends, and the mother was appreciative of the support. Destiny said having people at her birth made her feel "special," and Miranda said it made a difference "knowing that every time I needed something, somebody was there to help me."

Another important feature in these stories is that the mother portrayed a strong sense of her body. The birth may not have been free of pain or drama, but the mother conveyed a confidence in her body and in her ability to birth. Kalina told us, "I managed it pretty good," and Reina reported, "I knew when something wasn't right; I know my body." Although some of these stories conveyed mixed emotions, the overall tone was positive, with expressions of joy, humor, and pride as can be seen in the ending of Abrianna's story.

Surreal Birth

Heather's contractions started at night while she was lying in her bed with her boyfriend. She lay in the bed, feeling "pain and then no pain, pain and then no pain," until the morning came and they went to the hospital. Heather felt "like it wasn't really happening" and that it was "unrealistic."

I kept on thinking, "Oh, they're just going to send me home; it's not real labor." But it was. And I was feeling kind of like I didn't know what to expect.

She reported waiting in the hospital for a long time. She was unclear on many details and not sure what was going on. A nurse was asking her "all these questions" and she didn't know why she was there. Once she was in the birth room, she was "finally" able to get an epidural. She reports one nurse who was "really nice, really informative." This nurse would tell her "what's going to happen" and explain each procedure. The nurse also told her when to push and encouraged her by saying "that push was a good push." Heather felt she was "pushing a lot" but "wasn't really pushing" and that it was difficult waiting for the next contraction so she could push. She felt she "wasn't getting very far." Words of encouragement from her support people "made it feel not as bad." Heather reported the doctor "vacuumed the baby out" then "stitched me up and then left." After "they pulled [the baby] out," her "boyfriend cut the umbilical cord" and they laid the baby on her stomach.

There are three teen mothers in the surreal birth category and each expresses a different example of being surreal that ranges from unreal to dreamlike to fantastic. Heather's story is unrealistic to her. It is told in a confused and contradictory manner. Although she provided some details, she was not sure what happened or why things happened. Danielle's story was dreamlike. She didn't remember a lot of the details and described sleeping and engaging in recreational activities throughout her labor. She felt her labor was easy after her epidural, but although she remembered getting it, she didn't remember "what it felt like." She had a very planned and medicalized birth and appeared empowered to remain distanced and uninvolved in the process. Tonya's story was told with an emphasis on unusual events, blood, and gore and is an example of the fantastic or bizarre. Throughout the labor, her baby's heart rate "kept going up and down" as was her own blood pressure. Her boyfriend was nervous cutting the cord because of all the blood that "sprayed all over the doctor" and Tonya. She reported support people ready to faint at the sight of the placenta, and at one point, she felt she "was going to bleed to death."

An important feature for this group is the high degree of support they experienced. The support they received protected them in their surreal or altered state. They were able to rely on others,

who kept their births safe and made it alright to be confused or removed or if the events were bizarre. For Heather, a nurse was helpful because she kept her informed. By having the nurse tell her "exactly what's going to happen," it was okay that she was confused and a little distanced from the experience. Danielle's primary support came from her mother, who made the experience completely safe and allowed Danielle to tune out. Tonya had a large support system that made the experience safe in spite of the blood and gore drama. There weren't any negative support examples in these stories.

The three stories that make up this category vary in the degree to which the narrator appeared to be an active agent in her birth. Although none of the stories are told with the level of agency and awareness that is found in connected births, they are not portrayed as completely passive. For example, Tonya reports a lot of factual information and is aware of all that is going on around her; however, she attributes most of the action to other people or describes events as just happening, without attribution. There are very few instances where she attributes actions to herself. An interesting example is when she dichotomizes herself from her body ("I wasn't doing it, my body was doing it, doing the pushing, and she just came out."). Similar attributions can be found in Heather's story. Most of the action in Heather's story is attributed to others. The few times that Heather claims agency, she also contradicts it, such as when she states, "I'm pushing a lot, but I wasn't really pushing that much."

The emotional tone expressed across the three stories was also mixed. Tonya expressed not only shock over the events but also joy for her baby. Both Danielle's and Heather's stories were told with very little emotional expression. Although Danielle expresses joy and fascination with her son now that he is here, the birth itself is unemotional. The tone of Heather's story is primarily confusion, but there is also an expression of relief when the birth is over.

Disconnected Birth

Cyiarra's labor started in the middle of the night while she was asleep. She reported that she "just laid there" at fi rst, just feeling the contractions. Throughout Cyiarra's narrative, we hear how she described her birth as "exhausting." She was 2.5 cm dilated when she arrived at the hospital but didn't get her epidural until she had reached 6 cm. Cyiarra stated that the epidural helped her the most because "it stopped all the pain." After the epidural, she was "just really waiting and waiting and sleeping really." Her mother, her grandmother, and the baby's father were all in the hospital room with her. She found herself "frustrated" and "aggravated" by her support people, particularly her mother.

