DOING SEX, HAVING THE BABY:

YOUNG WOMEN AND TRANSITIONS TO

MOTHERHOOD

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ABSTRACT

This ethnographic study explores the experiences of seventeen young women, their significant others, and midwives, from pregnancy realisation through the early years of motherhood. It examines changes to significant relationships (as defined by the young women) over this period. Through an initial examination of the history of illegitimacy and the theme of 'unwantedness', I map changing attitudes to young women's reproductive activities and discuss moral discourses on adolescent subjectivity, especially as it pertains to adolescent motherhood. This thesis contributes to empirical research on the sociology of the adolescent female body at the convergence of two major life cycle transitions: adolescence and motherhood. Through an empirical analysis of embodiment and social construction, the diverse ways in which a selected sample of young women 'do' maternity are explored. The transmission of childbearing and rearing knowledges and practices, as passed from mothers to daughters, is also of central importance to this thesis.

Medical discourses play a significant role in policing and regulating women's bodies, in defining appropriate female behaviours, and in authorising socio-cultural constructions of femininity. Pregnancy and childbirth signalled the beginning of a different relationship between young women and their bodies as most had previously experienced little contact with medical services. Becoming a mother heralded an unaccustomed emphasis on the body and an expectation that young women would submit themselves, and their children, for regular monitoring and assessment. This thesis provides another set of lenses through which to examine the interplay of power and personal agency in the lives of young mothers, and to examine the relationship between the body and self-identity. Finally, the roles played by midwives and other health and related professionals, and the 'workings' of hierarchically organised institutions, are examined through respondents' narratives and set alongside discourses of choice and control in the contested arenas of female reproduction.

ACKNOWLEDGEMENTS

This thesis is dedicated to my long dead mother whose face I see crinkled in puzzlement as I try to explain to her that there is more than one type of 'Doctor'.

Girls Awake, Asleep

Young girls up all hours
devouring time-is-money on the phone:
conspiracies of mirth,
sharp analyses of friends' defects,
confession, slander, speculation
--all the little mundane bravenesses
that press the boundaries
of what can be thought, felt and talked about.
Their clear-voiced punctuation rings
up stair-wells, to where parents toss
and groan, a sense of their own intolerance
Some consolation for short nights, long bills.

Young girls in bed all hours
fathom sleep oceans,
drink oblivion with their deep breaths,
suck it like milk.
Curled round their own warmth,
they fat-cat on the cream of sleep
lapping dreams.
For this, they will resist all calling.
Surfing the crests of feather billows
they ride some sleek dream animal,
pulling the silk strands of his mane,
urging him on.

CHAPTER ONE: INTRODUCTION

When I commenced my PhD, I was involved with a national (England and Wales) research project evaluating the impact of a set of evidence-based leaflets on decision-making in maternity care (Kirkham and Stapleton, 2001). Although this project - the 'Informed Choice' (IC) research – would have allowed me to undertake a discrete piece of research, I was reluctant to pre-define my PhD in this way.

During the later stages of that study I started to focus on the behaviours and attitudes of health professionals towards their teenage clients. I noticed that the image of pregnant teenagers had changed since a decade earlier, when I worked in the NHS. The young women I was observing seemed to take up more 'space'. They were more visible, in their tight jeans, crop tops and stretch lycra clothing. Their piercings and tattoos were not hidden, but displayed as an identity statement. They appeared more *embodied*. But it was the 'rebellious' stance of these teenagers, and my desire to know more about their lives, which particularly interested me.

Co-incidentally, I had reached a point in the IC study where the findings from observations and interviews with pregnant teenagers were beginning to unsettle me. These young women often seemed to have a different 'take' on their situation than the midwives and others involved in their maternity care provision. Although my research role had enabled me observe hundreds of interactions between health professionals and childbearing women, the scale of the project did not allow for an in-depth understanding of what was going on beneath the surface of these exchanges. Whilst I appreciated intellectually that a degree of dislocation and frustration were inevitable consequences of an ambitious research agenda, I missed the emotional satisfaction provided by deeper engagement with research participants.

The lack of continuity with participants increased my dissatisfaction, especially with respect to knowing about birth and related outcomes. I became increasingly aware that the 'real' stories and the 'real' meanings about women's lives could not be conveyed in 'one-off' interviews, no matter how 'in depth' they purported to be. In particular, I wanted to know more about the outcomes of teenagers' childbearing experiences: whether A managed to birth her baby at home as she intended; whether B managed to avoid the midwife she disliked; whether C's baby turned from a breech position to head down before she went into labour. I also became more curious about these young women's lives, particularly their relationships with significant others (especially their mothers) and major life events beyond those associated with pregnancy.

My loneliness and isolation as a researcher in a constantly changing field, where I was unknown and often ignored, mirrored what I was reading in the teenagers' interview transcripts. I often felt bewildered and peripheral, especially in busy antenatal clinics. Sometimes this was at the micro level, not knowing if I was supposed to use the staff or the patients' toilets (and whether this mattered and to whom) or the 'pecking order' in the medical and midwifery hierarchies. At other times this 'not knowing' was about acceptable norms of behaviour in Welsh communities.

Health professionals' unitary perspectives on teenage sexuality

My data suggested that health professionals tended to view pregnant teenagers as an homogenous group of (bad or, at least, immature) girls, rather than as a category sharing only the experience of pregnancy. And, whilst many midwives had teenage daughters themselves, few made direct reference to their sexuality. In contrast, their teenage sons seemed to be viewed as relatively immune from the consequences of their emerging sexuality, as illustrated by the comment: 'Thank God I've only got boys!' I was bothered and intrigued by this double standard, especially coming from health professionals whose primary responsibility was the sexuality of young women.

From the reception many of the pregnant teenagers received from midwives and obstetricians, it seemed there was only one perspective on teenage pregnancy: it was an ill-advised adventure. Sex was not what 'wholesome' teenagers should be doing. The young women I observed, however, were rarely given the opportunity to tell their own stories about how they became pregnant. I would later discover a continuum of experiences, including falling in love, 'messing around', burst condoms, incest and rape. But, because the focus of maternity 'care' was primarily on the well-being of the foetus, the well being of the teenager was incidental.

The objectification of young pregnant women by more powerful others, their treatment as 'things' rather than sentient beings with feelings and opinions, caused me to reflect on how midwives attach significance to their status as 'autonomous' practitioners, whilst simultaneously denying autonomy to (particular) women in their care. Midwives' defence of their autonomous status is primarily about protecting their 'patch' from intrusions by obstetricians or more senior midwives. In the UK, midwifery autonomy is also viewed as a professional marker separating midwives from nurses, whom they tend to see as status-inferior, lacking in decision-making power, and overly deferential and compliant towards doctors. Even if these distinctions are accurate, they reflect a superficial and self-serving understanding of autonomy. They also disregard the rights to autonomy of the 'other' and are unresponsive to concerns about power positioning relative to this 'other'. There are implications here about 'knowers' and 'knowing' and the constitution of knowledge of particular groups (teenage mothers), who are then systematically marginalized by mainstream practices and practitioners.

There were many ways in which health professionals disregarded childbearing teenagers, who they seemed to view as unreliable witnesses to their own circumstances and life events. For instance, many practitioners did not introduce themselves, did not look up when young women entered the room, did not acknowledge their boyfriends, directed conversation to the teenager's mother and, when teenagers attempted to speak for themselves, cut across and/or infantilised them. Pregnant young women were seldom offered opportunities for self-disclosure and only very rarely did discussion focus on their concerns, especially if these were about events outside pregnancy and impending motherhood. This was very different to the interactions some midwives had with other (non-teenage) women in their caseloads, with whom they joked, inquired about other family members, and advised about issues such as maternity leave and the male partner's potential involvement in the birth. Whilst other categories of

pregnant women were also marginalized by health professionals, the plight of the teenagers got under my skin. It was something about their youth, and their lack of experience, facing discrimination whilst they were accessing maternity 'care' in a supposedly 'safe' environment, which angered me. Many of them attended the antenatal clinic alone, which also concerned me.

An individual's standing as a 'knower' is allied to, and dependent upon, their credibility within society. This is largely a matter of how they are seen by significant others: whether they are deemed capable of representing themselves truthfully, and whether coherence and factuality can be adduced from their account(s). Credibility may be influenced by sex, age, religion, class and ethnicity, but it is also inseparable from less well-defined factors such as 'reputation' and/or social standing. For example, the credibility of a female rape victim may be disputed if her persona and testimony do not accord with the stereotype of an 'innocent' woman, but instead convey an impression that she 'asked for it'. Teenagers have little credibility in the public imagination; their low status is especially noticeable in the case of young mothers. This echoes what Miranda Fricker has termed 'epistemic injustice' (Fricker, 2003:154), whereby the person telling the story is designated as unreliable because of a preconceived, although not necessarily intentional, prejudice on the part of the hearer. The speaker thus receives less credibility than s/he would receive if the hearer was operating from a position of openness to the speaker.

Being ranked as inferior actually makes one inferior (by way of expectations); this has been understood for many years (e.g. Merton, 1948). Empirical studies have confirmed that the 'Pygmalion' effect (Rosenthal and Jacobson, 1992) operates in educational, judicial and health-care settings and demonstrates that preconceived ideas about individuals may significantly influence outcomes. The values of powerholders may transform 'social inputs (class) into educational outputs (marks, scholarships, university places) through the mediation of those stereotypical categories of judgement [...] which enable *class*ification to be euphemised as *academic* classification' (Jenkins, 2004:168-170 original emphasis). The nature of stereotyping practices is such that young childbearing women are scripted to become welfare-dependent, inadequate mothers of unruly children who, in turn, are destined to repeat the cycle. The role of more powerful others in shaping events, and ensuring that outcomes for particular (stigmatised) groups are *always* negative, is regularly ignored.

An overview of the contents of this thesis

I see this study as an opportunity to map the experiences of childbearing teenagers. Its primary aims are: to explore the experiences of a sample of pregnant teenagers undergoing the transition to motherhood, and to study changes to significant relationships (as defined by the teenager) over this period. The overarching themes are gender, power and identity, within the complexity of relationships and in the context of two major life transitions: becoming an adolescent and becoming a mother.

Although I draw upon a diverse literature, my central 'scaffolding' is feminist literature focusing on a range of issues relating to women's lives and experiences, especially childbearing and rearing. I take

account of ongoing debates about (gendered) power relations and the role of medicine as an agent of social control (Lupton, 1994), the social construction of gender in medical discourses (Martin, 1987), and the significance of social class as a significant determinant of health outcomes (Doyal, 1995, Graham 1993a, 1993b). Women's lives, and their self-defined health and related concerns, including reproduction, are now firmly on the socio-political agenda, whilst cross-cultural studies of childbirth practices (Davis-Floyd and Sargent, 1997; Jordan, 1978) add another important dimension to research on women's experiences of childbearing and mothering. The experience of becoming a mother was a defining factor, metaphorically and literally, in the female relationships which are the main focus of this study: between the young women and their own mothers, between young women and their own babies, and between mothers, young women, boyfriends and midwives. Hence, motherhood, and mothering practices, are the central themes linking the first three background 'literature' chapters.

In the first of these chapters, Chapter Two: 'Teenage pregnancy and young motherhood', I explore competing accounts of teenage pregnancy, as a 'disaster' or a 'crisis' requiring effective management and damage limitation, or as 'lightning rods for stigma' (Kelly, 2000:20). I discuss the term 'teenage pregnancy' and its relatively recent career, following earlier discourses on 'illegitimacy', 'unmarried mothers' and/or 'promiscuous women'. I describe the links between these readings of non-conformist pregnancy and how they inform current political debates and social policy initiatives. In particular, I ask why young women who are biologically at the 'peak age of reproductive functioning' (Morgan et al., 1999:135), and therefore physiologically well-endowed for childbearing, have come to be labelled deviant. I consider why financial and professional investment from a range of agencies has had so little impact on young people's sexual health. I also consider recent changes and anomalies in legislation regulating adolescent sexual behaviour and examine the social construction of the category 'youth', particularly in terms of gender and changing notions of 'risk'. Finally I briefly summarise recent policy developments, and associated critical commentary, in the interrelated areas of teenage pregnancy, social exclusion and childhood poverty.

Chapter Three, 'Women and the mutable context of reproduction', describes various, competing constructions of (non-normative) motherhood. I open with an historical overview of illegitimacy as an enduring symbol of, particularly female, sexual non-conformism, and the ways in which different terminologies have emphasised moral readings of the same 'problem' at different historical periods. I conclude with a discussion of motherhood and mothering practices in contemporary Western society, in the context of broader debates about gender and power relations: women's altered role and position in society, changing family structures and arrangements for parenting, and alternative readings of adolescent sexuality and the female body.

In Chapter Four, 'Midwives and the Midwifery profession', I give an account of the historical events leading up to the first (1902) Midwives Act and its impact on both midwives and the childbearing women they served. I place this reading of midwives as an occupational group within the context of women's social position and describe how their poverty and powerlessness contributed to their inability

to protect themselves against the incursion of medicine. Finally, I describe the role of midwives in contemporary clinical practice and reflect on the difficulties they face in juggling competing sets of allegiances.

In Chapter Five, *Doing the research; methodological considerations and study design*, I explain the 'architecture' of my thesis: how I set about designing my study and the methods I employed to generate and analyse my data.

Chapter Six, *Theorising the data; social constructionism and embodiment* , describes the theoretical approaches I employed to contextualize my research findings, together with a justification for employing these particular theories in the context of my study.

Chapters Seven to Eleven, which describe my research findings, are based on the empirical data generated during the course of my research. These chapters provide an overview of respondents' maternal experiences and illustrate the practices embedded within the institution of motherhood. These chapters also illustrate something of the complex, and multifaceted, connections between mothers, daughters, and significant others. In particular:

Chapter Seven, *Pregnancy realisation and disclosure*, elucidates young women's discovery of, and responses to, pregnancy. I explore respondents help-seeking behaviours and responses from a range of significant others, including mothers, partners and health professionals. I also describe family and friendship networks, and the manner in which pregnant teenagers shared confidences (or not) and disclosed (or withheld) information, and for what purposes.

In Chapter Eight, *Through Pregnancy*, I trace individual young women's pregnancy journeys. I describe how pregnancy related events impacted on, and shaped, adolescents' developing maternal identities, and how these events affected their relationships with significant others. I also discuss aspects of mothers' childbearing and rearing experiences and knowledges and the impact of these events on daughters' maternal experiences. I periodically return to explore discrete aspects of this theme throughout the remaining chapters.

In Chapter Nine, *Labour and birth narratives,* I map young women's continued journeys through labour and birth, and their respective transitions to motherhood. I also discuss a number of key issues which confronted respondents during this period of major adjustment as they embraced the (sometimes harsh) realities of mothering a new baby.

Chapter Ten, *Mothering in the early postnatal period,* describes the early weeks and months of young women's lives after they rejoined their families and communities as new mothers. I examine the ways in which they negotiated their different maternal identities within their respective social worlds, and the helps and hindrances they encountered en route. I also discuss the intergenerational transmission of parenting norms, a theme I continue to explore in Chapter Ten.

In the penultimate Chapter, *Mothering in early childhood: identities and practices*, I describe how young mothers formulated their individual maternal identities and how these emergent personas were supported and/or undermined by kinship networks and maternity professionals. I also discuss

respondents' mothering activities, and the gendering of domestic responsibilities within the context of family life, wherever this was located.

Chapter Twelve, *Looking back, and looking forwards*, complete this thesis. In this chapter I gather together the sometimes disparate, but always complex, narratives from all the young women, their mothers and significant others, and elaborate key themes and major concerns. I also acknowledge the limitations of the study and make suggestions for furthering research in this area.

CHAPTER TWO: TEENAGE PREGNANCY and YOUNG MOTHERHOOD

Only recently has adolescence[1] been seen as a separate phase between childhood and adulthood. Hence, adolescents' childbearing accounts have been amalgamated with the narratives of other disadvantaged mothers. These narratives, which are referred to in more depth in Chapter Three, make for poignant reading, describing the cruel treatment of non-conformist mothers who, despite circumstances mostly beyond their control, were shunned by society. Any discussion of contemporary teenage pregnancy is defined by reference to its antecedents.

The percolation of feminist ideas, a more sexually permissive climate, and a more liberal understanding of 'family', began to undermine the conjugal rights claimed by men (which contributed to unwanted pregnancies in women). Whilst marriage was once perceived as protective against a disreputable sexual reputation, by the late 1960s women were employing alternative reproductive and relationship scripts to those promulgated by the nuclear family. Oppressive, patriarchal structures were challenged, threatening the institution of marriage that had previously exerted such a powerful control over female sexuality. A more tolerant view of coupling was adopted with 'de facto' and 'common law' relationships increasingly viewed as routine rather than exotic. In this apparently liberated climate, illegitimacy per se was viewed as less of a threat to the social order than economically unsupported mothers. Reconstructing teenage pregnancy as a problem based on utilitarian considerations (Wong, 1997), rather than as simply morally deficient, paved the way for legislation which attached more stringent conditions to welfare recipients (Geronimus, 1997; Mizen, 2003).

The shift in phraseology from 'illegitimate' to 'teenage' motherhood diluted the association with marriage. What had been portrayed as a *moral* problem was now (re)presented as a technical, or scientific, problem (Arney and Bergen, 1984). Around this time the mechanistic model of the post-war welfare state encouraged people to believe that medical experts could define, and manage, health and illness. In conjunction with this shift in practice and values, the Western model of childbirth was redefined as 'technological' and its practices as 'technocratic' (Davis-Floyd, 1987). Resolving technical, as opposed to moral problems calls for different approaches: where the latter discourage rational discourse, technical problems 'are those for which solutions are imaginable' (Arney and Bergen, 1984:15), which attract research funding and demand evidence-based reasons for interventions. Technical problems may be deviations from the 'natural' order, but rather than being censured for their lack of conformity, they tend to be subjected to 'technologies of correction and normalisation' (Arney and Bergen, 1984:11). Hence, teenage mothers are increasingly the subjects of debates and research. But whilst moral and scientific/technical problems may pose different challenges, I suggest that any

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[1] Adolescence is the transitional (gender-specific: womanhood or manhood) period between childhood and adulthood. It is a significant stage of development involving biological, social, and psychological changes during which a juvenile matures into an adult member of society. As distinct from the varied interpretations of who, or what behaviour, may be considered 'adolescent'. The word 'teenager' is more easily defined, describing a person who is thirteen to nineteen years of age. See: http://www.en.wikipedia.org/wiki/Adolescence

maternity occurring outside of conventional structures offends against the 'natural' order and is therefore vulnerable to exclusionary practices.

Contemporary representations of teenage motherhood

Throughout the industrialised world, pregnant teenagers are described 'in the language of stigmatised dependency' (Davies et al., 1999:45), consistently being portrayed in terms of a 'deficit' model[2], reinforcing negative stereotypes of 'troubled' and 'troublesome' girls (Dennison and Coleman, 1998; Hudson, 1989; Lees, 1989). Although the illegal status of illegitimacy was abolished by the 1987 Family Law Reform Act, and the use of the term 'illegitimate' has been replaced with more 'morally neutral' (Reekie, 1998:10) terminology, official discourses continue to employ terms such as extra-nuptial or extra-marital, the prefix 'extra' signifying exclusion and otherness.

Disapproving judgements of non-normative childbearing women, often from privileged and authoritative elders whose social status 'celebrate(s) the idea of being in control' (Arai, 2003b:212), generally fail to take account of the circumstances and preferences of teenagers themselves. When their perspectives are sought, qualitative research (Arai, 2003b; de Jonge, 2001; Kelly, 2000) suggests that parenthood is less of a problem for the young people concerned than for society in general, and for policy makers in particular (MacIntyre and Cunningham-Burley, 1993; Phoenix, 1991a). This may partially explain the only modest successes[3] of interventions intended to curb adolescent sexual risk-taking and reduce rates of teenage maternity (DiCenso et al., 2002; Wight et al., 2002; Woodward, 2003).

Until recently, sexual health interventions have been gender-oriented, targeting young women (Dennison and Coleman, 2000), perhaps because pregnancy is often portrayed as the ultimate health risk for this group. Failing to consider the health and related concerns of young people as a whole, instead of 'epidemiologically defined elements' (Ashton and Seymour, 1993:117), may reinforce negative aspects of this particular stage in the female life course.

Reference to the sexuality of young people themselves is generally absent in discussions of adolescent sex, although there is evidence to suggest that curiosity is a significant driver for the first

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[2] The theory of 'communitarianism', as advanced by the sociologist Amitai Etizoni (Etizoni, 1993) has been hailed by politicians as the answer to the 'parenting deficit' which Etizoni claims is responsible for many of the ills besetting modern society. He posits that parents, but especially mothers, fail to provide adequate parenting for their children because they privilege their own needs for rewarding careers and financial security over their children's needs for sustained emotional attachment and physical contact. Lynne Murray (Murray, 1995) has rejected Etizoni's claims. On the contrary, she asserts that work outside the home is crucial to women's health and well-being because it is preventive against maternal depression which, in turn, is injurious to children's developmental needs. A recent critique (Klumb and Lampert, 2004) has explored the complex relationship between women's well being and paid employment.

[3] UK under-18 conception statistics reveal an overall decline of approx. 11.8% since 1998 whilst the percent of conceptions resulting in legal abortion has increased by just over 4% during the same period. Under 16 conceptions have reduced by approx 1% during the same period and legal abortion rates by approximately 4% (TPU, 2007).

sexual experience (Dickson et al., 1998). Soliciting accounts from young women who enjoy sex remains largely taboo and, hence, the potential for alternative readings of female adolescent sexuality is reduced. The 'discourse of desire' (Fine, 1988:29) does not sit comfortably with current policy which, perforce, 'ideologically separates the female sexual agent, or subject, from her counterpart, the female sexual victim' (ibid:30). Entrenched beliefs about women's passivity, and lack of understanding about the constituents of female desire and pleasure, make it difficult for young women to assert their sexual preferences, whilst the pleasurable physicality of teenage sex remains largely undocumented in research texts. Societal attitudes largely uphold a 'sex-negative' attitude towards female adolescent sexuality, wherein young women are encouraged to take the initiative in protecting themselves against the predatory behaviours of men. As young women enter puberty, they are pressured to be 'nice girls and ultimately good women' (Tolman, 1994:324), and to contain their (hetero)sexual impulses until they are older and, ideally, married. Indeed, girls are socialised into accepting that sexual restraint is a positive female attribute (Fine, 1988).

There is little detailed documentation of non-coital sexual practices, all of which are low risk for pregnancy. The narrow focus on mapping the adult-derived, normatively ascribed, components of adolescent sexuality may disregard what young people themselves consider to be sex (or, indeed, what they consider to be abstinence). Semantic diversity in relation to 'sex talk' was perhaps most famously captured by President Clinton, who claimed that the oral sex he enjoyed with Monica Lewinski did not constitute 'proper' sexual relations. The phrase 'sexually active' then, generates multiple understandings which are always contextually bound; attempts to describe the sexual practices of others are inherently problematic.

Pre-existing factors contributing to young motherhood

Teenage motherhood is associated with family disruption, including parental marital breakdown (Kiernan, 1992; Michael and Tuma, 1985), sexual abuse and exploitation (Treffers et al., 2001), the experience of statutory care (Paton, 2002; Woodward, 2003), and foster or kinship care (Carpenter et al., 2001)[4]. 'Cared for' young women are vulnerable to becoming pregnant at the point of exiting care arrangements (Biehal et al., 1995). Changes in household family structure, and the adaptive responses required to integrate these events, have been noted as particularly stressful for daughters, reinforcing a propensity to earlier childbearing (Cheesbrough, 2002).

Growing up in poverty is arguably the most critical determinant of adult experience, including age at first conception (Hobcraft and Kiernan, 2001; Smith, 1993). Young women whose parents are unskilled manual workers are almost ten times more likely to become pregnant than adolescents whose parents have professional qualifications (Botting et al., 1998). It has been suggested that poverty contributes to increased fertility because 'the greater a population's disadvantage, the less difference

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[4] Similar factors have been reported for teenage fatherhood. See: Kiernan (1992).

childbearing in adolescence makes in determining long-term success' (Treffers et al., 2001:112). Hence, poor young women have fewer reasons to delay childbearing (Furstenberg, 1998). Motherhood during adolescence has also been linked to homelessness (Joseph Rowntree Foundation, 1995), criminality (Botting et al., 1998), lower educational attainment (Hobcraft and Keirnan, 1999), dislike of school (Bonell et al., 2003), and failure to participate in post-compulsory education (Paton, 2002), whilst the culmination of reduced occupational prospects is thought to create greater reliance on social security benefits (SEU, 1999).

British longitudinal studies (Kiernan, 1997), and local studies of general practice populations (Seamark and Pereira Gray, 1997), reveal intergenerational transmission of parenting norms, as evidenced by the substantial numbers of teenage mothers who are daughters of teenage mothers (Botting et al., 1998; Ermisch and Pevalin, 2003b)[5]. Female siblings of parenting teens are at higher risk of teenage pregnancy and this risk appears to increase over time (East and Jacobson, 2001). A significant proportion of young mothers become pregnant more than once during adolescence (Seamark, 2001).

Teenage conceptions are geographically linked with deprivation. A 'north-south divide' has been noted (Hardill et al., 2001:59), with the north of England returning above average pregnancy rates. Living in seaside and surrounding rural locations is also associated with higher than average rates of teen conceptions (Bell et al., (2004). Lower conception rates may indicate the presence of a young, female GP, and/or more available nurse time (Hippisley-Cox et al., 2000; Lee et al., 2004); higher rates are associated with selected black and ethnic minority communities (Berthoud, 2001; Higginbottom et al., 2006).

Some outcomes associated with early childbearing

Early childbearing is generally associated with adverse medical outcomes (Cunnington, 2001) and concerns about the resources required to support teenagers and their child/ren[6]. Prematurity[7], infant mortality and low birth weight are associated with early motherhood (Ancel et al., 1999; Botting et al., 1998; SEU, 1999) although some studies argue that only very young mothers (ten to thirteen years) are vulnerable (Treffers et al., 2001) which supports the claim made that, as the majority of teenage births are to adolescents at the older end of the age spectrum, there is little overall evidence of harm (Smith and Pell, 2001). More recent research suggests that absence of paternal involvement at the time of

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[5] In his comprehensive study of the history of illegitimacy, Peter Laslett (1997) makes the same point when he refers to the 'perduring sub-society of the illegitimacy-prone' (Laslett, 1977:4).

[6] One of the criticisms of adolescent motherhood is that it is resource-intensive although other groups of childbearing women, for example, older, middle-class women undergoing assisted reproduction also require considerable financial investment (Shennan et al., 2006; Bewley 2005; Jacobsson et al., 2004). Older age at conception is also linked to the recent rise in babies born with Down's syndrome (Wellesley et al., 2002) with the associated increased economic costs.

[7] Prematurity in adolescent mothers is associated with a 'low gynaecological age'. Gynaecological age (GA) is defined as the time lapse between the onset of menarche and first delivery. A low GA (< 2years) is linked to a 50% increase in premature births (Treffers et al., 2001).

antenatal booking – as evidenced, perhaps, by a lack of paternal details in the young woman's maternity record – significantly increases the risks of prematurity and low birthweight (Knight et al., 2006). Older infants of teen mothers are more accident prone, require more hospital admissions in childhood, and make more use of health services overall (Tripp and Viner, 2005).

Suggestions that childbearing in adolescence is linked with pregnancy-induced hypertension and eclampsia remain unproven. The aetiology of eclampsia (of which raised blood pressure is symptomatic), as an immunologic disorder arising from insufficient exposure to sperm, is now generally accepted as theoretically sound (Dekker et al., 1998). Eclampsia commonly affects 'first' pregnancies (including those resulting from a new partner, artificial donor insemination and oocyte donation); women who are consistently exposed to one partner's sperm are better protected. Teenage pregnancy often results from a relatively short-term relationship and hence a relatively short exposure time to a male partner's semen (Treffers et al., 2001); it is this reduced exposure which is linked to an increased risk of eclampsia and the need to expedite (premature) delivery. Adolescents who enjoy a trouble-free pregnancy are less likely than older women to encounter problems in labour, although there is some evidence that immaturity of the pelvic bones may cause obstructed labour in younger teenagers (Treffers et al., 2001).

Poorer pregnancy outcomes may partly result from young women being less likely to enjoy a trusting relationship with a health care provider (Sarri and Phillips, 2004) or to access appropriate antenatal care, especially in countries where this must be paid for (Treffers et al., 2001). Teenage mothers are more likely to be lone mothers (Hardill et al., 2001), to live in poorer quality housing (Allen et al., 1998) and, due to poverty, to have poorer mental and physical health (Hobcraft and Keirnan, 1999). Early childbearing (rather than early abortion) may negatively influence adult women's marriage prospects, their potential for home ownership, and their ability to attract a male partner with good employment prospects (Ermisch and Pevalin, 2003a).

There is, however, an alternative perspective which proposes that teenage pregnancy may confer health benefits, including protection against breast cancer (McPherson et al., 2000) and diabetes (Bingley et al., 2000). Young motherhood as a public health (Lawlor and Shaw, 2002), or social (Shaw et al., 2006), problem has also been challenged. These findings resonate with earlier research (Furstenberg et al., 1987; Kelly, 2000) suggesting that some of the negative outcomes of teenage pregnancy have been over-played and that many young mothers and their children fare reasonably well in the long term (Ermisch and Pevalin, 2003a; Shaw et al., 2006). Recent research into teenage parenthood and social exclusion suggests that there are no significant differences in long term 'consequences' for the children of teenage mothers, compared with older mothers (Wiggins et al., 2005a). Indeed, the 'weathering hypothesis' (Geronimus, 1992:207) indicates that young motherhood may be positive for disadvantaged women because of the accelerated health deterioration experienced by poorer people (Fessler, 2003). If teenage women are indeed at the biological pinnacle for

reproductive functioning (Morgan et al., 1999), it may thus make sense for them to become mothers earlier rather than later.

There are many reasons why the spotlight remains focused on limited aspects of the experience of being female and adolescent; these may have less do with qualms about the welfare of young mothers and their children, and more to do with sexual double standards. This may partly explain why young mothers continue to be harshly judged, when remedial action might be taken to address poverty and discrimination. The socio-economic distribution curve of teenage pregnancy suggests that most young mothers come from working-class communities, in which their mothers and grandmothers play a key role in childcare provision and will 'cushion' them from financial hardship. In this sense they are better supported by kinship networks than their older, more affluent, contemporaries. Given that 'successful' parenting appears to depend more on adequate material resources and social support than maternal age alone (Golombek, 2000), the persistence of negative views of teen parenting suggests a need for societal scapegoats.

Trends in adolescent fertility and sexual health

The UK has consistently returned one of the highest teenage conception and birth rates of all Western countries[8] (Nicoll et al., 1999; United Nations, 1997), although this must be set in the context of an overall drop across the developed world (Alan Guttmacher Institute, 2002). The USA has experienced a 27% overall decline since the early 1990s (Irwin, 2006), mostly amongst older African-American teenagers for whom early childbearing is routine but some of whom have deferred reproduction to take advantage of expanded employment opportunities (Colen et al., 2006). Whilst the UK rate is consistently higher than other European countries, it is not as high as other English-speaking countries, including the USA and New Zealand (SEU, 1999). Statistics for the decade 1980-90 suggested that pregnancy rates in the UK increased differentially, in line with local levels of deprivation (McLeod, 2001). Opinions vary[9] as to whether the UK trend in adolescent conceptions over the last decade is upward (Jewell et al., 2000; Nicoll et al., 1999), downward (TPU, 2007) or essentially unchanged (Botting and Dunnell, 2000; Tripp and Viner, 2005). Some sources (Peckham, 1993) argue that the trend was downward a decade before the current government commissioned its report on teenage pregnancy (SEU, 1999), that any subsequent decrease is only true for older teenagers, and that this

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[8] To place this in context, the UK rate is around 30:1000 which is twice that of Germany, three times that of France, and six times that of Holland. Japan has the lowest adolescent conception and birth rates whilst the USA and Georgia have the highest (SEU 1999; The Alan Guttmacher Institute, 2002).

[9] Statistical information on conception, abortion and birth rates is available from a variety of different sources but because each source accesses different baseline criteria and because there is no standard formula by which statistical data are aggregated, accurate interpretation is difficult. Conception rates are usually underestimated because of the difficulty in accurately recording the number of pregnancies which miscarry early (and which do not necessitate hospital admission) or indeed, those where women may not even realize pregnancy has occurred. There is an additional problem within the UK as statistics for Scotland are collected and reported separately from England and Wales.

mirrors a more general decrease in conception rates among childbearing women of *all* ages (National Statistics Online, 2001)[10].

Disquiet about adolescent fertility in Western societies is not new (Wallace, 1987). Historically, however, state intervention in the lives of the (reproducing) poorer classes was available only if they agreed to be monitored and supervised 'by an inspector from the prefecture whom they fear but whose advice they heed' (Donzelot, 1979:31). It was not until the early 1990s, and the setting of national targets for England and Wales (Department of Health, 1992), that teenage pregnancy became a public health concern (Spencer, 2001). During the last decades of the twentieth century adolescent parenthood was increasingly politicised, with successive Western governments introducing more stringent criteria for accessing state aid. This ensured an overall reduction in welfare provision for the most disadvantaged sectors of the population (Geronimus, 1997; Mizen, 2003).

The sexual health of UK adolescents is an area of growing concern (The Royal College of Psychiatrists, 2003) with some claiming that this group have the worst sexual health record in Europe (Boseley, 1999). Recent statistics reveal continuing increases in chlamydia, syphilis, genital warts and genital herpes (Health Protection Agency, 2006) with some strains showing resistance to conventional treatments (Hardill et al., 2001). More relaxed public attitudes may have positively influenced the uptake of adolescent sexual health services in the UK, although research also suggests that health professionals' tendency to disregard and infantilise young people (Free et al., 2002), especially men (Tabberer et al., 2000), remains problematic. Concern has been expressed that any apparent fall in adolescent births simply reflects higher termination rates, with worse health consequences for adolescents who delay help-seeking and are then ineligible for less invasive termination procedures (Ashton and Seymour, 1993).

The majority of teenage conceptions are purportedly unintended (Ashton and Seymour, 1993; Henshaw, 1998), occurring as a result of contraceptive failure (Churchill et al., 2000; Paton, 2004), a sense of personal invulnerability (Free et al., 2002), and/or impulsive behaviour fuelled by alcohol (Dickson et al., 1998). Some reports from teenagers themselves, however, suggest that early childbearing is a 'positive life choice' (Tripp and Viner, 2005:592) and a rite of passage to adulthood in the absence of middle-class aspirations and opportunities (SmithBattle, 2000). Some young women plan to become pregnant (Cater and Coleman, 2006; MacDonald and Marsh, 2005; Montgomery, 2001, 2002; Wiggins et al., 2005a), are pleased when they do (Baker, 1999), and express positive attitudes to being mothers (Seamark and Lings, 2004; Skuse, 1997). These data suggest that teenage pregnancy is not always 'bad news', although it is acknowledged that these alternative perspectives may simply reflect the fact that young people with poor employment prospects have less reason to defer pregnancy

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[10] For the decade 1990-2000, the conception rate among young women in the UK aged fifteen to nineteen fell to 63:1000 whilst for younger teenagers (aged thirteen to fifteen), conception rates over the last decade have remained consistent at between 8-10:1000 (National Statistics Online, 2001).

(Joshi, 1990). Growing up with adversity appears to be coupled with accelerated maturation (Wallace, 1987) and this may be an additional reason why working class girls assume a maternal role at an earlier age (Arai, 2003b). Anthropological research has emphasised the ways in which 'culture and social organization may influence contraceptive patterns and men's influences on those patterns' (Dudgeon and Inhorn, 2004:1383).

The age at which young people in Western societies become sexually active has been falling for some decades (Wellings et al., 1994) and the gender gap also appears to be declining, or even reversing[11] (Dennison and Coleman, 2000), possibly due to young people growing up in a more sexualised society (Coleman and Hendry, 1999). Earlier sexual activity is associated with earlier childbearing and is linked to ethnicity and social class (Wellings et al., 1994; SEU, 1999; Dennison and Coleman, 2000). Young people from less advantaged backgrounds commence their sexual careers on average two years earlier than more privileged adolescents, whilst those residing in seaside resorts are more likely to engage in unprotected sex due partly to the 'hedonistic' and 'carnivalised' environments created by local leisure industries (Bell et al., 2004:1). In addition to socio-economic disadvantage, cultural determinants, such as arranged marriage and the requirement to demonstrate early fertility, exert pressure on young women from some black and minority ethnic backgrounds (Higginbottom et al., 2005): hence female 'honour' serves as a marker of the social control of sexuality and female reproductive power.

Changes in the provision of, and access to, sexual health services, and the impact on fertility

The provision of, and access to, appropriate health services for young people is seen as fundamental to reducing teenage pregnancy rates (NHS Centre for Reviews and Dissemination, 1997; SEU, 1999). The proportion of adolescent girls accessing UK family planning services increased from 12% in 1988-9 to 22% in 1998-9 (Botting and Dunnell, 2000), which supports earlier studies reporting that contraception use overall has risen in this population (Smith and Jacobson, 1988; Wellings and Mitchell, 1998). Better provision of sexual health services, however, does not appear to have empowered young women to negotiate sexual relationships on their own terms (Dennison and Coleman, 2000). In this respect, the experiences of contemporary teenage girls may be compared with their eighteenth century counterparts, who 'had no or little control over their reproduction (hence) the result of sexual relationships outside marriage was often the misfortune of illegitimate pregnancy' (Evans, 2005:204).

The relationship between providing contraception and reducing conception rates is complex. Early research reported over 50% of teenagers used some form of contraception (Wellings, 1986), whilst a recent study reveals that most pregnant teenagers had consulted a health professional in the

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[11] The percentage of teenage girls engaging in sexual intercourse has steadily increased. For example, approximately 19% of girls born in 1926-30 had experienced intercourse by age 20 compared with over 50% for those born 1956-59. The numbers of females under sixteen having sex has similarly increased from 1% of girls born in 1931 to 5% for those born in the 1950s to 24% for those born in 1974 (Wellings et al 1994). Age at first intercourse fell during the early 1990s and is now stable at around sixteen years for both sexes (Tripp et al 2005).

year preceding pregnancy, and that almost 75% of such consultations were in order to obtain contraceptive advice (Churchill et al., 2000). Furthermore, an examination of the differential impact of the 'Gillick test'[12] found 'no evidence that family planning provision reduces either underage conception or abortion rates' (Paton, 2002:207). Indeed, Paton (2004) also claims that increased provision of family planning facilities for young people may, by favouring oral/injectable contraceptive methods over barrier methods, inadvertently encourage the very kinds of sexual activity which have produced sizeable increases in STIs amongst adolescents. Legislation which enables adolescents to obtain emergency birth control (the 'morning-after pill') from pharmacists may be associated with an increased abortion rate (Churchill et al., 2000), whilst the impact of easier access to this method has not been economically evaluated (Paton, 2004).

Limited knowledge of emergency birth control has been identified as an obstacle to its effective use (Graham et al., 1996), especially amongst teenagers from disadvantaged backgrounds (Free et al., 2002), many of whom lack the resources to seek appropriate guidance. Significant numbers of adolescents are thought to use ineffective methods of contraception (e.g. condoms inconsistently), whilst a previous pregnancy, including a termination, is associated with an increased likelihood of using hormonal contraceptive methods (Paukku et al., 2003). The negative effects of hormonal contraceptives on bone density in adolescence have also raised concerns, not least because the young women most susceptible to bone loss (and consequently to bone fractures) are unlikely to have the optimal nutrition known to be preventive (Gold and Bachrach, 2004).

Sex and the law

In this section I discuss some of the legal constraints on teenagers' access to sexual experiences.

1. The legal age of sexual consent

The legal age of consent for females and males in the UK is sixteen. The same laws apply to heterosexual and homosexual activity and apply to everyone over the age of ten, which is the age of criminal responsibility in England and Wales[13]. The UK Sex Offenders Act (2003)[14] became law in May 2004, aiming to reform existing law regarding sex offences (explicitly paedophilia and related crimes such as grooming young children via the internet), to remove existing discrimination against homosexuals, and to provide additional support for victims of sexually motivated crimes. Whilst the Act

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[12] The 'Gillick' test outlines a number of criteria which the young person must satisfy in order to be judged as competent to make their own decisions, including that they understand the advice being offered and the implications of decisions they make (Wheeler, 2006). The 'Fraser' Guidelines are sometimes used synonymously with the 'Gillick' test but whereas the former refers to the specific area of contraceptive advice, the latter has a broader remit providing clinicians with an objective test of competence to assess a young person's ability to make decisions concerning medical treatment in a wider context. Confusion persists, especially amongst young people, about the confidentiality of service provision, with approximately 33% not appreciating that they can access contraception without parental consent (Wellings et al., 2005)

[13] Different laws apply in Scotland. See the Brook Advisory Centre website for details: http://www.brook.org.uk

[14] See: http://www.homeoffice.gov.uk/justice/sentencing/sexualoffencesbill

abolished gender differences between underage teenagers, it potentially criminalised *all* under-sixteen-year-olds engaging in consensual sexual activity.

Where 'visible' evidence of intercourse was available, for example pregnancy or an STI, the law provided for young men to be pursued through the courts on charges of statutory rape or assault, regardless of the wishes of their young female partners. The Act now recognises, however, that mutually agreed, non-exploitative, sexual activity between under-sixteen-year-olds does occur, and as of April 2006, professionals are not obliged to report such teenagers to the police (Mayor, 2006b). The guidance developed by the UK Department for Education and Skills (DfES, 2006d) advises that decisions concerning possible referral to child protection agencies should be considered on a case by case basis, but that pre-teen (under thirteen years) sex will continue to be viewed as serious under the Sexual Offences Act, not least because minors cannot legally consent to sex. These issues highlight the contradictions and uncertainties embedded in policy directives which consider sexual responsibility in isolation from other adult responsibilities, and which separates sexual maturity from sexual responsibility.

2. Sex education [15]

In 1943, a perceived rise in both illegitimate pregnancies and venereal diseases prompted the UK Board of Education to recommend the provision of sex education in schools (Osgerby, 1998). Amendments to the 1996 Education Act removed responsibility for sex education provision from local authorities, investing accountability with head-teachers and school governors. Even though the UK has one of the highest divorce rates in Europe, government policy requires state-maintained pupils to receive sex education which emphasises the importance of marriage for family life and the appropriateness of this environment for raising children. A recent study of the sex educational needs of young people revealed that 32% of the sample received no information from home-based sources and a further 33% reported that what they received at school was insufficient (Salihi and Melrose, 2002). The same study found that boys were generally less well informed than girls about sex and related matters. The findings of a recent survey suggest that young people fare even worse in domestic settings with almost half (46%) receiving 'nothing' or 'not a lot' of sex and relationship information from parents and, although more than half (52%) reported finding it easy to talk to mothers, only just over a quarter (26%) found it easy talking to fathers (BMRB International, 2003).

3. Accessing contraception

Young people under the age of sixteen may access family planning services in order to obtain contraception if they are deemed competent to make their own decisions. This requires the young person to demonstrate that they are sufficiently mature to fully understand the advice offered. Following

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[15] For an overview of the history of sex education, see: Wolpe (1987).

clarification by the House of Lords, in the case of Gillick vs West Norfolk and Wisbech AHA and the DHSS in 1985 (Paton, 2002), parental consent for contraception provision is no longer required providing certain criteria, known as the 'Fraser' Guidelines (see Footnote 12), are met. Complaints that health professionals' use of the Gillick ruling is to the detriment of parental relationships with their (childbearing) daughters continues to arouse media attention[16].

Young people under the age of sixteen have as much right to confidentiality as anyone else and even when teenagers under sixteen are deemed insufficiently mature to consent to treatment, or to make decisions on their own behalf, the law permits that the consultation itself remains confidential.

4. Abortion

Two Acts of Parliament, the Abortion Act 1967 and the Human Fertilisation and Embryology Act 1990, regulate the provision of abortion in the UK. The Abortion Act requires two registered medical practitioners to agree that an abortion is indicated and it must be undertaken by a registered practitioner in an NHS hospital or in alternative premises approved by the Department of Health. Medical staff may refuse to participate in an abortion on moral grounds. A number of points must be satisfied before an abortion can be sanctioned, including observance of the twenty-four week upper time limit, proof that continuation of the pregnancy poses a grave and permanent threat to the health of the pregnant woman, and/or substantial evidence that the unborn foetus is seriously damaged. The use of emergency contraception is not considered to be a form of abortion because it is generally accepted that there is no established pregnancy to terminate.

The social construction of youth: gender and socialization

The concept of 'youth' as a separate category between adulthood and childhood surfaced during the nineteenth century when manual trades, and the need for apprenticeships, expanded. The requirement for cheap labour exploited the relative good health of poor young people, exposing them to dangerous and dirty work in the mills and mines of industrialising nations. Higher than average mortality and morbidity statistics supports the definition of adolescence as 'a life stage marked by social and physiological vulnerability' (Osgerby, 1998:2). The demarcation of adolescence as a separate, and distinctive, developmental phase resulted in an avalanche of protective legislation and the creation of welfare organisations and employment regulations. This marked the decline in numbers of adolescent apprentices - workers at the midpoint of childhood and adulthood - and a growing need for a better educated and more skilled workforce, which required young people to undergo longer periods of formal schooling (Donzelot, 1979). These changes created a niche in which 'youth' could be positioned as a 'specific status group with a superficially classless identity' (Somerville, 2000:62), albeit one with

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[16] For example, the 'Gillick test' was cited in the case of Melissa Smith, a 14-year-old girl from Mansfield who sparked a national debate after it emerged that her school outreach worker arranged for her to have an abortion without her parents' knowledge (Townsend, 2004).

particular needs and social practices. The construction of 'youth' can therefore be understood as shaped by the social, cultural, economic, and political concerns of a particular historical period.

The category 'youth' has been subjected to public scrutiny in recent years, perhaps because young people, and their (diverse) cultures, have come to symbolise both the scale, and the dynamics, of wider social change (Osgerby, 1998). Moral outrage and 'panics' about the activities of adolescents, particularly as regards their sexual behaviour and practices, regularly punctuate the (textual) landscape. Regardless of the meanings young people themselves ascribe to their behaviours, the visual images they project are prone to (mis)interpretation. Bodily gestures, behaviours, hairstyles, and other fashion trends may all be construed as anti-establishment displays requiring the institution of remedial action in order to curb 'quantum leaps' (Osgerby, 1998:10) in the scale of their purported delinquency. Crime 'waves' are often attributed to social upheaval, especially when displacement has been a significant feature. For example, in the immediate post-war period, absent fathers and working mothers were believed to contribute to a breakdown in socialization, so that war babies evolved into juvenile delinquents (Osgerby, 1998).