Because my mom, when she was in there, she was just talking and eating and everything and was not interested in what I was doing.

The nurses came in and checked on her but did not stay in the room. She didn't know which person in the room was her doctor but guessed the doctor came in right before she started pushing. After the baby was birthed, they "just threw her up there and there she was." Cyiarra considered this event the best part of the birth because she "finally got to get some sleep."

Four stories fit the disconnected birth category. In these stories, the mother portrayed her infant's birth as something to get through. There is a lack of involvement in the birth and a sense of distance from the birthing experience. An important feature is the passivity that comes across in the stories. The language used in telling these stories centers around what "they" do rather than what "I" do. In the disconnected birth stories, most of the action is attributed to others.

Another key feature is the lack of support or the problematic support that the narrator received. There is a tone of disappointment when they discussed the support that was provided. In addition to Cyiarra's aggravation described earlier, each of the other mothers reported problems with their support team. Charmaine opted to have just her boyfriend there but was disappointed when he slept through most of the labor. Jeri also conveyed disappointment when her doula was forced to leave and missed the actual birth. Yolanda reported very mixed support from her nurses. One was "like a friend in the hospital" while she was in labor, but after giving birth, she had a different experience with two nurses that she reported as "rude" when they told her to "suck it up because it's painful anyway."

The absence of positive emotion is notable in these stories. The strongest emotions seem to be disappointment and frustration, but even these appear muted. There is a lot of negative language (e.g., what they didn't do, what wasn't done, what others did to them) used in the stories, suggesting that the birth was experienced or remembered by what went wrong. Yolanda's story, for example, centered on what she couldn't do. She was not allowed to stay at the hospital when she believed she was in labor and then, the next day, had to go to work with her mother because there was no one to stay home with her while she labored.

Disempowered Birth

Josephine's boyfriend didn't think she was in labor at fi rst. Because her water had not yet broken, he contradicted her assertion that labor had begun. She corrected him, gently, and they proceeded to get confirmation from her mother and her doctor. When one doctor told her to wait, she called another doctor, who told her to go to the hospital. Her boyfriend drove her to the hospital, but he was nervous and was speeding. She reassured him and told him to slow down. At the hospital, she felt her progression was "too far," her contractions were "nonstop" and "intense," and "nothing [. . .] was helping" her. She passed a crowd of friends and relatives on the way to the birth room.

I just remember . . . passing a ton of people in there thinking "Oh my gosh, why?" Like there was not a reason for all of those people to be there . . . I was thinking, "Wait until after I had the baby. I need some space."

In the birth room, she walked around until she couldn't stay up. Then she lay down and decided it was time for an epidural.

The only time I used the breathing and it worked [was when] I was getting the epidural because I was having contractions and you are supposed to stay absolutely still and stuff. That was the hardest thing I did during my whole birthing experience.

The epidural did not give her the total relief she had hoped for because she still felt sensations and she believed waiting for it had slowed down her progress because her body couldn't relax. Her boyfriend, her mother, and her boyfriend's mother were all in the birth room. She "laughed at" her boyfriend but was annoyed by her mother.

My mom was just annoying me to death. All she did was talk, and the doctor was finally like "Look, she needs to stop" and I just said "sorry."

While laboring, Josephine would scream and then apologize. Her boyfriend's mother rubbed her arm and told her "you need to do what you need to do." Her daughter had the umbilical cord wrapped around her neck and the doctor had to cut it "real quick." They weren't able to give the baby directly to her, so all she saw "was her little legs" while they cleaned her up and she mentioned, "Everyone else got to see her first."

There are only two stories in the disempowered birth type. Although small, the category is important because the stories portray how agency can be tampered by problematic support. Both mothers portrayed strong agency. Josephine was confident in her knowledge and corrected her boyfriend when he contradicted her. She was also the one calming him on the way to the hospital. Stephanie perceived herself to be in labor after she fell in the bathtub and started to have contractions, but she reported the hospital "drugged me up with Percocets and sent me home." The next day, she took herself to the hospital by calling an ambulance and told her mother "I don't care what they say. I'm staying in the hospital because I know I'm in labor." Both of these young mothers were aware of what was going on around them, were actively seeking support, and were making decisions. They were engaged in the birthing experience. However, both also reported that nothing they did on their own helped and that even the epidural didn't work as well as it should have.