Social and political responses to youth have never been entirely negative: adolescents are vilified for being morally and culturally bankrupt, whilst simultaneously lauded for their future potential. The 'youth as trouble/ youth as fun' dichotomy (Hebdige, 1988:28) is thus a key motif around which social change may be both organised and understood. This is perhaps most obvious in economic analyses explaining youth employment patterns and opportunities. In the post war years, for example, teenagers were referred to as the 'bulge generation' (Ashton and Seymour, 1993:118), who enjoyed full employment status on account of an unprecedented, and widespread, shortage of unskilled labour. Economic independence facilitated social and sexual independence, which coincided with the development and marketing of the oral contraceptive pill. Hence, adolescents became an easy target for commercial exploitation (Ashton, 1983) and their new-found affluence gave rise to the social construction of the 'teenager', who embodied the mythology of classlessness and carefreeness (Osgerby, 1998).

Despite the importance of women to the post-war consumer boom, little consideration was given to researching their economic and social status. This was especially true for young women and/or working-class women whose identities tended to be bound to the young men with whom they associated. Indeed, a classic post-war study of youth had little to say about young women at all, beyond references to girls who were 'dumb' and 'passive' (Fyvel, 1963:96). This is surprising, given that this period was transformational for girls, primarily because of the new employment opportunities generated by the impact of the war, including the need to exploit female labour. With the expansion of consumer industries, and the clerical, retailing and business sectors, girls' economic and cultural horizons expanded and, at weekends and evenings, some rejected domestic constraints for dance halls and bars. They began to create more rebellious, assertive, and politicised, identities and hence expanded notions of femaleness.

The distinguishing features of youth as a discrete group, on the trajectory from childhood to adulthood, have varied across cultures and throughout historical periods, although there is general agreement that the physical changes associated with puberty are cross-culturally and historically universal (Bogin, 1988). Whilst certain biological markers indicate tangible moments in this transition, such physical indicators are themselves subject to social, economic, and cultural influences (Osgerby, 1998). The identification of adolescence as a distinctive stage in the life cycle, characterized by turbulences and crises, advanced the development of adolescent medicine and adolescent psycho-pathology as sub-specialties of medicine (Fabrega and Miller, 1995). Indeed, the specificity of behaviours, attitudes and developmental responses of adolescents in Western cultures are such that adolescence has been referred to as a 'culture-bound syndrome' (Hill and Fortenberry, 1992:73).

As I will demonstrate in the findings chapters of this thesis (see Chapters Seven to Eleven), teenage girls, especially those who become pregnant, generally have a tougher time than their male counterparts. Visible evidence of sexual prowess amongst girls is usually met with opprobrium and greater restrictions tend to be imposed on their freedom to access public spaces[17] especially those considered to be unsafe (Katz, 1993). Girls' socialization processes often engender a sense of fearfulness which acts to constrain their activities, especially at the level of corporeal existence whilst ideological constructs tend to reinforce mistaken beliefs that crimes against women's bodies are more likely occur in public spaces than in the privacy of the home or the workplace.

Boys, meanwhile, are expected (encouraged?) to 'cast their seed', 'sow their oats', and otherwise 'be' (hetero)sexual; they are rarely chastised for rule-breaking behaviours unless they violate the law. The socialization of adolescent males can thus be described as supporting risk-taking behaviours, encouraging them to exploit and manipulate their environment to best advantage. In short, boys develop the very skills and attributes which are most esteemed in male-dominated, capitalist, industrial societies (Katz, 1993).

Although the discursive space of teenage pregnancy has been identified, the 'politics of naming' (Cain, 1989:15), and the disassembling of female adolescent experience are only beginning. Finding words to talk about difficult experiences such as forced sex, or an abortion kept secret from parents, requires a consciousness capable of articulating the memory of distress and a culture that gives adolescents access to adult language, rather than encouraging the limited arguments of a 'sub-culture'. This is a complex undertaking because, despite adult rights in some areas, young people are denied full adult status. Working class girls face particular difficulties, not least because their voices are often perceived as neither authoritative nor credible. Furthermore, teenage sexuality cannot be discussed in isolation from the troubled relationship which many young women have with their bodies. This is evidenced by the substantial literature[18] covering a range of adolescent corporeal experiences including

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[17] For an analysis of the spatial restrictions imposed on women's pregnant bodies, see Longhurst (2001).
[18] Much of the early literature on this subject reflects the long history of the 'psychiatrisation' of women's experiences (Perkins, 1981; Showalter 1985; Millett, 1991).

self-harming behaviours and body dysmorphic disorders (or imagined ugliness syndrome), more recently referred to as 'body hatred' (Frost, 2001:10).

In many cultures, all major transitions, from being born to dying, involve initiation rites requiring demonstrable acts of individual bravery and courage. Risk-taking in this context is viewed as inevitable. The opposite focus is evident in contemporary Western societies, where survival (at any cost) is viewed as the most valued outcome, even if this is only achievable by (state) interventions that closely monitor and regulate health and related behaviours. Risk-taking in this context is viewed as anathema. The (health) risks to contemporary youth may be said to mirror those of 'any inexperienced person exploring new worlds' (Ashton and Seymour, 1993:117), but in Western societies risk-taking must subscribe to normative (class-based) notions of appropriateness if individuals wish to avoid being stigmatised. Hence the opprobrium attached to engaging in sex without using contraception and/or continuing a pregnancy which 'should' have been terminated.

Since the concept of 'safety' has been valorised and widely promoted as an achievable and laudable aim, health-related risk management has become big business. Health-care settings, and the personnel who work within them, are now routinely assessed from a risk perspective. In post-modern societies, markers which regulate the boundaries of safety and risk have given new meaning to an ever-expanding range of human activities and, in this landscape, 'safe sex' becomes a more labile term which may be equally applied within libertarian discourses and those which espouse the politics of fear. The myth of the 'zipless fuck'[19], and the implication that sex practised 'healthily' will not result in infection[20] or pregnancy, is thus counterbalanced by the 'precautionary principle' (Furedi, 1998:9) which, in turn, may be seen as a metaphor encapsulating 'an entire attitude to life' (ibid:9). Early childbearing for young women from disadvantaged backgrounds, however, turns the concept of risk on its head. It reconfigures this event as a relatively low-risk undertaking when compared with the continuous, and substantial, threats to personal safety and psychological integrity which many young women endure throughout their formative years.

A summary of recent policy developments in the interrelated areas of teenage pregnancy, social exclusion and child poverty

From 1997 when it came to power, the incumbent Labour government has continued to introduce various social policy initiatives, some of which have particular relevance for pregnant teenagers and

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[19] A zipless fuck, is defined as a sexual encounter for its own sake, without emotional involvement or commitment, between two previously unacquainted persons. The phrase was coined by Erica Mann Jong in her popular 1973 novel *Fear of Flying*.

[20] Sexually transmitted diseases are easily acquired: one report suggests that in a single act of unprotected sex with an infected partner, an adolescent female has a 1% chance of acquiring HIV, a 30% chance of contracting genital herpes and a 50% chance of acquiring gonorrhoea (The Alan Guttmacher Institute 1999).

young mothers[21] and, hence, are integral to the Teenage Pregnancy Strategy (SEU, 1999), and to my thesis. In the following section, I briefly summarise, and critique, some of these initiatives.

Teenage Pregnancy

Unacceptable economic cost, calculated at more than £65 million annually (Dennison 2004), was a major driver prompting the launch of the Teenage Pregnancy Strategy. This initiative sought to achieve two main goals: to reduce, and more specifically to halve, the rate of under-18 conceptions by 2010, and to reduce the long term social exclusion of teenage parents by involving them in education, training, and/or or employment schemes. Despite substantial investment, however, neither target is likely to be realised if present rates of progress are maintained. For example, an overall reduction in conceptions of less than 10% has been achieved (ONS, 2006) with some areas, including South Yorkshire, showing little change (TPU, 2007). Although the majority of young people use contraception at first sexual intercourse, an increase in unprotected sex amongst adolescents has been reported: from 78% in 2001 to 88% in 2004 for women, and from 81% to 86% for men ((Wellings et al., 2005). Failure to achieve educational targets, especially for the most marginalised children and young people, has also been noted (New Policy Institute, 2006).

The implementation of recent directives for midwives (DfES, 2007), Local Authorities and Primary Care Trusts (DfES, 2006c), aims to maximise opportunities for the most effective delivery of the Teenage Pregnancy Strategy over the remainder of the programme. Recent research (Cater and Coleman, 2006, MacDonald & Marsh, 2005) however, questions a central tenet of the strategy document: that adolescent pregnancy is 'accidental' and, hence, 'the first conscious decision that many teenagers make [...] is whether to have an abortion or to continue with the pregnancy' (SEU, 1999:28). Findings from my research reflects other work in this area and suggest that many young mothers making the transition to motherhood embark upon a chosen career trajectory (Thomas, 2003), the nature and significance of which has been largely overlooked by both policymakers and academics (MacDonald et al., 2005). Furthermore, New Labour's emphasis on interventions which emphasise participation through education, training, and/or employment is problematic because it disregards the multiple levels of exclusion young women experience, it dismisses their preferences to be full-time mothers to their infants, and ultimately attaches a moral 'weighting' to their already keenly felt sense of exclusion (Kidger, 2004).

Furthermore, the focus of the Teenage Pregnancy Strategy assumed that attention to single, linear, themes including improved access to contraception and provision of better sex education, would, in themselves, contribute to achieving set targets. These assumptions have been criticised on the grounds that decision-making processes underpinning teenage conceptions are multifactorial and

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[21] For example: The Working Tax Credit and the Child Tax Credit, Health/Education Action Zones; New Deal for Communities; Sure Start and Sure Start Plus programmes; Health Living Centres, Connexions.

complex (Arai, 2003b), and it is these issues that recent critiques of teenage parenthood have begun to address (Cater and Coleman, 2006; MacDonald & Marsh, 2005). Finally, whilst the Teenage Pregnancy Strategy emphasised the strong association of young motherhood with worsening material deprivation, further (including longitudinal) research suggests that it is the cumulative, and inherited, aspects of poverty, rather than early childbearing per se, which impacts most negatively on the lives of young mothers and their children (Ermisch and Pevalin, 2003a; Dennison, 2004; DfES, 2005). Despite these concerns however, implementation of the strategy is reported to have 'started well' and it is widely seen by government spokespeople as a 'model of joint working and inter-agency collaboration' (Wellings et al., 2005:6).

Social exclusion

Definitions of social exclusion typically incorporate structures, processes and characteristics of society as a whole, as well as the experiences of individuals situated within discrete communities. On account of its divisive connotations (the included majority v the excluded minority), the term is widely regarded as 'intrinsically problematic' (Levitas, 2005:7) although it is generally acknowledged to involve 'multi-dimensional disadvantage' (Levitas et al., 2007:117). Macro-drivers, including demographic change, variations in the labour market, and social policy directives, may aggravate individual risk factors for social exclusion, although establishing causation in social science research is not a straightforward process (Bradshaw et al., 2004). Structural factors, including power (Estivill, 2004), and polarisation processes whereby individuals are detached from their communities by the exclusionary practices of the socially included (Wiggins et al., 2005), contribute to 'a postindustrial social order dominated by globalizing capital and the superclass associated with that globalizing capital' (Byrne, 2005:182).

Poverty and social exclusion tend to be viewed as an 'inseparable dyad' (Levitas et al., 2007:3) although what it means to be poor varies in different societies (Lister, 2004). Differences in individual circumstances may be considerable and, hence, the finely nuanced understandings of the term social exclusion suggest that clear-cut distinctions can never be absolutely applied. An operational definition of social exclusion, which incorporates most factors described in the literature, might read thus:

'Social exclusion is a complex and multidimensional process. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in our society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole' (Levitas et al., 2007:9).

Different degrees in the severity of exclusion have been identified, including that of 'deep' exclusion:

'Deep exclusion refers to exclusion across more than one domain or dimensional disadvantage, resulting in severe negative consequences for quality of life, well-being and future life chances' (Levitas et al., 2007:9).

In 1999, Sure Start Local Programmes (SSLPs) were introduced into deprived neighbourhoods throughout England as a potential vehicle for reducing the social exclusion of the poorest families; by 2004 a total of 524 such schemes were in existence (Belsky et a., 2007). Current policy (DfES, 2006b) endorses the contributions these schemes make to the enhancement of children's well-being, and that of their families, and their positive value has been commented on by independent researchers in this area (Higginbottom et al., 2005, Attree, 2004). Sure Start has been described as operating on two distinct, but inter-related, levels: reducing health and socio-economic risks, and facilitating the development of supportive environments which stimulate future capacity building (Attree, 2004). The small, and some would say limited, effects of SSLP's appears to vary with the degree of social deprivation: children from relatively less socially deprived families (for example, non teenage mothers) benefit from living in SSLP communities, whilst children from the most socially deprived families (teenage mothers, lone parents, unemployed households) are adversely affected (Belsky et al., 2007). Criticism has been levelled at the organisational elements of local programs which, because of their local autonomous status, are neither required to produce, nor adhere to, protocols modelled on examples of best practice (ibid).

The Sure Start Plus (SSP) programmes, which commenced in 2001, were charged with reducing the social exclusion specifically associated with teenage pregnancy and young parenthood (the inclusion of young fathers was a central objective of SSP). A core aspect of the initiative stressed the importance of a co-ordinated, multi-agency, approach provided through the aegis of personal advisers offering one-to-one support to their young clients. Although some aspects of service delivery have achieved modest success, for example, in reducing the risk of conduct disorder in preschool children (Hutchings et al., 2007), and providing crisis support for pregnant adolescents and increased educational participation for under 16-year-olds (Wiggins et al., 2005b), there appears to have been little impact on maternal health-related objectives, including smoking cessation and improvements in breast-feeding rates. Most schemes also failed to attract young fathers, largely due to lack of resources and lack of a clear inclusion strategy (Sawtell et al., 2005).

The fact that both the Sure Start and Sure Start Plus interventions have failed to achieve government targets, however, should not obscure the fact that both these initiatives were generally well received at a local level and most managed to avoid generating the stigmatising reputations associated with similar Government interventions targeting poor communities. Besides, precise measurement of the 'impact' factor of these interventions was always likely to be problematic, not least because of the difficulty of disentangling the effects of the intervention from the multiple stresses this client group already experience on a regular, and on-going, basis.

<u>Childhood poverty</u>

The links between early parenthood, social exclusion, and child poverty are well established (Pantazis et al., 2006) and, whilst successive governments have suggested various eradication measures, it has remained firmly, and contentiously, on the policy agenda. The Child Support Act (1991) for example, established a policy framework that was purportedly 'hugely controversial, administratively inept and essentially flawed' (Ridge, 2005:123). Rather than it being lauded as an intervention to benefit children, particularly those who were already disadvantaged, the policy was widely perceived as a somewhat crude response to the then Tory government's concerns about the perceived economic burden on the state caused by lone mothers, many of whom were adolescent.

Following Tony Blair's historic pledge to end child poverty within twenty years (Blair, 1999), this topic moved to the centre of the policy agenda (Lister, 2002); a subsequent communication by the Chancellor of the Exchequer, Gordon Brown (Brown, 2000), reinforced the commitment to make the welfare of children a top priority of the Labour administration. Blair and Brown's speeches exposed a fundamental principle underlying policy strategy to reduce child poverty: a 'belief in the labour market as the primary agent of social inclusion' (Lister, 2002:33), a focus which privileges paid work and which incentivises welfare-to-work schemes as routes out of poverty. The repeated emphasis on employment as a route to inclusion is despite the evidence that, for the most marginalised and stigmatised families (especially young parents), regular, paid, employment is simply not an option (Preston, 2005).

Although some overall progress has been made in reducing child poverty, the Labour government has failed to achieve its policy objective of a 25% reduction by 2004/05 (Dornan, 2007). Furthermore, class-related health inequalities persist and are evident in all aspects of health; the limited information available on change over time (for example as demonstrated by low birth weights, and neonatal and infant deaths) provides further evidence that inequalities are not reducing (Palmer et al., 2006). Very recent research suggests that the risk of birthing a low weight infant may be determined as early as twelve weeks of pregnancy (Bukowski et al., 2007) and, furthermore, that economic disadvantage may be linked to intrauterine growth retardation (Reagan et al., 2007). These findings clearly expose the effects of poverty from the very beginning of the life cycle and this reiterates a point I made earlier: that it is poverty rather than age of first parenthood which is most damaging on health and life opportunities

The current UK Labour Government has repeatedly endorsed the 38 targets set more than two decades ago by the World Health Organisation (WHO, 1985) which were intended to reduce health inequalities, albeit by way of increasing the pressure on individuals to assume responsibility for their own, and their families, health outcomes. Despite the rhetoric, and the cyclical setting of (some would argue, symbolically important, but none the less unachievable) national targets under the Blair administration, inequalities in wealth and health have persisted and, unless more potent and redistributive polices are implemented, are likely to be transmitted to, and magnified by, future generations (Shaw et al., 2005).

It has been suggested that failure to achieve government targets to reduce child poverty reflects, at least in part, the legacy of existing policies which reinforce, rather than alleviate, trajectories of disadvantage (Sutherland et al., 2003). The psychological impact of being born, and of growing up, in poor, socially excluded, communities has also been a neglected consideration in policy development (Buchanan, 2006). For marginalised populations, escape from poverty and social exclusion will not be easy because the corrosive effects of chronic low self-esteem and a sense of hopelessness resulting from the cumulative, and intergenerational, effects of wide-ranging discrimination are deeply ingrained. Hence, presenting disenfranchised young people with new opportunities for education and training may be insufficient to convince them of the benefits of taking control over their own lives and developing the necessary skills which may provide them and their families with a more optimistic future.

Similar weaknesses, then, may be identified in the major policy directives which have informed interventions in teenage pregnancy, social exclusion and child poverty. As I will reveal in Chapters Six to Eleven of this thesis, the prospects for the infants born of, and into, the most disadvantaged circumstances appear grim. Hence, it would be unsurprising if their future adult identities failed to reflect this legacy - typically in the form of repeated truancy from school and an early exit from formal education, and early parental responsibilities in the absence of a stable relationship. It is these continuities in disadvantage which remain most intractable and which, therefore, present the biggest challenges to politicians and those charged with generating social policy initiatives.

CHAPTER THREE: WOMEN AND THE MUTABLE CONTEXT OF REPRODUCTION

In this chapter I present an historical overview of female sexual non-conformity and the ways in which illegitimacy has served as a social and historical marker of deviancy. I compare changing attitudes to constructions and understandings of female sexual autonomy and question why sexually non-conforming women continue to be marginalised, despite research, over three decades ago, which concluded that women giving birth outside marriage 'shared some of the same problems, feelings and attitudes about sexual relations and pregnancies that (we) could expect to find among *married* women' (Vincent, 1961:49 original emphasis). As this thesis focuses on one particular aspect of non-normative motherhood - teenage pregnancy - the discourses I am most concerned with are those which position young mothers as deviant outsiders: as women who are born 'bad' and whose life course thereafter continues to unfold on the 'wrong side of the tracks' (Young, 1954:5).

An historical overview of non-conformist motherhood

Common to both contemporary and historic discourses on sexual non-conformism is the framing of heterosexuality and marriage as legitimating agents and powerful determinants of social control. Indeed, 'the family' represents 'one of the basic institutions of any social system [...] illegitimate reproduction may represent a threat to this institution and therefore a threat to the continued existence of society' (Gill, 1977:vi). Accurate statistical information on births occurring out of wedlock is unavailable however, not least because 'bastard' children were frequently not admitted to birth registers (where these existed).

Discourses on 'illicit' childbearing tended to ignore the double standards which operate between men and women; it was as if women became pregnant through divine (or satanic) intervention, such was the collective amnesia regarding the biological requirements for fertilisation. The 'bastard' child evidenced the mother's (but not the father's) 'sin' and there was usually no option but for her to live henceforth as a 'refugee from public criticism' (Young, 1954:7), on the margins of society, with prostitution[22] often offering her the only means for survival. The fate of the woman's 'unplanned' (but not necessarily unwanted) child was little better, as they faced a lifetime of cruel discrimination and indeed, as recently as the 1970s, they were lumped together with the 'handicapped' (Crellin et al., 1971) and were often invisible in textual representations, appearing only as footnotes or statistics. The pioneering work of Mary Hopkirk (Hopkirk, 1949) introduced a new genre to the literature on this subject. By

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[22] The lives of 'shamed' women were shattered by the birth of an illegitimate child. Many died young after contracting venereal diseases and considerable numbers gave birth to babies infected with gonorrhoea or syphilis who subsequently died in childhood or were institutionalized because of their unattractiveness to potential adopters. Outcomes for 'lewd' women in earlier periods were even worse: in 1610 during the reign of James 1, women who gave birth to bastard children were interred for a year in a 'House of Correction' whilst a second transgression resulted in life imprisonment. Many women murdered or abandoned their infants to avoid such sentencing. See: Hopkirk, (1949).

positioning the illegitimate and fictitious child 'Sam' centre stage, the reader is exposed to every gruesome detail of his (accidental) life.

The absence of a paternal figure had devastating consequences for the welfare of illegitimate children, especially after amendments to the 1834 Poor Law ended a mother's right to compel marriage or to pursue maintenance (Swain and Howe, 1995). The oppressive, and extensive, range of discriminatory practices employed against unmarried mothers, which remained largely unchanged until the 1926 Legitimacy Act (Saario, 1967), makes present responses to teenage pregnancy seem enlightened by comparison[23].

Contextualising reproduction: some key historical and social issues

Illegitimacy has been described as a social problem for the last two centuries and as a moral problem 'since time immemorial' (Laslett, 1980:1); it has also been positioned both historically and contemporaneously as a 'purely female transgression' (Pietsch, 2002b:16). The laws of monogamy and the influence of Christian principles ensured that children born outside marriage were severely and permanently disadvantaged (Saario, 1967)[24]. Although presented in terms of kinship law and defined as a universal sociological principle, a moralistic stance is nonetheless also evident in early academic accounts of bastardy:

> 'The most important moral and legal rule concerning the physiological state of kinship is that no child should be brought into the world without a man – and one male at that – assuming the role of sociological father, that is guardian and protector, the male link between the child and the rest of the community. I think this generalization amounts to a universal sociological law, and as such I have called it ... The Principle of Legitimacy.' (Malinowski, 1930, cited in Laslett 1980:5).

The 'Principle of Legitimacy' as described by Malinowski positions illegitimacy as a social problem and situates marriage as a form of social control. Paternity assured a claim on blood ties and this determined the legal right to inherit (Krause, 1971). The stigma of an illegitimate birth was thus substantial and not easily discarded. Even when such children were adopted they, and their adoptive

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[23] This is a very truncated version of several scholarly accounts of the treatment of unmarried women and their illegitimate children. For a more in-depth reading, see: Gill (1977); Hopkirk (1949); Laslett (1980).

[24] However widespread the general practice of mistreating illegitimate children, variation in the way treatment was meted out during different historical periods has been noted. For instance, Roman law denied illegitimate children a paternal relationship but recognized the child's right to a relationship with its mother. This was in sharp contrast to practices in Central Europe during the Middle Ages when bastard children had no right to a legal relationship with either parent, were outlawed from public office and suffered a host of other indignities. Furthermore, the degree of parental 'sinfulness' factored in categorizing illegitimates: those resulting from 'stable' unions (e.g. born within 'concubinage') were favoured over those born of casual unions who, in turn, ranked higher than 'incestuous' or 'adulterous' bastards (Krause, 1971). Categorizing people on the basis of selected criteria has, of course, become an important element in the research process. In the absence of identifying certain 'kinds' of people to investigate and/or enrol in intervention programmes, issues such as social control, and the composition of social groups, would be impossible to investigate and, hence, the range of human behaviours available to inform policy makers would be substantially reduced.

parents, could never entirely escape stigma's potent influence, '*even if they themselves do not share the prejudice*' (Crellin et al., 1971:108 emphasis added)[25].