In both of these stories, there is not an absence of support but rather problematic support combined with positive support. The positive support is not strong enough to override the effect of problematic support. For Josephine, problematic support came from her friends and family: Her boyfriend was nervous, too many people showed up at the hospital, and her mother was annoying and embarrassing her in front of the doctor. For Stephanie, problematic support came from hospital staff. First, they turned her away and denied that she was in labor, and then, when the birth was over, they were completely unresponsive to her needs. During the birth, the only support person Stephanie mentioned was her mother, and although her mother was portrayed positively, she questioned Stephanie's knowledge of her body. Right before she gave birth, Stephanie woke up from a drug-induced nap and told her mother she felt "something coming." Her mother replied, "Girl, you don't feel nothing." Throughout both stories, there is a sense the narrators did not quite get what they needed or expected from others. The tone of the stories revolved around disappointment and frustration. Although they each demonstrated agency, they also each expressed doubt in their own abilities.

Discussion

In spite of a common narrative of a medicalized and supported birth, we found great variability between the individual stories and the four categories. The categories vary by level of agency, emotional expression, and role of support. It is important to note that agency, emotion, and support were not absent in any of the narratives but rather the degree and manner in which they were expressed differed by the type of narrative. Figure 1 highlights the variations found between the story categories. Among stories that expressed high agency, variation in support cooccurred with differences in the emotional tone of the stories. When agency was high and there was a lot of positive support, adolescent mothers expressed feelings of joy. However, when agency was high and support was problematic, disappointment and anger were represented in the stories. Distinctions between emotional tone were less clear among stories that expressed low or moderate agency. Stories with moderate agency and positive support had either muted emotional tone or expressed a full range of emotional responses within one story. However, stories that expressed low agency and problematic support expressed emotions of disappointment and

frustration. Overall findings suggest the importance of positive support from family, friends, and medical providers for adolescent women's birthing experiences.

Although association between support and positive birthing experiences has been found before (Sauls, 2002), this study is unique in its exploration of adolescent mothers' accounts of their childbirth experience. Findings suggest a complex relationship between agency and support. Although none of the young women in this study expressed overly negative or traumatic birth experiences, important variations in how participants told and remembered their birth stories centered on an interaction between the type of support they received and the level of agency they expressed. When support was problematic and the mother felt little agency over her body and her birth, she appeared disconnected from the events and reported more negative emotions. When support was problematic but the mother felt high agency over her body and her birth, the tone of the story was still more negative than positive. In the surreal birth stories, where level of agency was more mixed, the presence of positive support seemed particularly instrumental because it helped buffer the mother from frightening and/or confusing events. It is only in the connected birth stories, with both high agency and high support, that we see predominantly positive emotions.

Panazzolo and Mohammed (2011) contend that agency, dignity, and connectedness are essential elements of "a good birth" in America. They defi ne agency as the "ability to be in control and remain powerful" (p. 270). More than half of our participants told stories that conveyed either high or moderate levels of agency. However, agency, as it emerged in this study, did not always mean being in control or remaining powerful. All women should be allowed to birth in a manner that suits their personal needs and desires, including planning a highly medicalized and disengaged birth, such as was seen in Danielle's story. Agency does not have to mean being in control of the entire birth experience but does mean being able to choose how the birth is experienced. Danielle's trust in her mother's support allowed her to have the disengaged birth that she wanted and suggests a different understanding of birthing agency.

The study has several limitations. Participants were recruited as part of an evaluation study of a childbirth education and doula program designed to empower adolescent participants and provide a supportive birth experience. Although most pregnant adolescents do not receive any type of childbirth education (Broussard & Broussard, 2009), the study shows that even among a highly unique population, variability exists in how births are experienced. Likewise, it is important to note that even when a program is intended to promote a supported birth environment, problematic support can still occur and affect the experience for the young mother. However, it is also important to recognize that specialized programs for adolescent mothers can have positive effects because more than half of the birth stories portray high levels of support and at least moderate agency. Finally, the sampling was limited to teen mothers who attended a particular CBO. This CBO had noticed a recent decrease in the number of Latina women who use their services; only two Latina teens participated in the CBO's childbirth classes for the year. Therefore, Latinas were underrepresented in this study. The highest rates of childbirth are found among Latina adolescents (Kost & Henshaw, 2012), and future studies should focus on this population.

Implications for Practice

Findings suggest the importance of adolescent specific childbirth education classes and the need for childbirth educators and other providers who work with adolescent mothers to offer activities that foster agency and personal advocacy. Likewise, practitioners should be aware that agency may not look the same to all participants and some adolescents may prefer to create an environment that allows them to safely distance themselves during birth. In addition, programs

should supply training to friends and families so that appropriate and positive support is available to adolescent mothers as they birth. This study fills an important gap in the literature because the discourse around birthing choices in this country has been limited to White middle-class adult women. It is only by listening to the experiences of young mothers that we can move away from a deficit approach to adolescent motherhood and build supportive environments for young mothers to birth and parent their children.

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