Most societies have explanations for, and understandings of, illegitimacy, although the way it is defined is always culturally determined, with informal systems operating to censure 'wayward' women. Underage women, and those lacking a (male) provider, tend to attract particular criticism and are vulnerable to becoming societal scapegoats. As evidenced by regular media outbursts trouncing those considered too poor, too young, and/or uneducated, and therefore ill-suited to the maternal role, the condemnation of those who bear children 'unlawfully'[26] has not substantially diminished.

Bastardy also occurred within wedlock but whatever mitigating circumstances were advanced for her unmarried counterpart, they were withdrawn for married women (Young, 1954). Within marriage, women who were unable, or unwilling, to pass the child off as their husband's could claim little assistance and such women may therefore have had more reason to attempt disposal of their bastard children by resorting to perilous methods of abortion or infanticide. In later periods[27], the children born of adulterous relationships could be legitimated by marriage 'providing the husband is willing to condone the wife's adultery' (Jeger, 1951:15). Women were generally held responsible for their children's welfare whether or not they could provide for them: children born out of wedlock were seen as 'related to their mothers for all purposes and to their fathers for limited purposes only' (Saario, 1967:4). Local communities generally tolerated philandering men providing they maintained their lawful family. In this respect, a pregnancy conceived within an adulterous relationship posed far more of threat to the social order than did a covert, sexual relationship.

In the late modern period, many working class mothers earned an additional income by suckling infants other than their own. These included abandoned 'foundlings' and the babies of wealthy mothers who were unable, or unwilling, to engage in the 'thankless task of breastfeeding' (Donzelot, 1979:10). The activities of 'wet nurses' - as such women were called - were eventually regulated; nurses were generally remunerated for their services, usually by the parents, but sometimes by the state (as in France). Wet nurses were regularly accused of manipulating the system to maximise personal gain: some accepted more babies than they could adequately feed; others arranged for newly-delivered

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[25] That said, a recent study, 'written out of a frustration with the limitations of the existing historical literature on illegitimacy [suggests that] the conception of bastard children was a complex and varied phenomenon that cannot be explained by single causes and was not responded to by institutional authorities or communities in one particular way' (Evans, 2005:63). Furthermore, it was only following a transformation in attitudes towards the poor, and towards poverty, followed by a declining interest in philanthropy at the turn of the nineteenth century, that the reputation and circumstances of unmarried mothers took a turn for the worse.

[26] In English common law, the term '*filius nullius*' or 'no-one's son' was widely applied to 'bastard' children (Krause, 1971).

[27] Ambiguity and conflict concerning the legal definition and interpretation of bastardy was widespread in England throughout the 16th and 17th centuries. A critical distinction was made between 'general bastardy' - where the parents failed to marry following the birth, and 'special bastardy' – where, espoused or not at the time of birth, the parents married afterwards. Disputes of 'general bastardy' were tried in the ecclesiastical courts but 'special bastardy' could only be tried in the common law courts because this was not recognized by the church (Macfarlane, 1980).

mothers to 'abandon' their babies, only to later 'discover' them and subsequently claim their nursing fee, which they would split with the mother; wet nurses also abandoned their own babies, reclaiming them at a later date (Donzelot, 1979). Wet nurses thus enjoyed paid employment and later, a pension. Hence, the set-up provided poor women with a degree of financial security for the price of a brief period of separation from their infants. Manipulating the system to benefit oneself and one's child/ren then, is not a modern phenomenon. The nursing aspect of the mothering role, however, remained a paradoxical, and troublesome, aspect of maternal identity, arousing 'suspicions of laxity, abandonment, self-interestedness, or hopeless incompetence' (Donzelot, 1979:31). Indeed, it was through contact with their (wet) nurses that children were seen to acquire 'a fundamental baseness and malice [...] (and) all their vices. They would have been decent if their (own) mothers had nursed them' (Donzelot, 1979:11, quoting Buchan, 1775). Wet-nurses were also charged with contributing to shockingly high rates (by today's standards) of infant mortality, through feeding babies 'ill milk' or falling asleep whilst breastfeeding and hence smothering their charges by 'overlaying' them (McCray Beier, 1987:232).

Illegitimacy is arguably 'more acceptable, less deviant and therefore probably less stressful in those sections of society where its incidence is highest' (Crellin et al., 1971:40). Prior to the 1930s, birth out of wedlock emphasised female immorality and mental deficiency; culpable girls were understood to be born 'oversexed' and/or 'backward' and their situation was not helped by a perceived 'natural' lack of control over their sexuality (Young, 1954). By Young's reasoning[28], non-normative sexual behaviours were innate and made manifest by inappropriate company – by falling in with the 'wrong' types. A change of research focus, however, subsequently identified the 'classed' nature of reproduction outside marriage and the significance of external factors, including the experience of growing up in poverty, parental separation, and being engaged in menial work (Vincent, 1961). By the mid 1960s, illegitimate births had ceased to be the exclusive province of poor, uneducated, girls and were increasingly associated with 'urban living and sophistication' (Crellin et al., 1971:27). Unmarried mothers were also tending to keep their babies rather than 'volunteer' them for adoption.

Anthropological studies introduced the concept of 'culture' into readings of non-conformist births and, hence, illegitimacy came to be seen as a routine experience for particular groups of women. The post-war period heralded the first wave of what would become an ongoing, and intensive, study of mothers and their infants by clinical psychologists, psychotherapists and other members of the 'psy forces' (Donzelot, 1979:220)[29]. The period from the late 1950s through to the mid 1970s saw a backlash against the methods and rationales of psychiatry, which created an opening for the 'anti-psychiatry' movement. Seminal texts by RD Laing (Laing, 1959; Laing, 1971) challenged social constructions of individual, and family, reality. 'Sickness', and its corollary 'saneness', were (re)located to the level of

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[28] Clarke Vincent (1961) has criticised Leontine Young's (1954) psychiatric theory of illegitimacy, particularly her methodology which sampled only unwed women residing in public institutions, welfare agencies, and psychiatric clinics. Vincent suggested such representations of unwed mothers as young, poor, uneducated or psychologically disturbed were distortions of reality.

[29] See also Lawler (2000).

'society', and individuals were understood to be conduits for the expression of social malaise. Over the past two decades theoretical understandings and political acknowledgements that structural causes play a significant role in unwanted pregnancy have advanced debates in these areas[30]. In addition, corporate crime and the revelation of sexual abuse by Catholic priests mean that traditional classed and raced stereotypes of criminality may no longer be so readily available.

Families in Western societies: demographic trends and current practices

Concepts of family and family life are a 'complex historical, social and cultural phenomenon' (Christensen, 2004:380). This is nowhere more fluently described than in *Worlds we Have Lost* - a historical account of family life and household structures by the social historian Peter Laslett (Laslett, 1965 (2000)). Laslett challenges long-held assumptions about family groupings and age at marriage, including the widely-held belief that marriage rules during earlier periods condoned unions between teenagers[31]. He also debunks the notion of the nuclear family as a modern invention, suggesting that our ancestors mostly lived within small family groupings. The one social group who did not conform to this social norm were those who employed servants, as it was through their ranks that the 'family' was extended.

The contours of Western family life have undergone considerable change[32,33] over the past three decades, as indicated by increased rates of single households, co-habitation, the birth of children outside marriage, separation, divorce, and re-constituted families, including lone, and same-sex, households, and childbearing occurring at a more advanced age[34]. Indeed, changing relationships, and women assuming greater agency in the construction and management of their maternal status, have been described as creating 'a new political unit: (the) 'motherandchild' (Mitchell and Green, 2002:3).

Research examining changing notions of family and kinship in contemporary society (Silva and Smart, 1999; Smart et. al., 2001) suggests that attempts to portray family units as predetermined or representative is untenable. As research efforts have shifted from studies of 'the' family as a social institution under a capitalist/patriarchal organising system, to a focus on the interiority of family life and the personal relationships of individual family members (Williams, 2004), the diversity of family structures, and their individually constructed arrangements for self-management, have emerged. For example, when lone motherhood is examined from a life-course perspective, it emerges 'less as a

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[30] The 1987 Family Law Reform Act abolished the status of illegitimacy. Thereafter, children were awarded equal maintenance and inheritance rights whether they were born inside, or outside, of marriage. The same act permitted unmarried fathers the right to apply for parental responsibility.

[31] It was, however, relatively common practice for young people to be *espoused*, sometimes from childhood.

[32] Although there appears to be general agreement that family patterns and practices have changed, the *rate* and *extent* of change have been contested. Elizabeth B Silva and Carol Smart (1999) argue that such change has often been framed in 'alarmist' terms and has frequently been exaggerated for political expediency.

[33] In her moving ethnography of the 'violence' embedded in discourses of mothering in Brazil, Nancy Scheper-Hughes (1992) reminds us that *any* demographic change affects perceptions of human life, personhood, life stages, family roles and social sentiments (including mother love).

[34] This is not to suggest that variations in relationships and parenthood have not always existed but rather, until recently they have not described *normative* patterns of family life.

distinct family form and more as an experience coloured by the lone mother's place in a network of relationships, as well as her place in her broader personal, social and historical context' (May, 2004:401). Hence, post-modern understandings of 'family' view this terrain as a fluid and flexible site for constructing 'webs of relationships' (ibid, 2004:401) between ever more diverse groupings of (unrelated) adults and children.

Traditional gender divisions, and the enduring nature of marriage, have been challenged by those who support the 'optimists' democratization thesis'[35] (Williams, 2004:20), which argues that relationships which are open to negotiation, and which uphold the principles of reciprocity and egalitarianism, are more mutually satisfying and rewarding than those based on obligation and duty. Individualisation, and the assumption of personal responsibility, is viewed as a central tenet of this project. As intimate relationships between adults become less achievable, and are perhaps accorded less importance, however, the parent-child relationship may be in danger of being invested with an emotional weighting which potentially exploits the child's immaturity and lack of experience (Beck and Beck-Gernsheim, 1995; Beck and Beck-Gernsheim, 2002).

Contrary to media reports of the dilution of parental authority and the dissolution of family ties, recent intergenerational research from the USA (Bengston et al., 2002) reports that most children describe feelings of affection towards their parents who, in turn, continue to exert influence over their children's lives. Empirical research within a UK context, examining family life following divorce (McCarthy et al., 2003, Smart et. al., 2001), also reported that kinship obligations and family ties continue to matter to individual family members. Whilst looser arrangements for 'doing' family have generated debate in the tabloid press, such changes are not necessarily indicative of family breakdown - hence the need to detach understandings of family 'decline' from family 'diversity' (Mitchell and Green, 2002:2). As long-established shibboleths of Western family life are disassembled, the links between (hetero)sex/marriage/reproduction are unfastened, leaving individuals with greater freedom to create family structures of their preference. Or so the rhetoric goes.

Feminist theorists have long argued that the organization of the household mirrors the articulation of, and the tensions between, production and reproduction[36]. The combined forces of capitalism and industrialisation create particular difficulties as women attempt to balance the demands of the domestic environment, the workplace, and intimate relationships. Additionally, demographic variables, such as a reduced fertility rates, a decrease in the age diversity of children so that siblings are more likely to be of a similar age, the increasing commercialisation of childcare, and the transition from large to small

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[35] The entry of married mothers into the paid workforce, the rise in lone mother households and in the numbers of children who lack a 'father figure' and a male wage earner, are contributory factors in what has been described as 'the pessimists' demoralisation thesis' (Williams, 2004:19).

[36] Indeed, radical feminists such as Shulamith Firestone (1970) claimed that it was *reproduction*, not *production*, which was the driving force in history and, as such, it was the *'sexed'* nature of class struggles which were problematic.

families[37], have also significantly influenced childbearing and rearing patterns. Despite the greater sense of egalitarianism which constitutes 'modern' relationships, however, it is women who continue to exercise moral agency in undertaking the 'caring' work[38] involved in building and sustaining contact, especially between absent fathers and their children (Bornat et al., 1998). Furthermore, the increased participation of women in the waged labour force has done little to disrupt the gendered division of domestic labour. In the vast majority of households women continue to undertake the bulk of duties associated with servicing the home[39] and caring[40] for other family members, including an expanding population of young adults whose continued financial dependency impedes their departure from the family home to independent living. The gender bias[41] in women's caring responsibilities is not limited to the domestic environment, however, but extends into the workplace where women are over-represented in the lower paid, lower status 'caring' professions, including nursing, teaching, and social work, and in marginal status occupations such as cleaning.

Understandings of relationship intimacy (Giddens, 1992; Plummer, 1995), family solidarity and reciprocity (Bawin-Legros, 2004), and family responsibilities (Finch and Mason, 1993) are thus more malleable in this era of 'liquid modernity' (Bauman, 2000). The de(re)construction of 'family', which has taken place at an accelerated rate over the past decade, has unsettled previously secure(d) family structures and affiliations, to the extent that 'elective logic'[42], rather than previously held norms of reciprocity have become important drivers in determining family solidarities and affinities. New understandings of 'family' recognise the contributions made by alternative groupings, including step-families (Smart et al., 2001), gay and lesbian families (Weeks et al., 2001), and lone-parent families including lone mothers (Silva, 1996), lone teenage mothers (Allen et al., 1998; Fahy, 1995) lone black

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[37] Smaller families have resulted not only from reduced fertility, but also from a corresponding reduction in infant mortality and child death. The dialectic between fertility and mortality is expressed rather differently for many women in non-Western countries for whom birth represents not so much a new life, as (another) potential premature death. For an historic overview of events leading up to the social construction or 'invention' of infant mortality as a discrete category, see: Armstrong (1986).

[38] The term 'caringscapes' was coined to explain the multilayered aspects of women's caring roles and to facilitate further study of the various, and changing, perspectives across the interface of the 'caring' project. The concept of 'healthscapes' develops this concept in the health arena (McKie et al 2004).

[39] Carol Thomas's (1999) work on the (invisible) contributions of women's domestic labour to the betterment, and maintenance, of family health and the subsequent benefits of this work for public health services, deserves mention here. Thomas's thesis challenges Thomas McKeown's (1976) earlier hypothesis that health improvements owe more to changes in social and economic conditions than to medical advances.

[40] Feminists have long argued the unhelpfulness of discussing 'care/ing' as an organizing concept because it implies that women have an a priori response to those deemed in need of care (Croft, 1986). But neither can women who want, and value, their caring roles be discounted as 'cultural dupes', their preferences dismissed as acts of 'false consciousness' and/or as evidence of the enduring nature of the values embedded in a patriarchal system.

[41] It is apparent that although women's positions have improved as a result of legislative, economic, and cultural changes, their relative disadvantage in relation to men continues. For most women, their economically disadvantaged position in the public domain mirrors their positioning within the hierarchy of the traditionally arranged, heterosexually determined, domestic sphere (Arber et al., 1995).

[42] 'Elective logic' rests upon an understanding that more care/help is available to family members who are favoured (for whatever reason) by the individual concerned and less assistance is given to those who are not (Bawin-Legros, 2004).

and ethnic minority mothers (Duncan and Edwards, 1999) and lone fathers (Simpson et al., 1995). As the macro elements of family structures have changed, so have the microstructures. Recent intergenerational research within a UK context (Wade, 2005) reveals a greater emphasis on children's emotional well-being in contrast to the previous focus on their physical and material needs. As conceptualizations about safety and risk have changed, children living in contemporary societies are subject to a more intensive parental gaze intended to protect them from 'stranger danger' (Valentine, 1997:42) and other possible threats.

Mothers, mothering and motherhood

Regardless of whether women are biological, social, surrogate, or adoptive, mothers, representations of motherhood reverberate with the perceptions individual women hold of their own maternal bonds and their infantile experiences of being mothered. The term 'mother' is weighted with multiple contradictions. It functions as a conduit for debates on a range of contentious issues including family values, family health and well-being, the significance of nature and culture and the place of nurture in the development of gender roles and identities, employment rights, and notions of citizenship. Understandings of motherhood are thus multifaceted, rooted in socio-cultural concerns, and integral to economic and political deliberations and reforms.

The status of motherhood in society is intimately linked to the status of women and to understandings of female roles and identities, which are irrevocably bound up with understandings about the construction of gender. In contrast to *biologically* derived motherhood, *social* mothering does not require a biologically derived child-object as the focus of (maternal) attention, but may include the nurturing and befriending of chosen others. Maternity as a biological fact, grounded in the female body through the act of giving birth, is therefore differently understood from the (culturally constructed) activity of *mothering*, which is grounded in specific historical and cultural practices.

Patriarchal societies have emphasised the exclusiveness of the mother-infant bond and the importance of biological connectedness: the woman who bears the child should take responsibility for raising it. The role of the father (if one is identified) has tended to be defined by the exigencies of financial provision and male 'protection'. Mainstream psychoanalytic theories, premised largely on Freudian understandings of an (inferior) female sexuality unable to come to terms with its penile envy, have similarly tended to promulgate a belief in maternity as a biological imperative, viewing women who choose childlessness as somewhat aberrant.

The early feminist case against an essentialist, biologically driven, motherhood (Friedan, 1974; Millett, 1970) argued that Freud's ideas were simply a product of, and a reflection on, a white, Western, masculinist culture that positioned women as docile and powerless[43]. From this perspective, women's

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[43] Sociologist Anthony Giddens (1986) has been similarly criticized for 'telling only half the story' in his 'malestream' (Murgatroyd, 1989:148) theorizings on power and exploitation because he omits to acknowledge the

roles are not so much biologically pre-determined as a product of socialisation processes which emphasise dependency and subservience; the same processes cultivate a belief in male supremacy. Feminist academics (Oakley, [1974a]1985) have long refuted assertions that all women *need* to become mothers simply because they are biologically equipped to do so, but insist that most do because of social and cultural conditioning, and a lack of alternative opportunities. In defence of her arguments, Oakley ([1974a]1985) cites studies which reveal that women who had been abused were more likely to abuse or neglect their own children; and women who had not seen their own mothers breastfeeding were unlikely to adopt this practice themselves. These observations, grounded in empirical studies, suggested that mothers, and their capacity for mothering, are made, not born. This echoes a claim made two decades earlier with reference to the defining processes involved in the construction of 'woman' (de Beauvoir, 1953). The deconstruction of terminology is a theme I return to in Chapter Six.

In her ground-breaking book *Gender Trouble,* Judith Butler (Butler, 1990) argues that gender may not be so variable and volitional as other feminists have suggested, but that cultural pressures act as significant determinants. Butler suggests that feminist writings may (unwittingly) reinforce binary notions of gender relations and hence effectively block future possibilities for the re/deconstruction of individual identity/ies. The need to develop a theory of subjectivity in relation to maternal identity[44] has been argued by psychoanalytic feminists (Chodorow, 1978[1999]) who reject essentialist claims to motherhood as a pre-destined function. Theorists have argued that debates concerning motherhood have been unnecessarily constrained by biological and socio-cultural ideologies which have inhibited alternative conceptual developments, including women's motivations for *choosing* motherhood. Hence the question as to why women should want to maintain the structural inequalities and the destructive gender arrangements which characterize so many mothering practices, and why so many women (especially those who have other choices) continue to see themselves as potential mothers. Some feminists (Glenn et al., 1994; Phoenix et al., 1991) have criticised the psychoanalytic standpoint for perpetuating a universalist (white, middle-class) representation of motherhood and whilst the historic binary divisions may persist, contemporary discourses assume that socio-cultural influences are at least accounted for (Lawler, 2000).

Images of mothers are often portrayed as stereotypes: the composed and serene mediaeval Madonna with her baby nestling in her arms or contentedly suckling at her breast; the aristocratic mothers of earlier periods who abandoned their offspring to wet nurses or fosterage (and of course their contemporary counterparts whose children are bundled off to boarding schools); the (feckless) working-

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significance of gender and ethnicity. More recently, his omission of children's perspectives has raised concerns (Silva et al., 1999).

[44] To put theorizing about a distinctive female identity in context, Carol Gilligan made the wry observation that it was not until the 1970s that 'the really stunning intellectual discovery (was made) that the human world (of psychology) is being mapped without talking to women, or people of colour, or gays or lesbians; you could do this whole map of the human world without feeling you were missing anything. ... People simply chose to talk about adult development or adolescent development ... *as if women were something like men'* (Hamer,1999:179 emphasis added).

class mother with insufficient means to provide for, and control, her (too many) children; the 'modern' mother juggling a busy career with the pressure to spend 'quality time' with her family; the (surrogate) mother-as-incubator whose reproductive efforts are intended for (an)other. More recently, the plight of the 'Mothers of the Disappeared'[45] has given a public face to the grief of mothers caught up in the machinery of military regimes.

Although many of the practices associated with motherhood have changed over time, psychoanalytic theories have tended to promulgate images of 'ideal' (middle-class) mothers whose (unconditional) love for, and attachment to, their children is seen as fundamental to their healthy development. Hence the reification of a particular ('classed') representation of motherhood. Modern (middle-class) motherhood parallels aspects of women's professional lives in so far as 'good' mothers, and 'good' workers must be seen to 'be there' in order to demonstrate role potential and capacity. And whether 'there' is a staff meeting scheduled outside of working hours, or kids sports days or Christmas concerts, attendance signifies commitment to a normative 'truth' of motherhood as a happy and fulfilling enterprise (Benn, 1998). Idealised versions of mothering have a tendency to obliterate alternative readings in which the everyday pain and suffering of ordinary mothers is exposed. Perhaps *because* there is so little (conceptual) space within which women's unhappy accounts of their mothering experiences might be made available, explanatory frameworks are mobilised which fit the dominant discourses. Hence diagnoses of 'postnatal depression' or 'traumatic stress disorder' as (medical) explanations for maternal distress.

The difficulty in locating, and the hope for, a 'middle ground' from which the unravelling of the multiple, and antagonistic, discourses on motherhood and mothering might begin, has been succinctly expressed by Nancy Scheper-Hughes:

> '...perhaps there is a middle ground between the (two) rather extreme approaches to mother love – the sentimentalized maternal 'poetics' and the mindlessly automatic 'maternal bonding' theorists, on the one hand, and the 'absence of love' theorists on the other. Between these is a reality of maternal thinking and practice grounded in specific historical and cultural realities and bounded by different economic and demographic constraints' (Scheper-Hughes, 1992:356).

The importance of positioning a *particular* child in relation to a *specific* mother - who exists not in a vacuum but in social relationship to others, and within a geographical, age, and class context - has been somewhat disregarded in contemporary academic accounts of motherhood. The intersections between class, race, and age, and the specificity of the mother-child dyad, have particular significance in this thesis, because these junctions illuminate variations in child-rearing and parenting practices. They also resonate with concepts such as 'good enough' parenting, because they illustrate the futility of seeking to

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[45] 'Las Madres de los Desaparecidos' (Ruddick, 1989:226).

define universal standards for optimum childrearing[46]. This stance has particular resonance for my research because it unsettles constructions of motherhood (and childhood) and questions the parameters of 'normality': practices which might be considered harmful in one social setting are judged differently in another. Anthropological accounts have reiterated this point and decry the ethnocentric standards against which culturally specific concepts, such as childhood 'neglect' (LeVine et al., 1994), or maternal 'grief' (Scheper-Hughes, 1992), may be measured or understood[47].

Stereotyped images and accounts of motherhood frequently depict children as either monsters[48] or angels; as 'unnatural' products of inadequate (lone/poor/teenage) mothering, or the well-behaved, socially competent, offspring of economically stable families. The unexpressed agendas here concern class and the relationship between parent(s) and their child/ren. As Stephanie Lawler (Lawler, 2000) reports, when working-class childhoods and parenting techniques are appraised against middle-class norms, the former are frequently seen as deviant and/or inadequate. Failure to conform to normative (idealised) standards of mothering results in stigmatisation and discrimination and nowhere is this more apparent than for teenage mothers. Unlike motherhood at an older age, adolescent motherhood tends to be viewed as a manifestation of subordinate status rather than as a normative component of the female life course.

Women who 'choose'[49] motherhood are pressured by multiple, and oppositional, forces. At a material level, the very visible, and highly persuasive, advertising industries aggressively promote the latest 'must have' products and rely on the 'pester power' of children to reduce adult resistance. At the corporeal level, women-as-mothers are targeted by health promotion campaigns extolling the benefits of exercise and 'healthy diets' and warning about the hazards of obesity and 'recreational' drugs including tobacco and alcohol. Mothers must also convey the 'right' messages, to ensure that their (sexually adventurous) teenagers complete their education and make a successful transition to the workforce, unmarked by a police, or maternity, record. Hence mothers are routinely positioned as the moral arbiters of family behaviours and standards and may be harshly judged when family members fail to meet approved standards of behaviour. The mothers of childbearing teenagers tend to be identified as failures in this respect.

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[46] The theory of 'maternal bonding', as promoted by Marshall Klaus and John Kennell (1976), and which continues to have saliency in contemporary midwifery practice, may be seen in this light because it promotes an essentialist scripting of femaleness and motherhood.

[47] Nancy Scheper-Hughes (1992) makes the point that contemporary (Western) ideas about a mother's love for her child/ren derive from a particular reproductive 'strategy' which advocates few pregnancies, giving birth to a small number of children, and 'investing' (emotionally and economically) in each one. Such a strategy was alien throughout most of European history and remains so today for poor women. Scheper-Hughes goes on to point out that the use of terminology such as 'investment' and 'strategy' in this context reflects a Western mindset wherein the commodification of all experience (including those pertaining to reproduction) has become normative practice.

[48] The two children who are arguably conceived in the (UK) public imagination as being the most notorious in this respect are Robert Thompson and Jon Venables, the ten year olds convicted for the abduction and murder of a two year old child in the north of England in 1993. See Morrison (1997), for a thoughtful, and provocative, literary account of this event.

[49] And of course many women are not at liberty to make such 'choices'. Many more women also die, or are physically and/or psychologically damaged, as a result of their childbearing experiences.

Although I acknowledge that lone mothers are not necessarily always teenage mothers, the reverse is generally true. Lone motherhood has been identified as being particularly problematic because of concerns about welfare dependency and the costs to the state of supporting such dependency (Roseneil and Mann, 1966). These debates, however, often result in *all* lone mothers, whether they are mothers by choice or circumstance, and whether or not they are recipients of state welfare, being viewed as inadequate: 'good' women do the 'right' thing by marrying, at an 'appropriate' age and before they have children, whilst 'bad' women procreate regardless of age and marital status and subsequently become reliant on state support to raise their children. Dichotomizing women along the lines of good/bad has a long history, but it is in only in more recent times that young women have been singled out as a particular category. James Wong has noted that the creation of categories or 'kind making' is a central focus of the social science enterprise as it seeks to examine, and to understand, 'patterns of law-like regularities in the subject matter of their investigations' (Wong, 1997:274). The information collated from social science research, however, may be used to 'control the people investigated or to predict their behaviour in ways that can inform policies' (ibid: 274) instead of necessarily benefiting them.

If concerns about welfare dependency[50] are put to one side, state regulation of families provides some curious, and unexplored, paradoxes. Regarding childcare, for example, many young mothers have access to uncommercialized, informal childcare through family and kinship networks. Although they are generally not expected to remunerate the care-provider, young women may be required to reciprocate in kind. Friends and relatives may provide childcare although if the child is being cared for in their (the carer's) own home on a regular basis, and the carer is receiving payment, the carer must be registered with the local authority. The paradox is that whilst (unfamiliar and unknown) state registered childminders may claim public money for their services, family members may be prohibited from doing likewise on the grounds of an existing blood relationship: i.e. they are disallowed *because* they are family.

Until recently, women exercised little control over their reproductive potential. Adrienne Rich (1997) made this point almost three decades ago when she distinguished between two superimposed meanings of motherhood: 'the *potential relationship* of any one woman to her powers of reproduction and to her children; and the *institution*, which aims at ensuring that the potential – and all women – shall remain under male control' (Rich, 1977:13 original emphasis). Absence-of-control theories are prevalent in discussions about marginal groups, because their age (too 'young'), their mental health status (too 'mad'), and/or indictments of criminality (too 'bad'), are widely perceived as rendering them incapable of

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[50] It has been argued that political campaigners in the industrialized west have sought to redefine the contours of the welfare state such that this institution is increasingly seen not as a major *protector* from risk but as a *generator* of risk because it acts to disincentivise initiative at both the corporate and individual level and this encourages dependency and the development of an 'underclass' of citizens, all of which decreases competitiveness abroad (Williams 1999).

making appropriate decisions, especially about reproduction[51]. Teenage motherhood unsettles dominant (patriarchal) discourses about sexuality because childbearing is not class neutral: young women who become pregnant and go on to become mothers, do so because the life course they inherit is pre-inscribed with disadvantage and inequality.

Power differentials in sexual relationships may be defined in a number of ways. Blanc (2001), makes an important distinction between the power individuals possess when acting within a social group, and their (relative) power when in dyadic heterosexual relationships, where one partner may act independently of the other and hence dominate decision-making. Gender relations are affected both by the assertion of power *over* (the ability to assert one's own goals and wishes even when opposed by the other) and power *to* (the capacity to self determine, and achieve, one's own goals and wishes) (Blanc 2001). The modelling of power relationships, and the multiple ways in which these may be enacted, have consequences for young women, in so far as men assume significant control over many aspects of women's reproductive lives (Dudgeon and Inhorn, 2004). The concept of gender-based power, therefore, derives from social meanings underpinning biological differences between men and women, and the expectations regarding (sexual) behavioural norms. Sexual power tends to operate in favour of men and this reinforces a sexual 'double standard' whereby men's greater sexual freedoms, and their rights to sexual self-determination, are in sharp contrast to the denial of such rights for women.

The control young women may exert over their sexuality, and indeed over their sexual health[52], is not only limited by their relationships with men, but is also significantly influenced by social constructions and understandings of what constitutes 'appropriate' female behaviour for this age group. For example, school-aged girls who are known to be sexually active may be considered immoral and/or deviant[53], because they contradict the stereotype of a young woman. This is somewhat ironic, given that adolescence is a phase in the life cycle which is typically characterised by exploration and risk taking, as young people move from the (asexual) zone of childhood to the (sexual) zone of adulthood.

Stereotypes of female behaviour emanate from a (middle) class-consciousness wherein female morality, sexuality and identity are interwoven. Whilst diverse, and often contradictory, explanations for 'doing' adolescent sexuality abound (Woollett et al., 1998), the meanings attached to sexual activity are nonetheless classed and gendered and hence reinforce girls' subordinate status. The exercise of personal power in sexual relationships tends to be very limited for poor young women, not least

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[51] In July 2004, a number of fourteen year old girls were ridiculed after they approached a fertility specialist seeking in vitro fertilization because they had been sexually active for two years but had not succeeded in becoming pregnant (Horsey, 2004).

[52] The World Health Authority (2002) defines sexual health as: 'a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled' (WHO 2002).

[53] By defining women as (contaminated and unreliable) 'other', medical discourses have played an important role in defining notions and constructions of femininity. to the extent that it is argued that this is now the dominant discourse controlling women's bodies (Ussher, 1992).

because this is often 'neither the only, nor the most salient, site of struggle and negotiation' (Woollett et al., 1998:371).

CHAPTER FOUR: MIDWIVES AND THE UK MIDWIFERY PROFESSION

This chapter provides an historical overview of UK midwifery, including the demise of the modern midwife's forebears; the 'handywomen' who lived and worked within their local communities undertaking domestic and health related duties, particularly those associated with birthing and dying. I focus on events immediately preceding and following the 1902 Midwives Act, describing how professionalisation emphasised the midwife's role as passive observer rather than active intervener. I discuss the institution of statutory midwifery supervision and describe the evolution of this instrument, from its original policing function to its current role as a support mechanism, albeit one which insists upon midwives' compliance with organisational and medical norms. I discuss how the inception of the NHS influenced midwifery practice and the status of midwives, and affected midwives' relationships with childbearing women. I conclude this chapter by describing the gendered nature of health-related institutions and how conflicting ideologies create tensions between different groups of midwives and between midwives and childbearing women.

The regulation of midwives and midwifery practice

There was little regulation of midwifery practice until the end of the pre-industrial period. Prior to this, midwives were exclusively female[54] and they delivered almost all babies, only very occasionally calling in a surgeon ('chirurgeon') to assist with difficult cases - which often resulted in the infant being 'delivered in pieces and the woman endangered as well' (McCray Beier, 1987:16). Midwives' practice during this time was not exclusively concerned with providing maternity care; they were also responsible for the welfare of kin and neighbours living within their localities. They learned their trade by observation and experience and skills were generally passed down the maternal line from mother to daughter. Such skills demonstrated 'domestic' as well as 'clinical' expertise: competence in making a poultice or laying out the dead was as important as managing a long labour and difficult birth. In the absence of formal instruction and examination, these midwives were licensed by the Bishop's court, conditional to producing testimonials of good character from their clients.

Until recently, women were the primary officiators and arbiters in matters concerning major transitional states in the human lifecycle. The cyclical nature of their own hormonal bodies, marked by the corporeal events of menstruation, childbearing, and the menopause, linked women to one another. The midwives of this early period were multi-skilled and demonstrated considerable prowess as

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[54] The 'man-midwife', in existence from the 1600s, was a new order of practitioner who, by dint of access to anatomical and academic studies denied to females, was perceived as better placed to deal with difficult births. By the beginning of the eighteenth century man-midwives were increasingly consulted, especially by the wealthy classes, and by the end of this century had expropriated many traditional midwifery skills. The foundations were thus well prepared for a complete take-over of midwifery by the practice of 'obstetrics' in the following two centuries (McCray Beier, 1987; Donnison, 1988; Witz, 1992).

pharmacists, abortionists, anatomists, healers and herbalists. More recently, midwives have been described as 'professional friends' (Pairman, 2000:207) and as 'professional servants' (Cronk, 2000:19).

Before the first world war, and indeed up to the 1930s in some parts of England, the birth attendant for the majority of working class women was not a professional midwife but a local (working-class) woman, otherwise referred to as a handywoman or simply, 'the woman you called for' (Leap and Hunter, 1993:1). Such women, usually older and married[55] or widowed, lived in close proximity to the 'social group they served' (Kirkham, 1996:164). Their careers started early and finished late; many were well into old age before infirmity prevented them from continuing their work. The majority of such midwives were very poor and most had little formal education, acquiring their knowledge and skills through apprenticeship. Although unsalaried[56] as such, most handywomen negotiated a fee, or were paid in kind.

In short, midwives practising before the first (1902) Midwives Act generally matched the social class, and subscribed to the same cultural norms, as the childbearing women and families in their care. Most births, including multiple and breech births, occurred at home with the midwife in sole charge. If she needed assistance, she tended to seek out a neighbouring midwifery colleague rather than a doctor, not the least because of the prohibitive fees doctors charged and the likelihood that they would subsequently appropriate the maternity care.

During the latter decades of the nineteenth century[57], in response to growing concerns over the social and economic effects of ill-health and poverty (reflected in high maternal and infant mortality rates), a group of elite women campaigned to regulate the training and practice of midwives (Heagarty, 1996; Leap and Hunter, 1993). Their activities resulted in the formation of the Institute of Midwives in 1881, which subsequently became the Royal College of Midwives. The Institute's original membership comprised women in positions of power and influence within the nursing profession, in public roles involving philanthropic work, and/or affiliated to missionary movements promoting Christianity. By exploiting sympathetic connections with politicians, medical men and other influential people, these women engineered the 1902 Midwives Act for England and Wales[58] and, with it, the regulatory and disciplinary apparatus of the Central Midwives Board (CMB). The CMB produced rules for practice and training which focused on hygiene and the prevention of infection, and the need to summon (medical)

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[55] Following the 1902 Midwives Act, practitioners who gave birth outside of marriage faced deregistration. For an account of the consequences of failing to comply with middle class notions of morality, see Heagarty (1990).
[56] The independent, and self-employed, status of midwives ended with the 1936 Midwives Act which introduced a salaried midwifery service with midwives becoming employees of local authorities.
[57] For earlier historical accounts, see: Siraisi (1990) and Marland and Rafferty (1993). For an account of the history and development of medical care for pregnant women, see Oakley (1984). Whatever written accounts remain of women's activities in relation to midwifery practice however, they represent only a partial view as many left no trace of their activities in written records due, in part, to widespread illiteracy, and because practice was 'limited' to the domestic sphere and therefore not considered worthy of reportage. During this period, women were routinely excluded from (medical) education and therefore could not compete for the most lucrative and prestigious areas of (medical) practice – which included the more difficult maternity cases.
[58] The first midwives act for Scotland was passed in 1915.

aid when 'abnormalities' or 'deviations' from (medically defined) norms of practice were detected. Midwives continue to be governed by Standards and Rules[59] detailing their limits of practice.

The Institute thus expedited the decline of the 'handywomen', who they viewed as unkempt, uneducated, morally suspect, and ill-fitted for the task of assisting women in childbirth[60]. The 1902 Act forbade any person who was a not a certified midwife or a registered medical practitioner, or who was not acting under the instructions of the latter, from attending a woman in labour 'habitually and for gain' (Leap and Hunter, 1993:7). Rather than challenge the medical profession and resist efforts to incorporate midwifery within its domain, the CMB leadership fraternised with it. Indeed whilst the original CMB Articles of Association included the names of prestigious medical men and Members of Parliament, midwives did not feature. Whilst the original founders of the midwifery profession ensured registration for an all-female occupation, its members 'had the unenviable distinction of being the only profession controlled by a body on which its members must never be more than a minority' (Donnison, 1988:177).

Although the 1902 Act relinquished control of midwifery practice and education to a rival faction (primarily doctors), the registration of midwives as a separate group did prevent their disappearance from the childbirth scene, as occurred in North America, Canada and Australasia. The damage to traditional midwifery practice notwithstanding, the 1902 Act was a noteworthy and remarkable achievement, as it was introduced at a time 'when there were no female MPs, when no woman had the vote and when the idea of registering midwives was a huge and bawdy joke for many Commons members' (Donnison, 2004:181). The Act was nonetheless a watershed in the history of midwifery, naming and making visible power relations that have played a key part in the socialisation of midwives and which continue to influence contemporary practice.

Following the 1902 Act, handywomen, also referred to as 'granny' or 'lay' midwives, were registered and afforded a period of grace during which they practised on an equal footing with formally trained midwives. Midwives registering via this route were referred to as the 'bone fides'. They were required to produce a character testimonial from a local clergyman and to show evidence that they had been practising for at least one year. They were then accepted onto the register only until such time as the newly established training programmes produced sufficient numbers of 'properly' qualified midwives. Midwives who were unable to comply with registration requirements were required to pay a fee and pass written and oral examinations. Those who failed (and many did on account of illiteracy and poverty) were required to undergo a fee-based period of training. This prevented poor, working-class

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[59] For the latest version, see http://www.nmc-uk.org
[60] The view of lay midwives in England at this time was shaped not so much by the practice of real midwives but as by Sairey Gamp, a fictional character created by Charles Dickens (1844). For a more sympathetic account of the (fictional) positioning of the handywoman and her contribution to the welfare of local childbearing women, see Thompson (1978). But neither were real-life midwives in continental Europe uniformly held in high regard. Indeed, in one account, their reputation for being work-shy earned them the phrase 'money for a midwife, money for a whore' (Zanolla, 1990:189). For a fuller account of midwives' lives and practice across Europe in the early modern period, see Marland and Rafferty (1993).

midwives, some of whom had been practising for most of their lives, from continuing their work. Payment of fees also disincentivised potential recruits from the working classes, who might otherwise have followed the traditions of their maternal line.

The 1902 Act made provision for the statutory supervision of midwives, a mechanism designed to enforce regulation of midwifery practice and one which remains unique to the profession. The jurisdiction of Supervisors (originally 'Inspectors') was not limited to clinical practice as their class backgrounds invested them with a moral superiority which licensed them to judge midwives' personal lives. Midwives were thus required to conform to middle-class standards and morals or risk having their licenses revoked. Midwifery supervision ensured the social control of midwives (Heagarty, 1996) and ensured that professionalisation was achieved by a highly trained and disciplined workforce[61].

Midwifery supervision was initially undertaken by individuals who were themselves not midwives, nor indeed allied health professionals. They nonetheless carried considerable authority to inspect and pronounce upon the midwives practising within their localities. Midwives were, and indeed remain, largely ignorant about the nature and purpose of statutory supervision (Stapleton et al., 1998) and, hence, were vulnerable to its more punitive aspects including suspension from practice and/or periods of supervised practice, for relatively minor offences. The statutory requirement for midwives to be supervised continues and, until recently, the organisational aspects remained largely unchanged. It was not until 1977 for example, that the requirement for a medical officer to act in a supervisory capacity was abolished and, with it, came acknowledgement that midwives were finally 'deemed capable of supervising themselves' (Jenkins, 1995:54). Pressure for legislative change has tended to originate from outside the profession, or from small groups of marginalised midwives, including those working in a self-employed capacity[62]. Change has focused on the need for more supervisors who are peer nominated, who undergo approved training, and who are remunerated. Supervisees are encouraged to perceive supervision as less punitive, to see supervisors more as 'professional friends' than policing agents, to take a more pro-active approach in accessing their 'named' supervisor in advance of difficult

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[61] A Foucaudian (Foucault, [1997]1991) understanding of the notion of 'docile' bodies is apposite in the context of this discussion. The process whereby a workforce becomes 'professionalized' requires, amongst other things, that individuals demonstrate their allegiance to a professional 'body' whose core requirements will effectively monopolise, and constrain, members' time, energy and capacity. An inevitable result is the production of obedient and willing (or 'docile') bodies who will work unceasingly and unquestioningly to further the aims of the organisation.

[62] The demand for self-employed midwives diminished after the 1936 Midwives Act which required all Local Supervising Authorities to provide a domiciliary service; the introduction of the NHS in 1946 simply accelerated this trend. The demise of a viable home delivery service in the 1980s sparked a resurgence of self-employed practitioners, a trend which peaked in 1994 following a successful, and costly, legal challenge against an independent midwife. The Royal College of Midwives subsequently withdrew the indemnity insurance it had previously offered to all its members. Unlike employed midwives, who are covered for vicarious liability through their employers' insurance, self-employed midwives found themselves in the invidious position of being unable to find, or afford, insurance cover. Hence the small number of self-employed midwives currently working in the UK (n=approx 65) practice without vicarious liability insurance as, even if they were able to source an insurance underwriter, the cost of the annual premium (in the order of £20K+ p/a) exceeds their average annual income. See: http://www.independentmidwives.org.uk/

clinical situations, and to seek support in the event of untoward clinical outcomes. For all its limitations and troubled history, the majority of midwives wish to retain supervision (Stapleton et al., 1998).

The National Health Service (NHS) and the impact on midwifery

The 1946 NHS Act arguably marked the end of a 'golden era' (Allison, 1996:1), as midwifery autonomy became increasingly constrained by government policy and medical interference. Prior to the inception of the NHS, domiciliary (district) midwives worked on their own or in partnerships, providing maternity care to women within their communities. Most women gave birth at home, with midwives routinely managing a range of clinical events which have subsequently been (re)categorised as 'high risk' and beyond the scope of midwifery expertise. Hence, midwives in the first half of the twentieth century worked as autonomous practitioners who arranged their own time and clinical commitments in accordance with the pressures and demands of a fluctuating caseload.

The effect of the NHS Act on domiciliary midwifery was not immediately obvious, as midwives continued to practise independently, undertaking consultations with women in their homes or in local clinics. The most significant change heralded by the NHS Act concerned midwives' remuneration, as Local Supervising Authorities assumed responsibility for employing midwives or for making alternative arrangements to provide maternity care to local women (Allison, 1996). The change in employment status, from self-employment to employee, meant that midwives' allegiance to childbearing women was increasingly threatened by hospital managers, medical doctors, and midwifery supervisors. Successive government reforms encouraged General Practitioners and hospital-based professionals to compete for maternity bookings, which resulted in a progressively more fragmented maternity service and a dramatic decline in home births (Allison, 1996).

Hence the stage was set for the 1970 Peel Report[63] and its recommendation for 100% hospital births. This was quickly followed by the 1974 National Health Service (Re-organisation) Act, which 'united' hospital and community (midwifery) services, but which also disrupted long-established patterns of community-based care. The endorsement of multi-disciplinary management teams eroded midwives' unique professional identity, 'whose responsibilities require self-management and professional control' (Allison, 1996: Appendix E). The 1974 Act transferred statutory supervision from the community to hospitals, where midwifery practice was already tightly controlled.

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[63] Otherwise known as 'The Domiciliary Midwifery and Bed Needs Report' (Allison, 1996). The basis for this report, that the risks to life associated with childbirth are less if birth takes place in hospital, were robustly challenged (Tew, 1990). Although the claim promulgated by the medical profession and government officials - that hospital births were safer than home births - was later disproved, the damage was done and the collective psyches of midwives and childbearing women gradually came to believe, despite generations of embodied experience, that birthing at home was unsafe. The current funding of services to support women who chose the option of home birth reflects the 'post-code lottery' of other aspects of NHS service delivery (White, 2004). Positioning home bir;h appropriately on the safety-risk continuum is a difficult undertaking as evidenced by the fact that as recently as 1992 home birth was considered to be a form of child abuse in the USA, whilst in the same year, home was the location for more than one third of all births in the Netherlands which, incidentally, has a lower rate of perinatal mortality than the USA (Wagner, 1994).

This was an extremely difficult period for domiciliary midwives. Subordinate to doctors and occupying a lowly place within the hospital hierarchy, they discovered that their sphere of practice had been redefined without consultation. Where previously they had provided maternity care for childbearing women experiencing 'normal' pregnancies and/or labours, within hospital environments they found the parameters by which 'normality' was determined were more constrained. The practice of domiciliary midwifery was at odds with the norms of obstetrics, which defined pregnancy and birth as normal only in retrospect. The hospital setting also required midwives to radically alter their working hours: labour and postnatal wards required staffing '24/7', whilst antenatal clinics required only daytime, and weekday, staffing. Domiciliary midwives worked alongside, but deferred to, medical staff, the midwifery and nursing hierarchy, and hospital administrators and managers. Midwifery 'care', which was previously undertaken by one or two midwives as a complete maternity 'package', became fragmented, with large numbers of midwives each carrying out a small number of tasks, on a 'conveyor belt' maternity system.

Hence, the establishment of the NHS and the attainment of professional status significantly affected midwives' relationships with childbearing women: their primary allegiance shifted and was no longer located 'with women' but was increasingly aligned with employers and professional and regulatory agencies (Heagarty, 1996; Kirkham, 1996; Marland and Rafferty, 1997). The continuity of care that women and midwives had previously enjoyed, and which had extended over many generations, vanished. Midwifery's professionalisation was achieved by deferring to the dominance of medicine (Freidson, 1970) wherein the role of the midwife as 'handmaiden' or 'obstetric nurse' was deemed entirely suitable in a female-dominated profession. Such an analysis, which fits within the "machismo theory of professionalisation' (Parkin, 1979:104), resonates strongly with midwifery's history to date.

Gendered roles and midwives strategies of resistance

I have described how different sets of gendered values underpinned, and subsequently undermined, the practice of working-class midwives, whose historical legacy was to provide a local maternity service. Whilst the exigencies of such provision would always impose limitations on the delivery of individualised care, these long-established, often inter-generational, relationships facilitated 'woman-focused' decision-making, usually without reference to a third party. Although most midwives might be described as generally apolitical, in that most rarely attempted to marshal outside support to oppose structural changes, they were nonetheless devoted to servicing the maternity needs of 'their' women, from which they derived tremendous satisfaction. In keeping with women's traditional role, they worked hours which were not only long and unsocial but were potentially injurious to their health, as the service they provided demanded they subjugate 'the demands of their domestic and social lives to the needs of the domiciliary midwifery service' (Allison, 1996:127).

The gendering of institutions continues to this day and is evident in the NHS where, although women constitute over three-quarters of the labour force, they are under-represented in the most

prestigious occupations, 'particularly in management and in medicine, that carry the highest levels of status and reward' (Davies, 1995:46). Although the Victorian values which structured the lives of those who founded professional midwifery have gradually weakened, the centralisation of medical technologies in hospitals, and the drive for maximum efficiency, reflect masculine values and create a hierarchy of institutional expertise (Freidson, 1970). Midwives are low in the institutional hierarchy (Kirkham and Stapleton, 2001) and their position, as 'subcontractor' to biomedicine (Schwartz, 1990:58), demonstrates the gendered (female) skills of support, caring, and being 'with' parturient women[64].

The increasing medicalisation of childbirth contributed to the emergence of a counter culture by the 1970s. Public attitudes were also changing as more (married) women continued to stay on in employment, motherhood no longer signalled the end of a woman's career, and (middle class) women began collectively to talk about their (unsatisfactory) experiences of hospital-based maternity care[65]. Midwifery training also began to attract articulate and opinionated 'independent thinkers' (Newburn and Hutton, 1996:224), who were not only educationally better qualified but were also middle class and, hence, better positioned to further political ideals. Outside midwifery, an international feminist movement was gathering momentum and providing a conduit for subversive voices to speak out against the continuing oppression of women, particularly against taken-for-granted health and related practices. Small, but determined, numbers of spirited, and politically engaged, midwives, including students, and childbearing women who were deeply unhappy with the existing state of maternity care, supported radical change. The combined energies of consumers and providers of maternity care was a powerful alliance and helped support the emergence of grassroots organisations in their challenge to conventional obstetric thinking and practice[66]. A small number of these organisations continue to work to inform policy developments in maternity care and midwifery education despite lack of interest or outright opposition from mainstream establishments. Perhaps for these reasons, some of these organisations continue to be perceived as a thorn in the side of the maternity establishment.

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[64] This is not to ignore the existence of hierarchies within the nursing and midwifery professions, nor to disregard the contributions of women in early public health reforms, especially regarding nutrition and hygiene management. Success in these domains was perhaps most famously captured in the nursing careers of Mary Seacole (1805-1881) and Florence Nightingale (1820-1910).

[65] The material circumstances of women's lives influenced their views on their experiences of maternity care. For example, working class women were more inclined to see the move to hospital birth in a positive light because their choice of help in childbirth had traditionally always been more limited and because working class women tended to be pregnant more often and hence badly needed the rest and nourishment afforded them by a hospital confinement (Garcia et al., 1990).

[66] For example, The National Childbirth Trust (originally the Natural Childbirth Association) and The Association for Improvements in Maternity Services (AIMS) founded in 1956 and 1960 respectively, were arguably the first pressure groups to position maternity care as a primary focus. Both organisations have significantly influenced debates concerning childbirth in the UK (Kitzinger, 1990). The Association of Radical Midwives (ARM) and the formation of the Independent Midwives Association (IMA) have also been instrumental in challenging the status quo and hence in providing women and midwives with alternatives to mainstream practices. See: http://www.radmid.demon.co.uk; http://www.independentmidwives.org.uk/

Comparisons between earlier, and contemporary, midwifery practice

Prior to the 1918 Maternal Child Welfare Act, the concept of antenatal care as a discrete, preventative intervention was non-existent. Even for some decades following this Act, unless something untoward arose, there was relatively little formal contact during pregnancy between midwives and the women they were booked to deliver. Pregnancy was viewed as a normal process which did not require monitoring. Hence, the midwife might visit during the antenatal period but this was only to confirm arrangements for the birth; her energies and skills were primarily deployed during labour and the postnatal period.

The focus and norms of midwifery practice have changed dramatically. The majority of childbearing women encountering present-day maternity services will experience fragmented care, whilst the 'post code lottery' allocation of NHS resources results in some women being denied their preferred choices, for example a home birth and/or the most effective antenatal screening techniques. Childbearing women also face escalating intervention rates, including caesarean sections[67]. Meanwhile, the advent of foetal medicine and an increasingly sophisticated array of monitoring techniques for assessing foetal development, has further eroded the midwife's role and greatly diluted her clinical responsibilities to the point where it has been suggested that many midwives are no longer with women but rather, 'with the powers that be' (Kirkham, 1996:164). With antenatal and intrapartum care now consuming most of midwives' time, there is little provision for women in the postnatal period, hence the reference to this phase of the maternity episode as the 'Cinderella' (Thomas, 2003:403) of care provision. The climate in which midwives practise has also arguably deteriorated. Problems with midwifery recruitment and retention have resulted in widespread staff shortages, with some midwifery establishments experiencing considerable difficulty in filling existing vacancies. Government imperatives which stress the need for midwives to fully inform women about all available options, and to fully involve them in decision-making processes, have increased time pressures, whilst inflexible working arrangements, workplace bullying, exposure to physical and verbal abuse, and an increasingly litigious culture, have been identified as factors contributing to midwives exiting the profession in growing numbers (Ball et al., 2002).

With the relocation of birth from home to hospital, the regulation of women's childbearing bodies was appropriated by the apparatus, and personnel, of biomedicine. As they were amalgamated into the maternity system and subjected to institutional regimes, women ceased to be autonomous agents in control of their own birthing experiences. Centralising childbearing processes extended the 'medical gaze'; midwives, especially those based on labour wards were co-opted as conduits for monitoring and surveillance duties. Because they lacked decision-making power within the hospital hierarchy, midwives had few options but to participate in the interventions visited on labouring women: attaching them to electronic foetal monitors, rupturing their amniotic sacs, injecting them alternately with labour accelerants and opiate derivatives to dull the pain they had (inadvertently) caused. Women's

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[67] Delivery by caesarean section in the UK was 4.3% in 1970, rising to 10% in 1983, 15% in 1994-95 and 22% in 2002-3 (Smith & Jacobson 1988; Department of Health 2002).

compliance with, and midwives lack of resistance to, newly established institutional protocols greatly advanced the power and eminence of obstetricians. The status of midwives, however, was reduced to that of a 'handmaiden' whose primary function was no longer to support childbearing women in labour, but to report on their physical (dys)functioning. Midwives' roles in surveillance may be seen as yet another example of their (historical) inability to defend themselves against challenges by a more powerful 'other'; this certainly undermines their position as authoritative, and knowledgeable, keepers of a unique corpus of knowledge about childbearing.

As described earlier, following a brief period of 'grace' the 1902 Midwives Act required all midwives to undergo a formal period of training and to pass an examination. This determined their eligibility for admission to the professional register. Historically, midwifery training was linked with practice and until the 1990s and the move to university-based education, educational facilities were in close proximity to the clinical environment. Prior to the introduction of university degree programmes, the conventional route to midwifery registration was to obtain a secondary qualification following a general nurse training[68]. Indeed, in many countries outside the UK, a nursing qualification remains a prerequisite for midwifery training and registration. With an increase in 'direct entrant' (DE) programmes, requiring evidence of educational attainment rather than a nursing qualification, however, there are growing numbers of practising midwives no longer in possession of a dual qualification.

Prior to 1979, the Midwives Act still banned the attendance at birth by 'a man who is a registered midwife [...] except in a place approved in writing by or on behalf of the Secretary of State' (Jenkins, 1995:31). Following a lengthy legal battle in the UK, men won the right to be admitted to the midwifery register in 1983. In 2005 (the latest figures available), 158 male midwives were registered as currently practising - 0.4% of all practising midwifery registrants in the UK (Nursing and Midwifery Council, 2005). By comparison, 10.5% of the total number of nurse practitioners are men, an increase of almost 2% in the past decade (Nursing and Midwifery Council, 2005). As the historical gendering of jobs becomes more blurred, and the traditional (vocational) origins of midwifery undergo a 'make-over', it has been suggested that higher pay and professional status will attract more male applicants to midwifery training schemes (East, 2003). There are, of course, advantages in being a male minority within a female professional group, with one early source suggesting that 'the best way for a man to insure his advancement is to prepare for a field of work in which most employees are women' (Kadushin, 1976:441). The entry of men into midwifery has not been without vociferous debate - much of it in opposition - from birth activists and other (female) midwives[69], some of whom have argued that admitting men to the profession has ended the protection of an all-female occupation enshrined in statue through the 1902 Midwives Act.

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[68] See: http://www.rcm.org.uk/ for information about training routes leading to midwifery registration in the UK. A more radical proposal for midwifery education has been formulated by the Association of Radical Midwives. See: the: http://www.radmid.demon.co.uk/vision.htm
[69] See: McCray Beier (1987:x) and the website for the Association of Radical Midwives: http://www.radmid.demon.co.uk/archive.htm

Fear, and the technological imperative, dominate contemporary childbearing domains. Midwives work in environments in which the threat of litigation is an everyday reality. The law currently permits complainants twenty years following a birth-related incident in which to sue for damages. It has been argued that the costly 'success' of malpractice claims accelerates the trend towards a more conservative, and defensive, practice, wherein all health professionals are encouraged to use technological interventions as a kind of 'prophylaxis' against being sued (De Ville, 1998). Recent research examining the culture of the UK maternity services demonstrated that midwives, like childbearing women and others of low rank, tend to conform with local practice norms and 'go with the flow' of (obstetric) opinion in complying with the options presented to them (Kirkham and Stapleton, 2004). Colluding with, rather than challenging, medical authority is functionally appropriate for those in subservient positions; preserving the status quo, maintains power relationships and ensures that the demands of the institution can be met with the least possible expenditure of energy.

CHAPTER FIVE: DOING THE RESEARCH; METHODOLOGICAL CONSIDERATIONS AND STUDY DESIGN

This chapter begins with a section explaining, in more detail, the origins of my PhD research in a larger research project - the Informed Choice (IC) study - evaluating the influence of a set of evidence-based leaflets[70] on decision-making in maternity care (Kirkham and Stapleton, 2001). I follow this with an explanation of the methods used in my PhD research and conclude this chapter with an explanation of epistemological and methodological issues peculiar to this study.

The development of the IC leaflets followed on from the publication of *Changing Childbirth*, a government policy document designed to stimulate change in maternity care in the UK (Department of Health, 1993). It charged providers of maternity services with making facilities more woman-focused, by emphasising the principles of choice, control and continuity. It also provided an opportunity (and a justification) for the midwifery profession to develop an alternative to the techno-medical model of childbirth. The failure of the IC leaflets to effect change in decision-making practices has been reported elsewhere (O'Cathain et al., 2002; Stapleton et al., 2002b). Suffice it to say here that (gendered) power relations played a significant role.

Significant changes to the organisation and delivery of maternity care occurred in the decade following the publication of *Changing Childbirth* but these were not without consequences for midwives, including 'burnout' (Sandall, 1997:106), as many of the innovations were poorly resourced and overly reliant on good will. More significantly, the majority of changes failed to take account of, let alone seek to improve, the situation for groups of women already marginalised by mainstream services.

The study design of the IC project was based on a mixed-methods approach (O'Cathain and Thomas, 2006), including qualitative and quantitative methodologies. The focus was on pregnancy-related information, and whether, and how, information influenced women's childbearing decisions. The broad remit of the IC study did not allow for an in-depth exploration of teenagers as a discrete category.

During the second phase of the IC study - based in Wales - I undertook eleven 'one-off', opportunistic, interviews with pregnant teenagers and some of their mothers. A précis of one such interview appears later in this chapter. This mother's contribution was a major turning point in my PhD research, influencing my decision to shift the focus of my inquiry from maternity care provision to a wider social context.

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[70] In 1996, The Midwives Information and Resource Service (MIDIRS), initially in collaboration with the NHS Centre for Reviews and Dissemination, launched a series of leaflets summarising the research evidence on a range of discrete, pregnancy-related, topics. The leaflets provide research-based information to facilitate childbearing women's (informed) decision-making. They are produced in pairs: the woman's version summarises the research evidence; the health professional's version details this evidence in greater depth and is fully referenced. The professional's version is also intended for women who want more in-depth information. There are currently 21 (pairs of) leaflets available (in pdf format) and the topics, which previously concerned only pregnancy and labour, now also cover the post-natal period. See: http://www.infochoice.org/

I commenced the longitudinal phase of my PhD research in South Yorkshire on one of the sites which had participated in the IC study. Six teenagers, four of their mothers and one 'substitute'[71] mother, were recruited between October 1999 and June 2000; final interviews were undertaken during November and December, 2001. Participation in the study for this cohort thus varied from eighteen months to just over two years. See Appendix Six for pen portraits of the seventeen teenagers, and Appendix Seven for pen portraits of the four South Yorkshire mothers who participated in the research.

The teenage respondents[72] ranged in age from fourteen to seventeen years at the time of conception, with those in the Welsh cohort at the upper end of the range. Both research areas are economically deprived and report traditionally high rates of teenage pregnancy[73]. Most respondents were white and working-class. Family members of both cohorts lived in close proximity to one another; twenty miles was considered a fair distance, and forty miles a long way to travel. Perception of distance may have been exaggerated by a widespread lack of access to private transport and generally poor public transport links.

Some teenagers (n=6) were attending school at the time pregnancy was confirmed; many had considerable experience of social exclusion. All but three of the young women were pregnant for the first time; two from the South Yorkshire cohort (Jade and Tracey) became mothers for the second time during the study period[74]. See Table A for details of teenagers' ages at conception, dates of entry to, and exit from, the study, etc.

Data were generated through one-off and serial interviews, and selected observations of interactions between midwives and respondents in domiciliary and hospital settings. See Appendix Three for an example of the number, and variety, of contacts made with one teenager-mother dyad throughout the period of fieldwork. See Tables B and C for sample characteristics. An additional data stream was generated by the teenager-mother dyads mapping their support networks, both at the time they joined the study, and at the point of exit. See Appendices Four (a) and (b) for examples of this data.

In order to maximise the potential for anonymity, all identifying data have been changed. Respondents were invited to nominate a pseudonym of their choice and some accepted this invitation

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[71] Four biological mothers consented to participate in the South Yorkshire (longitudinal) phase of my research. One young woman was estranged from her mother for the majority of the study period and did not want me to contact her. She did, however, permit me to enrol the female manager of the hostel where she was living. The mother of another young woman suffered from serious mental health problems which occasionally resulted in displays of extreme violence, especially towards her daughter. I decided not to invite her to join the study, as I was concerned about compromising her daughter's welfare.

[72] I have deliberately chosen the term 'respondent', rather than the more commonly used term 'participant', because I dislike the inference of mutuality and equality suggested by the latter term and which I cannot claim to have demonstrated in my relationships with those whom I researched – at least not until my research was nearing the closing phases, and then only in some instances.

[73] Although both my recruitment areas follow the national trend in demonstrating an overall decline in under-18 conceptions, they remain above the national rate for England and Wales (42.6 in 2002). See: http://www.statistics.gov.uk/

[74] Approximately 20% of births to under-18s are to those who are already mothers (Wellings et al., 2005).

with alacrity. On the occasions that names were selected which were already in use, or where these were the real names of other respondents, I chose an alternative name.

Reflexivity and the research enterprise

Whilst undertaking fieldwork in a hospital antenatal clinic in South Wales, observations of interactions between pregnant adolescents, their mothers, and maternity staff, prompted me to wonder whether, and to what extent, maternity service provision was meeting service users' needs. The following vignette, taken from my fieldnotes, describes a brief interaction with one mother whose daughter was attending antenatal clinic for her first 'booking' consultation. This encounter stimulated my interest in how young women were 'seen' by health professionals, especially by midwives, with whom they generally have most contact.

I've been here (in this clinic) all morning, observing midwives, obstetricians and ultrasonographers in their consultations with women of all ages and at all stages of pregnancy. The vast majority of women are white and many are accompanied by children, for whom there is no (play area) provision. A fair number of women seem to know each other; the small friendship groups dotted about the clinic, some of whom are speaking in Welsh, serve to make women who are sitting alone appear very isolated.

It's late morning and the speed of 'throughput' has decreased noticeably in the last half hour. This is evidenced by the number of empty (orange plastic) chairs and plastic drinking cups, and the magazines and tabloid newspapers strewn about the clinic. A round, tired-out-looking midwife in an ill-fitting uniform trundles her squeaky trolley, piled high with the case notes of women seen that morning, past the reception desk. She pauses. The receptionist, who is drinking from a red mug with the words: 'Don't try me, I'm not tested' emblazoned in white on one side, smiles at the midwife as she hands her the list of 'DNA's' (women who were booked, but who 'did not attend' for their appointments). The midwife stuffs the piece of paper in her pocket, before returning to the business of manoeuvring her overflowing trolley through the heavy swing doors and out of the clinic.

I am mulling over the meaning of the caption on the receptionist's mug when I notice a middle-aged woman sitting alone on a bench behind me. I swing around and we start talking... She tells me her name (Angharad) and that she is attending the clinic with her teenage daughter (Alys) who's 'got herself in trouble'. I comment to the effect that her daughter is lucky to have her mum alongside her, as I'd come across quite a few teenagers in similar circumstances whose families had disowned them. Her reply disturbed me. She said that she doubted whether she would be of any help to her daughter 'because everything's changed from when I had my last one (ten years previously)... To be honest now, I didn't understand a lot of what midwife there were saying... She was on about all these tests to tell whether baby was normal or not. But I don't know whether she (Alys) should have them (tests) or not... The midwife just kept telling her that it was all her choice... But how can she know, she's just a girlie, isn't she?' Fieldnotes, antenatal clinic, South Wales

This interaction with Angharad helped me to appreciate the degree to which midwives, through the use of rhetoric such as 'informed choice', might be contributing to the alienation of pregnant teenagers from maternal support. This was of some concern because childbearing adolescents are a vulnerable group who are generally inadequately resourced. I began to acknowledge that the IC research agenda did not square with the developmental needs of young mothers, for whom events, including pregnancy, mostly

'just happen'. The application of pre-meditated decision-making models, which would be of relevance if a teenager were to make an 'informed' decision about a maternity related event, seemed out of context in a mother-daughter relationship where it was the mother, not the daughter, who generally made the important decisions.

I was very affected by Angharad's posture: her body curled in on itself in an attitude of defeat and loneliness. She seemed absorbed in her own world, impervious to her surroundings and oblivious to the rapidly emptying clinic. During the course of our brief conversation she told me she was recently bereaved (her husband having died suddenly a few months earlier) and that her daughter had told her only a few days previously that she was unexpectedly pregnant. Tears filled her eyes as she spoke about how angry and disappointed her husband would have been, but that 'her Da loved Alys... He'd have come round...eventually.' Later I would come to appreciate the weight of the projections Alys carried on behalf of her dead father; his dreams that, as 'his bright wee girlie', she held the hope, for the family, of being the first 'to get a proper education, to go to the university like...'

I was also emotionally disturbed by my interaction with Angharad. My own father had died suddenly and unexpectedly during my early teenage years, and Angharad's distress stirred memories of my mother, and her grief-crazed reactions, during those bewildering twilight months after death collapses domestic routines. I recalled the range of aberrant behaviours me and my five siblings exhibited in the chaotic aftermath of my father's death and I wondered whether Alys's unplanned pregnancy might be understood in a similar way. Hence, my interest in the contexts of adolescent pregnancy, specifically in the changing nature of relationships and the structural components underpinning and regulating those changes. I wanted to find out more about how the events of childbearing were experienced by young women themselves, and by their mothers and significant others. I was also interested in their perception of midwives and midwifery practice.

At the time I commenced my study I was too self-conscious to articulate my personal motivation for undertaking research within working-class family contexts, although I acknowledged resonances with my own background, including growing up in a large, poor family which suffered significant disruption following my father's death. However 'underground' my motives, the prospect of undertaking 'useful' research, which also had potential for personal transformation, was a powerful incentive. As Beverley Skeggs has noted, all researchers bring personal values to the 'doing' of research but 'just because we value something does not mean that we cannot come up with an objective account. Also, values may enable us to recognise things that others would prefer to overlook' (Skeggs, 1997:33).

Core values that I brought to the research enterprise included a tendency to see the workings of institutions, and the staff who populate them, as self-serving; a desire not to romanticise mother-daughter relationships; and a misplaced notion of solidarity with working-class people that denied the reality of the middle-class position I now occupy. Although I did not appreciate it at the time, I was setting up an experiment in self-deception that was doomed from the outset. Although I was never able

to fully acknowledge (to myself) the terms of my engagement with respondents, I realised that the artifice I had created made it difficult to relate in a spontaneous and authentic manner. It also prevented me from appreciating the extent of the commonalities, as well as the many differences, in our lives.

This more reflexive stance did not just 'happen' in response to a changed research orientation. Rather, it was shaped by a peculiar set of research-generated circumstances and by my gradual realisation that 'distance' and 'detachment' were contrived positions, adopted because, at that point, I still believed that it was possible to produce 'uncontaminated' and 'objective' accounts of fieldwork . Through the process of 'double distancing' myself (Jenkins, [1992] 2002:xvi), and stepping back from my own life experiences and from my reactions to those experiences, however, I began an epistemic shift to what has been termed 'participant objectification' (Bourdieu, 2003:281). Bourdieu (2003) argues for a personally incorporated understanding of reflexivity which examines not only 'the anthropologist performing the anthropological analysis of a foreign world but the social world that has made both the anthropologist and the conscious or unconscious anthropology that she (or he) engages in her anthropological practise – not only her social origins, her position and trajectory in social space, her social and religious memberships and beliefs [...] but [...] also, and most importantly, her particular position within the microcosm of anthropologists' (Bourdieu, 2003:283). Engaging in the (life-long) process of participant objectification is not, however, to encourage the researcher to indulge in 'narcissistic confessions' (ibid:283), nor in the 'facile delights of self exploration' (ibid:283).

Methodology: taking an ethnographic turn

As the orientation of my study changed, so the need for a different research strategy became apparent. The 'one-shot' interview, or 'meeting between strangers' (Mischler, 1991:24), demanded by the constraints of the IC study, was neither necessary nor appropriate in my research with young women and their significant others. Hence my adoption of a more focused ethnographic approach, with a longitudinal involvement in which my identity (and indeed my subjectivity) would be less defined by my occupational role as a 'midwife' researcher.

Describing and theorising the diversity and complexity of human experience ethnographically requires the researcher to spend extended periods in a naturalistic setting (the 'field'), observing and interacting with research respondents. In this research the setting was the 'family'[75] environment and to a lesser degree, the maternity facilities accessed by respondents. This approach afforded greater flexibility in my research relationships, which, in turn, provided the 'contextual basis for interpreting responses to particular questions that may or may not touch areas relevant to the respondent's life

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[75] I use this term with hesitation as some respondents could not claim to having (ever) lived in a 'family' environment in so far as this concept might normally be understood. For example, one respondent lived in 'temporary' accommodation throughout both her pregnancies, another remained at home but moved between the one bedroom and the living room in response to visits by her mother's (numerous) boyfriends, whilst a third respondent mostly lived at home throughout her pregnancy but occasionally was forced to seek refuge elsewhere because of the unpredictable and violent behaviour of her mentally disturbed mother.

circumstances' (Mischler, 1991:24). The particular socio-cultural context in which I was working thus provided a vehicle for the production of research narratives; it also ensured these accounts were situated within a 'real-life' framework. This helped me to appreciate that 'the methods for making sense of experience are always personal (and that) life and method are inextricably intertwined' (Denzin, 1994:501).

Ethnographers examine the diversity and complexity of human experience. Questions about data interpretation arise because emphasis is placed on giving equal consideration to both the fine detail, and the broad sweep, of experience. In other words, the researcher strives to absorb a holistic impression and seeks to expose, and describe in maximum detail, the traditions and conventions of the culture under study. The aim of interpretive anthropology then, is not so much to produce a narrative of incontestable truthfulness, nor one which may be regarded as answering every question, 'but to make available to us answers that others, guarding other sheep in other valleys, have given, and thus to include them in the consultable record of what man [sic] has said' (Geertz, 1973:30).

It often requires considerable effort to maintain long-term interest in research endeavours. The exhaustion resulting from 'doing' ethnography is comparable to attending social gatherings on a daily basis and enacting the same (tiresome) business of introducing oneself, being agreeable, and most importantly, never being offensive. Another analogy is embodied by John Sassall, the country doctor who John Berger describes in his book, *A Fortunate Man: The Story of a Country Doctor* (Berger, 1989). Although the archetypal representation of the General Practitioner described by Berger may have vanished from modern medical practice, Doctor Sassall, a deeply humane individual who is kindly disposed towards his patients but who is also eternally curious about them, bears comparison with an ethnographer. The reciprocity in the relationship between doctor and patient (and between ethnographer and respondent) is underpinned by mutual need for, and an acceptance of, difference: whilst his patients think the world of Sassall, they do not look on him as one of them. Berger likens the doctor's role to that of a 'clerk' or a 'keeper of records', who spends his time observing, monitoring, and interpreting key events and transitional moments. He is entrusted (burdened?) with his patients' secrets and is expected to scrupulously observe the demarcation between private and public knowledge. Like the ethnographer, the country doctor requires an almost intuitive sense of timing: knowing when to speak and when to remain silent. S/he also appreciates the need to speak '*care*-fully' (DeVault, 1994:2) and understands that the ethnographer, like the doctor, will be changed by the experiences of those whose stories they are privileged to hear.

Despite the apparent closeness between doctor/ethnographer and patient/respondent, an approximate understanding of the other's point of view is the best either party can hope to attain. This is because, conceptually at least, there is a distinction between what Clifford Geertz characterizes as incidents which are 'experience-near' compared with those which are 'experience-distant' (Geertz, 1983 [2000]:57).The 'near' experience reflects how individuals think about themselves and their worlds and how they might then, spontaneously and unselfconsciously, describe their interpretations to someone of

a similar background. Such descriptions generate intimate and colourful detail; the 'thick description' (Geertz, 1973:6) which is a defining element of the particular kind of intellectual effort required to 'do' ethnography. By contrast, the concept of 'experience-distant', which is 'one of degree rather than of polar opposition' (Geertz, 1983 [2000]:57), is the interpretation which the 'specialist' (expert/academic) lays over the aforementioned description.

Doing feminist ethnography: subjectivity and the research context

I often struggled with my research role, particularly in relation to the teenagers. I fretted about my perceived obligations concerning reciprocity as, initially at least, I doubted whether I had much to offer them. Although I had acquired a degree of research experience in my five years of contract employment, I was uncertain whether my skills were transferable to this, very different, environment. Whilst I was adept at the organizational aspects of research, I felt less secure in settings where my identity (research midwife) had no currency and I could not call upon a familiar sense of 'self' to gain entrée into teenagers' worlds. These environments were also more complex because I needed to establish ongoing, trusting relationships with a variety of respondents, including young women's mothers, which would require me to reveal more of myself than previously. I was less concerned about gaining the confidence and trust of the teenagers' mothers, however, largely because we were closer in age.

The endeavour to position myself in relation *to* the epistemological stance I was seeking to establish, has been described as 'an additional category of involvement', whereby the researcher assumes a 'membership role' (Adler and Adler, 1987:33) in relation to respondents. Epistemological positioning cannot be separated from personal history and biography, or beliefs and values; subjectivity matters and is integral to the design and analysis of a research project (Stanley and Wise, 1993). The degree of involvement between researcher and respondent is variable, however, and is shaped by a number of factors including funding arrangements, the cooperativeness of respondents, the gender and psycho-social attributes of the researcher and researched, etc. Hence, internally and externally derived characteristics are involved in the construction of a 'taxonomy' of researcher involvement where, at one end of the spectrum, the researcher remains at a distance from respondents and, at the other end, totally immerses her/himself in the culture under study - with the attendant risks of 'going native'. Sandwiched between these extremes are three discrete membership roles: 'peripheral', 'active' and 'complete' (Adler and Adler, 1987:33).

I moved between 'peripheral' membership, the least involved of the three roles, and 'active' membership, when I participated in important activities but did not necessarily share respondents' core values and goals. I maintained geographical distance, as I lived a forty minute drive from respondents' homes. I saw myself, and was undoubtedly perceived by others, as an 'outsider'. Although I had not been engaged in clinical practice for some years, I nonetheless promoted a midwifery identity to clinical colleagues because I was dependent on their negotiating my access to pregnant teenagers. Since I

fulfilled no 'useful' role as a clinician or educationalist, however, I was generally not considered a 'real' midwife.

I tried to conceal my midwifery background from 'lay' respondents because I imagined it might be more troublesome than helpful. The absence of a uniform, and a lack of clinically associated paraphernalia, assisted me in this respect. I also thought my demeanour was sufficiently distinctive to separate me from my professional group, although, as Jade suggests in the following excerpt, I was only partially successful in my attempts at a 'makeover':

> I was packing the recording equipment away in the much stronger bag I had taken to using since my department had replaced our old tape recorder with a heavier, and much more expensive, product. I disliked the bag because I had acquired it at a midwifery conference and hence it sported an associated logo across one side. The powder pink colour didn't help either but, as it was the only spare bag I had, I tried to remember to carry it with the logo side towards my body in an effort to conceal it. Jade and I said goodbye in the doorway of her house. As I walked down the footpath she announced that I 'looked just like a midwife'. I tried to hide my surprise as I turned and asked her 'How come...?' She pointed to the bag, saying: 'That (bag). Says it all really...' Jade, fourteen months following the birth of her first child. SY

It was not only The Bag which marked me out as different to my respondents; my (New Zealand) accent, which I regarded as barely perceptible after twenty-five years living away, also identified me as 'other'. Accents and idioms of speech were sometimes mutually baffling, particularly during initial exchanges with the teenagers, many of whom used language which was peculiar to place and peer group. There were also marked class differences. In the poor neighbourhoods in which I was working my appearance signalled wealth: my accent was pronounced '*posh*', my clothes '*designer*', and my '*nice car*' referred to as '*very modern*'. I felt pained by these delineations of my status, as, like other feminist academics who have hobbled into academia from working-class backgrounds (Overall, 1998), my respondents' poverty smelt familiar.

During the early months of my research, then, I felt unsure of my ground and often doubted my ability to inspire confidence. First meetings were particularly difficult, as often the pregnancy had just been disclosed and both mother and daughter were 'at war' with each other. Additionally, I worried that my middle-aged identity might alienate some teenagers and suggest greater empathy with adult, rather than adolescent, viewpoints. Although I gave all respondents my home and mobile phone numbers, I did not attempt to insinuate myself into their lives. I did invite them to contact me if they were worried or frightened, and I offered to be on call for labour.

Respondents did phone and text me, and some sent Christmas cards and photos and invited me to family events including christenings, weddings and a funeral. I reciprocated these gestures by sending cards, taking small gifts for newborn babies and new mothers, offering taxi services, assisting financially by putting small amounts of money in gas/electricity meters, helping to complete official forms, and assisting more vulnerable respondents with official business with the law courts, benefit and

housing offices, and debt collection agencies. I was mindful however, about the need to avoid creating dependency relationships, especially with lonely and isolated young women.

A feminist approach to research does not imply that a single, universally accepted, set of techniques is employed: there is no one position to which all feminists subscribe, but, rather, a cacophony of 'feminisms' is often evident in qualitative research. Indeed, it is arguable whether a 'feminist' ethnography is achievable or even desirable, because ethnographic methods *per se* may expose research subjects 'to greater risk of exploitation, betrayal and abandonment' (Stacey, 1988:21) than might be the case if they participated in research projects employing traditional 'positivist' methodologies. Methodological pluralism is now widely accepted and not all feminists share a common standpoint, or a 'totalizing theory' (Smith, 1992:88). It is reasonable to suggest, however, that all feminists believe in the importance of describing women's diverse experiences and the need to devise means to end oppressive practices.

This is the basis for feminist standpoint research (Harding, 1986, Hartsock, 1987, Smith, 1987) and the argument that the views of the lower ranks are more credible because they are less concerned with maintaining the status quo. Introducing a political (Marxist) dimension into the discussion, Hartsock argues that attention must be paid to the *materiality* of women's lives, including their (gendered) labour relations; these are fundamental to the research enterprise. Smith (1987) contends that the standpoint of women is located not so much in extending theoretical arguments into textual events - where 'the concept is moved upstairs, so to speak, and reduced to a purely discursive function' (Smith, 1992:89) – as in 'practical politics', including 'relations of ruling' (ibid:89) which constitute the reality of women's everyday lives. A standpoint position then, is not simply an interested position, but rather one which is engaged and engaging. In this sense, it operates as an epistemological device which grows and develops in unpredictable and contradictory ways, but always in relation to women's physically embodied experiences – including those of the researcher. Underpinning the feminist quest for alternatives to 'malestream' research is the effort required to elucidate the unobvious, to remain steady with the 'exotic', and to articulate the ordinariness of female experience, which may otherwise pass unnoticed and unrecorded.

Interpretation is a critical aspect of the feminist ethnographic endeavour, which demands an 'ethnographic attitude (incorporating) a mode of practice and theoretical attention, a way of remaining mindful and accountable' (Haraway, 1997:39). A feminist understanding of epistemology seeks to understand not only 'what' is known but 'who' can be a knower and hence who might be regarded as a legitimate producer of knowledge(s) (Harding, 1987). This raises questions about power in research relationships, an area in which I experienced difficulty as, although I was attempting to do feminist research, the women I was researching would not have identified, to themselves, as being feminist (Millen, 1997). The degree to which I was able to accurately interpret my respondents' worlds, whilst simultaneously acknowledging the very real differences between us, especially regarding our understandings of gendered experience, troubled me throughout my study.

This is not to suggest that resolving differences is a simple matter of selecting an appropriately gendered methodology with which to re-author women's experiences. As feminist philosopher Lorraine Code (1991) has argued, the fundamental question of whether women can ever be regarded as 'good' knowers hinges on whether the purported 'neutrality' and 'universality' of mainstream (middle-class, white, male) epistemology can be effectively challenged by the female academy. Code (1991) illustrates this point by calling attention to the 'politics of knowledge' and the work of Alice Baumgart (1985), who exposed the double standard operating within medicine, wherein women's (nurses') knowledge is downgraded as second-class *experience* compared with men's (doctors') cognitive authority: 'In the health care system, doctors have been regarded as the only 'rightful' knowers. What the doctor-nurse game is really about is that nurses know, but can't let the world know that they know' (Code, 1991:222). Dorothy Smith (1987) reiterates this point when she reminds us that the relations of ruling which govern everyday practices do not stand in equal relation to each other but that the 'world as constituted by men stands in authority over that of women' (ibid, 1987:86).

Research which claims a feminist basis, then, is not so much concerned with the methods used to generate and analyse data, as with the lens through which the researcher views underlying epistemological, methodological, and philosophical issues. The kaleidoscopic nature of the researcher's viewfinder is such that there is no distinct (anthropological) point of view but that rather 'there are as many perspectives as there are anthropologists' (Peacock, 1986:viii). Even if the subjective lens of the ethnographer were to remain constant, social groups can themselves undergo change, and thus it is most unlikely that an ethnography of any particular group can ever to be replicated in its entirety.

Methods employed in this study

Access and Recruitment

I contacted pregnant teenagers through community midwives, for whom I arranged a number of presentations about my research. At these meetings I explained my research aims, articulated my needs regarding recruitment, and explained my recruitment criteria: pregnant teenagers, ideally in their first trimester of pregnancy[76] and at the lower end of the age spectrum[77]. I also wanted to involve young women's mothers, and midwives, at key points in the respondents' childbearing trajectories. Nine teenagers who fitted the selection criteria were recruited over a nine-month period. Three were subsequently lost to my research: one moved out of the area, another signalled an initial interest but then failed to meet me for scheduled appointments, and the mother of a third young woman blocked her participation.

Given my 'outsider' status, most community midwives were surprisingly generous with their time. A small number obstructed my access to young women, because they regarded them as 'too

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[76] Medicalised constructions divide pregnancy into trimesters or approximate thirds. The first trimester, from conception or the first day of the woman's last normal menstrual period, ends around 13-14 weeks; the second trimester ends around 27-28 weeks; the third trimester continues until the birth of the baby.
[77] See Appendix One for Project information sheet.

young' (aged thirteen), 'unsuitable' (on account of a previous psychiatric history), 'too complicated' (because they were homeless or living in 'squalid' accommodation). I reciprocated midwives' helpfulness with recruitment wherever I could: by loaning one midwife a number of text books and helping her with a written assignment, responding to requests for journal references to clinical research, and accepting lecturing invitations to discuss aspects of research practice. Once the study was under way and recruitment was complete, the midwives played a relatively minor role in my research, as very few had ongoing relationships with respondents; local service organisation did not prioritise continuity in maternity care provision.

Making and managing data

     o   Interviewing

Interviewing is a central aspect of qualitative research. Grounded in the everyday iterative practices of asking and answering questions, the process demands mutual understandings of socio-cultural norms and some agreement about the expression of personal beliefs and intentions (Mischler, 1991).

Qualitative interviews are sources of both verbal and non-verbal data; they also provide opportunities to clarify impressions formed by observation. As mentioned earlier, the remit of the IC study required a focus on issues concerning information, choice, and decision-making. Some of the Wales-based interviews followed on from a routine antenatal consultation where I had observed interactions between young women and health professionals (midwives, obstetricians, ultrasonographers). These 'follow-up' interviews explored issues arising from the consultation, particularly concerning young women's perceptions of information exchange; the interview thus provided opportunities to clarify my understanding of exchanges between teenagers and maternity staff. Qualitative interviewing may serve as an empowering process, helping respondents to tell their own stories, in their own words. The 'standard' interview, however, with predetermined questions covering a limited area of experience, emphasises hierarchy between interviewer and interviewee and may simply 'further reinforce the deeper and more pervasive sources of alienation in contemporary society' (Mischler, 1991:120).

Despite pre-arranged appointments with respondents, they were sometimes busy or out when I arrived. Given that none of the young women maintained a diary, and a number of them led fairly chaotic lives, I was constantly surprised that most *did* honour meeting arrangements. Sometimes my visit coincided with visits from others. If I had not previously met those present, I introduced myself, explained the reason for my visit and asked the young woman if she would prefer me to come back another time. On only two occasions, and very early in my PhD research, was I asked to reschedule my visit. Guests usually stayed a while and thus I was able to establish acquaintance with respondents' wider social networks.

My intention at the outset of the research with the South Yorkshire cohort was to undertake the majority of the interviews with young women separately from their mothers, because my experience

interviewing the Welsh cohort was that mothers tended to silence their daughters by speaking over them. In the event, I had to be more flexible. Rather than risk upsetting respondents at an early and crucial stage in the research process, I raised no objections to a mother's presence at early interviews, although this usually resulted in their speaking at length *about* their daughters. Mothers and daughters often acted as 'translators' for each other, however, especially concerning childbearing and childrearing practices. In some cases fathers, siblings, and/or young women's male partners were present when I visited and sometimes joined discussions; male members of the household appeared less often and were rather less inclined to join in.

Hence, first interviews with young women often followed on from an observational session, for example, after the first antenatal 'booking' visit with a midwife. First interviews with all young women began with an open-ended question: 'Can you tell me what it's like for you as a pregnant teenager?' whilst my opening question to their mothers (or substitutes) was: 'Can you tell me what it's like for you to be the mother of a pregnant teenager?'

As the study progressed, and my relationships with respondents deepened, my interviews became more focused and more interrogatory. I was less concerned with obtaining 'official' accounts - which required that I always be unfailingly polite but absolutely not myself - and more concerned about establishing contact with respondents which felt genuine and which I hoped would generate authentic data. I made use of 'probes' to explore pertinent, and sometimes contentious, issues with respondents. Probes were typically provided from media sources, for example Sonia, a character in 'Eastenders' who became pregnant as a teenager, and from interview data, as when one respondent disclosed her self-harming habit.

In addition to these serial interviews, I also sought interviews with midwives who attended the teenagers at key points in their childbearing journey. For example, midwives who undertook the first 'booking' consultation, and/or the 'birth plan' visit (a home visit normally carried out around thirty-six weeks of pregnancy and intended to prepare women for birth), and the midwives who attended during labour. Most of the young women experienced such fragmented care, however, that sometimes it was only with great difficulty that the relevant midwife could be identified. With respect to labour, individual midwives also tended to downplay their contribution to the teenagers' care by asserting that they had *'only'* performed the 'ARM' (artificial rupture of membranes), or *'only'* arranged for the syntocinon infusion, or *helped* with the insertion of the epidural, or ventouse[78]/forceps/caesarean section delivery.

With the exception of two midwives, all respondents consented to having their interviews recorded. This is not to say that all interviews necessarily *were* recorded, however, as circumstances were not always conducive to setting up equipment and nor was it always appropriate to do so (for example when privacy could not be guaranteed, or when the prevailing noise level was such that transcribing would have been difficult). Interviews which were recorded were transcribed in full by me or

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[78] A ventouse delivery is performed by the application of an appropriately sized suction cap to the baby's head to facilitate birth.

by a professional transcriber. A small number of taped interviews were 'lost' due to operator error or equipment failure. The duration of interviews varied enormously, from approximately twenty minutes to well over two hours. Interviews with the teenagers were often interrupted by mobile phone conversations or text messaging to third parties, or cut short altogether in the event of them receiving a more exciting invitation to pass the time.

Initially I dallied with feminist principles underpinning emancipatory/participatory research, for example by 'member checking', whereby respondents are invited to comment on interview transcripts and/or emergent themes. I decided against involving respondents in this way because of: educational and literacy differences between respondents, especially between mothers and daughters; limitations on my time; concerns with managing temporal relationships between respondents; the delivery of challenging research material at difficult moments in respondents' lives; and breaches of confidentiality. Finally, most respondents lived in family homes where they had little or no privacy, and where there was no safe place for confidential information to be kept – where indeed, the very notion of confidentiality was suspect and could be interpreted as 'having something to hide'. This latter issue was a major concern where transcripts contained material which was highly critical of other family members.

o   Mapping support networks

At the first and final interviews, I asked the teenage-mother dyads to describe their support networks (see Appendices Four(a) and Four(b)). Outlining respondents' support networks served as an 'icebreaker' for the first interview. More importantly, it enabled me to map family and kinship networks, to assess the level and quality of available support, and changes over time.

o   Observation

When introducing the study I explained to all respondent groups that, wherever possible, I wished to observe interactions between teenagers and health professionals at key points during the young woman's transition to motherhood. Although I hoped that formal observation would approximate real-life interactions as much as possible, I also acknowledged that constraints, including self-consciousness, might make this problematic. I reiterated that my observer status precluded me from playing any (clinical) role in consultations and hence I adopted a very low profile, avoiding eye contact and seating myself as far away from proceedings as possible. Observation sessions were not tape-recorded, but I was able to make notes.

Observation work constantly reminded me of my lack of neutrality; how I noticed some things but not others, and how my capacity to absorb the ramifications of non-verbal communication varied. One aspect I found difficult to manage was whether to remain silent or to speak out on the (frequent) occasions that my sense of outrage was triggered by health professionals' attitudes towards, and treatment of, the teenagers and/or their significant others. Protesting meant risking alienating myself and incurring possible negative consequences, for the respondent concerned, myself, and my research.

Maintaining the status quo assured my future access but often left me feeling as if I was 'selling out' on respondents. This sense of betrayal had been influential in my decision to leave the NHS some years earlier, to practice as a self-employed ('Independent') midwife. It also echoed the difficulties I had experienced in my attempts to establish a sense of personal autonomy, initially within my own family of origin, and in my professional relationships.

o Fieldnotes

Ethnography is not only a matter of recording, describing and interpreting 'data', it is also about constructing data. Hence the importance of maintaining a field diary in order to portray, in maximum detail, the people encountered and the events witnessed, as well as the researcher's uncensored thoughts and feelings. The attitudes of individual anthropologists towards their fieldnotes varies (Jackson, 1990): some view them as an indispensable reference source during the course of writing up, whilst for others, fieldnotes serve no purpose beyond that of an historical record. The content of fieldnotes is also variable, with some writers adopting a minimalist approach whilst others take the opportunity to purge themselves through writing intimate, and detailed, descriptions of events, the 'confessional tales' referred to by John van Maanan (1988:7).

Throughout the study period I made detailed notes of each contact with respondents. My fieldnotes were mostly recorded and written up contemporaneously but there were a few times when this degree of orderliness and rigour was impossible. I was then left to struggle with my own (poor) handwriting, and, on the occasions I had forgotten my notebook, with making sense of the scraps of paper on which I had omitted to record a date. Besides the additional information which I recorded about people and events, I also used my field diary as a vehicle for personal debriefing after stressful episodes.

At the point I completed data collection, the oldest child (Clare's daughter) was almost two years old and the youngest, Tracey's second son, was just six days old (see Appendix Five).

o Data analysis and management: competing voices and the difficulties of representation

A widely held maxim in qualitative research is that analysis should proceed in tandem with data generation. With any (methodological) 'rule', however, reality is often rather different. For various reasons, mostly to do with the pressures of my contract research post, and subsequently my role as primary carer for a terminally ill relative, I found that data piled up and sometimes many weeks (occasionally months) would pass before I could examine it in any depth. During these periods my field diary helped me to maintain my emotional connection with respondents, reinforced by listening to interviews whilst driving. I also read the transcripts of key interviews and undertook some preliminary coding at this point.

The final stage of data analysis involved a thematic analysis (Attride-Stirling, 2001) of all data including transcript materials and fieldnotes. Initial readings of transcripts from a critical ethnographic

perspective (Thomas, 1999) illuminated key themes and enabled a coherent framing code to be devised. Re-readings of selected transcripts foregrounded oppositional voices and contradictions; this process was also crucial in sensitising me to possible differences of interpretation.

Compared to other stages in the research journey, unpacking the process of analysis is something of a neglected issue in qualitative research, perhaps because the inherent 'messiness' of coding is extremely difficult to articulate along the clean and logical lines described by research texts (Mauthner and Doucet, 1998). Although many authors stress the centrality to the feminist project of listening to respondents' voices and attempting to write them into research accounts 'in and on their own terms' (ibid:120), there are still very few examples of 'how this general methodological principle can be practically operationalized within the actual research process and, in particular, in terms of data analysis' (ibid:120).

Data analysis requires the researcher to select a particular interpretation from a multitude of possibilities. It forces a confrontation with personal values and beliefs, the product of which must then be accurately, and thoughtfully, articulated. Whilst signing up to a reflexive stance offers the opportunity for the researcher to 'come clean' about selected or vested interests, personal prejudices are not necessarily so transparent or available for self-conscious scrutiny.

I used the software package NVivo to code and manage the data sets. I use the word 'manage' deliberately, to convey a particular understanding of how I employed this technology to order the research process. Whilst I acknowledge that some researchers harbour reservations about the use of computer technologies in qualitative research, I am not sympathetic to concerns about computers 'taking over' analytical processes, or of a new methodological orthodoxy emerging from their use (Kelle, 1997). I do not claim to have used NVivo for theory building, but, rather, employed this software to mechanize the more clerical and administrative tasks associated with data analysis: coding, retrieval, interrogation and archiving activities.

Writing: reflexivity, representation, and interpretation

Reflexivity refers to understandings and interpretations of personal experience which the researcher brings to the research enterprise; it requires individuals to continuously acknowledge their subjectivity and capacity to engage in acts of critical self-consciousness. Feminist efforts towards reflexivity stress the importance of 'writing in' the material body and thus animating (her) with human qualities[79]. Before reflexive practice became 'trendy', however, many feminists were already probing interpersonal relationships, questioning (ab)uses of power, examining the manifestations of difference, and dissecting the politics of everyday life (Wolf, 1992). This is not to imply that every feminist engaged in social science research adopts a reflexive stance, but evidence of persistent questioning about methodological issues, and the positioning of researched and researcher, is more likely to emanate from this group than from mainstream researchers.

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[79] For an example of a text in which the anthropologist describes the emotional impact of the research process, see: Behar (1996).

An insistence on naming and making visible the intersections of power and privilege is an essential aspect of the feminist 'plot'. The researcher undertaking a feminist enquiry, then, is no invisible, nameless voice of authority, but rather a 'real, historical individual with concrete, specific desires and interests' (Harding, 1987:9), which originate within a precise socio-cultural context. Acknowledging the ethnographer as a (female) human being means acknowledging limitations, accepting idiosyncrasies and shortcomings which may effect a less than perfect performance. As one eminent anthropologist suggests: 'We cannot rid ourselves of the cultural self we bring with us into the field any more than we disown the eyes, ears and skin through which we take in our intuitive perceptions about the new and strange world we have entered' (Scheper-Hughes, 1992:28). If we accept that the purpose of a 'good enough' ethnography is not the production of a complete and 'objective' account but rather a narrative capable of portraying and communicating human 'truths', then we may consider it has as much in common with literature than with science. Despite efforts to 'write into' the research processes the gendered, classed and raced identity of the researcher, however, crises of representation inevitably frustrate the ethnographer's ability to produce a 'good enough' ethnographic text.

Social scientists have argued that textual representations achieve credibility through the production of theory (Denzin and Lincoln, 1994). It is during the 'writing up' and presentation of research results, however, that the researcher may struggle to avoid becoming a duplicitous, and self-serving, negotiator[80]. The 'crisis' of representation is complicated by the fact that criteria for evaluating and interpreting data tend to be disregarded by postmodernism and, with terms such as reliability and validity[81] rendered suspect, the question of how qualitative studies might be effectively appraised remains unsolved. Representation is also complicated by researcher prejudice: 'all facts are necessarily selected and interpreted from the moment we decide to include one thing and ignore another, or attend this ritual and not another [...] understanding is necessarily partial and is always hermeneutic' (Scheper-Hughes, 1992:23-4). The American novelist William Maxwell adds a further twist by drawing attention to the (un)reliability of memory and the role of the narrator in presenting any credible account of events:

'What we, or at any rate what I, refer to confidently as memory – meaning a moment, a scene, a fact that has been subjected to a fixative and thereby rescued from oblivion – is really a form of storytelling that goes on continually in the mind and often changes with the telling. Too many conflicting emotional interests are involved for life ever to be wholly acceptable, and possibly it

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[80] In drawing on the same set of events to produce a piece of fiction, a set of fieldnotes, and a social science article respectively, this conundrum was beautifully, and creatively, described by Margery Wolf (1992). Most importantly, Wolf distinguished the fictional, from the non-fictional, elements in all three texts and conveyed this to the reader.

[81] The subjective nature of ethnographic accounts often raises questions about observer bias and the affect on validity and reliability. In a similar way that health professionals are exhorted to maintain a 'safe' distance between themselves and their patients, so too are social scientists encouraged to maintain an empathetic, but neutral, stance in relation to their respondents. Resisting over-involvement ('going native') is generally regarded as an important aspect of professional demeanour.

is the work of the storyteller to rearrange things so that they conform to this end. In any case, in talking about the past we lie with every breath we draw.' (Maxwell, 1980:27)

This excerpt reinforces an observation about interpretation and meaning that has been made elsewhere: that 'interviewers are deeply and unavoidably implicated in creating meanings that ostensibly reside within respondents. [...] Meaning [...] is actively and communicatively assembled in the interview encounter' (Holstein and Gubrium, 1997:114).

Ethical issues

My PhD research was completed before substantial changes were made to the NHS Research Governance Framework (Department of Health, 2001a; Department of Health, 2001b). Ethics clearance had been obtained from the relevant Local Health Authorities for the original Informed Choice study. Whilst I was returning to undertake further research on one of these sites, this was not within the context of the original study; hence, I re-applied for, and was granted, further ethical clearance to proceed with my research. Although the particularities of ethics and governance committees may differ, the researcher is usually required to address concerns that include consent, confidentiality, and respondent safety.

o   Informed consent and social science research

The guidance relating to the ability of minors (under sixteen years) to give consent on their own behalf is based on the assessment of decision-making competency with regard to *treatment*, including medical and surgical procedures. Young people over the age of sixteen are presumed competent to give consent to treatment for themselves. Younger children can also consent to treatment providing they fully understand what is involved, although their parents will also ideally participate in decision-making processes. If consent is given by a minor who is acknowledged as 'competent', a parent cannot over-ride that consent. The child in this instance is referred to as 'Gillick competent.' Doctors, rather than the judiciary, are generally seen as the most appropriate people to administer the Gillick ruling, in accordance with the Fraser Guidelines[82].

There is rather less guidance detailing consent processes for involving young people in social science research. Current good practice suggests that minors should be provided with age-appropriate information and that those who agree to participate in research should be encouraged to sign a suitable consent form. A basic principle underpinning social science research with minors is that of ensuring their best interests are protected and that research which inconveniences or disadvantages them, should not proceed. These safeguards do not, however, constitute consent – which is a legally mandated process - but rather assent, or permission based on mutual co-operation and affirmative agreement (Piercy and Hargate, 2004).

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[82] See Footnote 12, Chapter Two: Teenage Pregnancy and Young Motherhood

The incompatibility between notions of 'informed consent' and qualitative research, which employs an inductive approach and hence precludes the researcher knowing the precise direction of the study, has been debated elsewhere (Malone, 2003). Additionally, a researcher has 'a vested interest in dissimulation [and] does not want to magnify risks to the degree where co-operation is withheld and may not want to say too much for fear of changing subjects' behaviour' (Dingwall, 1980:877). Debates about informed consent aside, I fulfilled the obligation imposed by my local ethics committee to collect signed consent forms from all respondents (see Appendix Two for a sample form). The 'informed' aspect of the consent process requires researchers to renegotiate consent at each subsequent point of contact. This became more difficult, however, as time went by and my relationships with respondents deepened, and my anxieties least they decide to leave my study, became more pronounced.

o   Confidentiality and disclosure

Protecting confidential information, and respondents' identities and rights to anonymity, were problematic issues throughout the study. Although I regularly stressed the importance of not discussing material which was divulged in the research context, my efforts to protect confidentiality were frequently challenged, especially by younger respondents in the South Yorkshire cohort. I was conducting my study in a small town where people knew one another and where keeping (salacious) gossip secret was anathema. Most respondents (including midwives) talked about one another (and possibly about me, although if they did, I was unaware of it) and fell in and out of favour with each other; they also shared their various happinesses and misfortunes. Whose teenager was pregnant, and by whom, was common knowledge.

Initially I maintained tight control over respondents' individual identities but this gradually dissolved as I came to appreciate the extent of friendship (and adversarial) networks. I found it increasingly difficult to take refuge in the artifice of confidentiality on the (numerous) occasions I was challenged to divulge information about another respondent. I knew (and they knew I knew) that certain disclosures were an inevitable, and perfectly acceptable (to them), part of the process of negotiating continued access. It was when one of the teenagers disclosed the reason why another had dropped out of my study and accused me of 'not being bothered', because I showed no apparent interest in discussing the matter, that I accepted defeat and stopped trying to maintain my 'neutral' stance, which effectively denied the realties of respondents' lives.

Attempts to ensure a confidential space for interviewing were also problematic. Although the home tends to be 'reified as a private space' (Valentine et al., 2001:122), the privacy afforded to family members is often in direct relation to their position of power and their perceived trustworthiness. In both respects young people fare badly. They also tend to be subjected to more intense scrutiny because their predilections and behaviours are more inclined to arouse anxiety and suspicion in adults. Most respondents lived in very cramped domestic conditions, where the demands on available space were such that ensuring privacy for interviewing was often impossible. Furthermore, many of the mothers

initially assumed that I wanted them to be present when I interviewed their daughters, who similarly thought I welcomed their mother's presence when interviewing them. As the study progressed I felt more able to arrange separate interviews with mothers and daughters, to seek a room where it was possible to close the door, and to negotiate time when the interviewee would be alone.

With respect to disclosure, I experienced difficulty with midwife respondents, some of whom expected me to keep them abreast of what was 'going off' with 'their' teenagers. Some also expected me to join them in acting as part of the surveillance mechanism policing young women's compliance with the norms of clinical practice. Other midwives disclosed sensitive information to me which concerned the teenagers, but which they had not discussed with them. Examples included the scheduling of a case conference to discuss the removal of one young woman's baby at birth, and the diagnosis of a sexually transmitted infection in a teenager who was unaware her boyfriend was having sex with other girls. I encountered further difficulties when information was disclosed to me about respondents which, initially, I could not explore further because of imposed confidentiality embargoes. The most serious examples included instances of serial, including sexual, abuse. With regard to self-disclosures, I generally did not divulge information unless I was asked an explicit question. Where questions concerned matters relating to the information I might be expected to know through dint of being a 'professional' (midwife/academic), answering was usually very straightforward. Questions of a more personal nature I sometimes experienced as problematic.

A study of teenage pregnancy takes the researcher (and the reader) into terrain which is widely acknowledged as emotionally charged and in which pregnant young women are widely perceived as stigmatized (Whitehead, 2000) and socially excluded (SEU, 1999). The concept of stigma is based on understandings of social relationships wherein individuals or groups are signified as 'different', usually on account of behaviour judged as failing to meet socially prescribed norms of morality. Stigmatised relationships are neither exceptional nor atypical (Jones et al., 1984); indeed as the late Susan Sontag observed, one of the largest stigmatised groups comprises the 'kingdom of the ill' (Sontag, 1983:3). The size of group membership however, does little to dilute the discrimination and prejudice which separates the 'normal' from the discredited self (Goffman, 1990).

For the purposes of this study, I have expanded the concept of the stigmatized and socially excluded 'other' to take account of a peculiar kind of mutedness which marked my interactions with some respondents. I borrow from John Berger (Berger, 1989) again as I suspect this trait may be similar to what he referred to as the 'inarticulateness' (ibid: 98) of the patients served by Doctor John Sassall, the country doctor whose life he profiles. Sassall's patients struggled to communicate their experiences; 'to translate what they know into thoughts which they can think' (Berger, 1989:99) and this was linked to a sense of (cultural) dispossession originating in shame about their lowly place in the class hierarchy. I struggled when my enquiries met with long silences, monosyllabic responses and 'blanking' behaviours from respondents and I sometimes felt frustrated when they did not (could not?) express themselves verbally with any degree of fluency. Conversational gaps and hesitations were unsettling, especially in

the early days of my research when I often found myself tempted to formulate 'answers' to my own questions which I might subsequently insinuate into the conversation and later recover as 'authentic' data. Whilst it is not my intention to disavow personal responsibility for the omissions and failings in my research techniques, nor to suggest that respondents were inadequate in any way, I do wish to illuminate some of the difficulties I experienced in attempting to see, and describe, things from the 'native's point of view' (Geertz, 1983 [2000]).

CHAPTER SIX: THEORISING THE DATA; SOCIAL CONSTRUCTIONISM AND EMBODIMENT

In Chapters Seven to Eleven, I provide data to illustrate the futility of attempting to reduce young motherhood to a unitary category of experience. Whilst early childbearing has been conceptualised as inappropriate: a case of 'children having children' (Brooks-Gunn and Chase-Lansdale, 1991:467) and/or a route to 'social death' (Whitehead, 2001:437), it has also been described as a normative family 'transmission' (Cheesbrough, 2002:79). The multiple 'faces' of young motherhood conveyed by these descriptions suggest that 'social construction is not merely descriptive [...] it is cultural history with a message' (Hacking, 2003:422). For a number of the young mothers who contributed to this thesis, these messages were not benign. Pregnant teenagers face something of a double-bind, as they are deemed too young to be adequate mothers although the evidence of their active sexuality places them firmly on the other side of childhood. Pregnant teens, inhabiting adolescent bodies, must cope with conflicting demands, as they demonstrate their competence as mothers-to-be whilst asserting their right to inhabit a social world consistent with their position as young adults transiting a particularly turbulent phase in their life cycles.

As I have previously explained, the consequences of early childbearing for mothers vary substantially, not only by the well-established variables of poverty, ethnicity, and class, but also with reference to the constitution of, and dynamics within, individual families and the particular trajectories they follow. If, for example, a young mother cannot count on support, or if that support is contingent upon her behaving in particular ways, then her transition to motherhood, and her ability to mother, is likely to be more difficult than otherwise. My research also reveals that when rejection and disrupted family living are routine events in young women's experiences, they seem to find greater difficulty managing appropriate relationships with authoritative others. This is problematic because pregnant women are required to engage with a succession of health and related professionals throughout the maternity episode.

Whilst young fatherhood may also be problematic for adolescent men, their bodies are not automatically subjected to the disciplinary regimes which have become an integral aspect of contemporary maternity 'care' provision. Furthermore, men do not, indeed cannot, experience the corporeality of childbearing and childrearing activities. Neither do many take on responsibility for the maintenance or welfare of bodies other than their own. Furthermore, as I hope will become apparent in the following chapters, men tend to relinquish certain body specific tasks to women: it is generally women who organise contraception, change nappies, and nurse ill family members. This focus on the corporeal aspects of women's lives is central to the theoretical framework upon which my analysis rests.

Deconstructing theory: social constructionism

In analysing my data, I have drawn upon two broad theoretical perspectives: social constructionism and embodiment. The solidity of the phrase 'social construction' has been challenged in recent years with suggestions made for the adoption of an alternative terminology, which more cogently describes how processes of human experience are 'unpacked', and how conceptual frameworks are released from their 'encrustations' (Wong and Checkland, 1999). Arguing that the term, as metaphor and as statement of fact, is over-used, Ian Hacking (1999) urges authors who claim a constructionist orientation to clearly and precisely explicate the 'what' of the construction enterprise. Hacking also argues that the very word 'social' is redundant, because the social context is implicit whenever 'any idea that is debated, assessed, applied, and developed is situated in a social setting' (Hacking, 1999:423). The social component of human interaction is always and everywhere present; without this we cannot create meaning. Hacking says that the 'construction' element of the term is also misleading because it conflates several discrete items, including experiences, memories, discourses, and behaviours, into a unitary concept. He suggests the word 'shaping' is a more accurate description of the processes by which ideas, beliefs and attitudes about categories of people (he cites abused children, pregnant teenagers, and women refugees) are translated into theoretical propositions. Other authors propose that words such as 'making' (Wong, 1997:273), 'fabricating' (Armstrong, 1983:457) and/or 'inventing' (Oyĕwùmí, 2006:540) more accurately reflect the 'construction' element of human experience.

As an antidote to Hacking's precisionist stance, Diane Elam (1994) cautions against over-inflating the need for intellectual consensus, in this instance about whether social constructionism can, or cannot, continue to stand as a legitimate *theoretical* viewpoint. Elam suggests that 'if we spend too much time trying to find the right way down the lexicographical road' (Elam, 1994:4), in attempting to find a unified understanding, we may simply detract from the effort needed for problem solving. More worryingly, we may lose sight of significant issues that need to be addressed with respect to the corporeal dimension of female experience. My research findings suggest that whilst the bodies of all childbearing women are regulated and disciplined through encounters with maternity institutions, young mothers fare particularly badly because they are ill-equipped to deal with the more pernicious aspects of power. I do not mean to imply, however, that this particular group are so lacking in agency as to be necessarily complicit in accepting their marginal status, but rather that they are particularly vulnerable to being socially scripted in negative ways, and they may experience difficulty accessing the necessary authority to effectively challenge and refute these discursive constructions. For these reasons then, I consider teenage pregnancy and young motherhood to be an inescapably authentic biological, and physiological, event, as well as sexually (and culturally) constructed.

Whilst definitions may censor and limit discussion, they may also promote a conceptual understanding which facilitates communication about the boundaries of knowledge categories: 'the danger of thinking you know it all is at no time greater than when it comes to grasping hold of definitions'

(Elam, 1994: 4). The core features of a feminist social constructionist approach may be summarised thus:

1. Facts are dependent on the language communities which have created and sustained them; hence all forms of naming are socially constructed.

2. People create their realities from the languages available to them; words do not simply 'map' our world but rather create how we comprehend that world.

3. Explanations about the nature of reality are dependent on the historical and cultural location of those explanations; every culture has its own understanding of what is 'real'.

4. Ethical standards cannot be considered as having universal application, because all 'facts' are socially constructed.

5. All sensory experiences are mediated through language and hence claims to having a grasp on 'reality' should be viewed with scepticism (Davis and Gergen, 1997: 5-7).

By way of illustrating how language might advantageously be deconstructed in order to release alternative meanings, Davis and Gergen (1997) employ the phrase 'family values' to explain how shifts in meaning reduce multiple, and complex, interpretations to unitary, and morally weighted, readings. So instead of stimulating debate about the different kinds of values held by different kinds of families, for Western audiences this phrase is unlikely to generate more than a brief, and possibly heated, conversation about the differences between 'good' (financially independent, law abiding) families and 'bad' (welfare dependant, unruly) families. Social constructionists would argue that linguistic mutations of this kind have implications for the ways in which language impacts upon, and ultimately changes, our perceptions of reality. Such phrases do indeed become 'value-laden'. The concept of power, and the analysis of power relations, are integral to social constructionist approaches because there are always 'implications for what it is permissible for different people to do, and for how they may treat others' (Burr, 2003: 5). The social constructionist orientation, then, is based on the assumption that 'the terms by which the world is understood are social artefacts, products of historically situated interchanges among people [...] the process of understanding is not automatically driven by the forces of nature, but is the result of an active, cooperative enterprise of persons in relationship' (Gergen, 1985:267).

Social constructionism, whilst providing for the situated nature of gender and its contingency within social settings and interpersonal interactions, tends to somehow avoid dealing with the 'dangers' associated with female bodies, particularly those of adolescents (Pillow, 2003). Furthermore, social constructionism fails to address in any appreciable depth the embodied aspects of gender identity and experience, such as are rooted in the physical bodies of women.

Theorising the body

The environment in which bodies are produced and operate is of particular salience to this study, because the constraints affecting oppressed groups 'leaves its traces not just in people's minds, but in

their muscles and skeletons as well' (Fay, 1987:146). Hence bodies, especially female bodies, not only 'bear the weight of discursive representations' (Pillow, 2003:148) but are also vulnerable to being 'silenced most effectively by their association with maternity' (Walker, 1998:1).

Bodies are also, of course, sites of power and are necessary for the transformation of power; equally, they are sites of resistance to power (Foucault, 1979 [1990]). As a result of power struggles they are multiply marked with the signatures of their class, gender, culture and race. Bodies, after all, 'grow and work, flourish and decay, in social situations that produce bodily effects' (Connell, 1987:86). For women in patriarchal societies, to carry and give birth to a child is to appreciate that the dominant 'male imagination, indisciplined and uninformed by immediate bodily clues or immediate bodily experience, may have contributed disproportionately to the cultural superstructure of belief and practice regarding child-bearing' (Mead, 1962:222). Despite the lack of qualifying experience of the 'often unpredictable and sometimes irrational penchant of female experiences' (Aitken, 1999:108), the male imagination is, however, seldom discouraged from authoritative pronouncements on how childbearing and rearing practices should best be performed.

Theorising embodiment then, is particularly apposite in a thesis which focuses on the physical bodies of childbearing adolescents and their children, and on the spaces inhabited by these bodies at different times, because 'for those women experiencing an unplanned pregnancy, bodily disruption and symptomatology is conception's first, if not only presentation' (Pietsch, 2002a:3). Pregnant teenagers undergo two hugely physical transitions almost simultaneously: that associated with the onset of puberty, and that connected to pregnancy and motherhood. Through these deeply sensual, and ultimately somatic, events the bodies of young women are irrevocably changed, often in ways over which they have little control. These experiences are not wholly (socially) constructed, but neither can they be theoretically 'packaged' and put to one side, 'because pregnant embodiment is a complex constellation of social discourse and political dynamics' (Pietsch, 2002a:9). The bodily learning that young women acquire, for example through their physical experiences of childbearing and childrearing, plays a significant role in shaping their maternal identities and mothering capacities. Brian Fay encapsulates the importance of this mode of learning for social theorists: 'understanding the way it occurs will not involve ferreting out hidden symbolic meanings which their subjects have internalised. It will require instead discovering the material processes through which these bodies are moulded through direct behavioural influence and physical environment '(Fay, 1987:148).

A further aspect of the embodiment trajectory to which I wish to draw attention, and which I hope will emerge during analysis of my data, is the place of emotions in shaping the evolution of mothering identities. An appreciation of the role and function of emotions helped me to piece together a rudimentary understanding of respondents' lives and subjective embodied experiences, and of my responses to these events. Mapping the realm of sensations and feelings created an opening to include 'that half which goes on *inside* the bearer of identity or identities, and the process of internal negotiation which this involves' (Craib, 1998:4 emphasis added). This dimension of human experience is not split

off from corporeal or cognitive existence, nor was it separate from the material circumstances of individual respondent's lives.

The material presented in the following chapters speaks to what Elizabeth Grosz has termed a 'corporeal feminism': feminist work which emanates from, and responds to, the (female) body as an incarnated and fleshy substance; as the 'repressed or disavowed condition of all knowledges' (Grosz, 1994: 20). The processes of parturition are an inescapable, biological reality (Earle, 1998) which constitute the physiological and 'organic' embodiment (Jenkins, 2002:122) of *women's* bodies. These bodies are not only 'constructed' (socially or otherwise); they are very real, carnal and licentious bodies, which leak and grunt and sweat their way along their respective childbearing and rearing trajectories. This focus on the specific bodies of maternal teenagers probes another facet of women's fluctuating identities and destabilized bodies, and will, I hope, contribute to ongoing debates in these areas.

An analysis of embodiment discourses is central to understanding teenage pregnancy because within contemporary tabloid and political discourses, young women's identities are often constructed as irresponsible and problematic, particularly with reference to their physicality. The bodies of school-girl mothers have been described as having 'leaky needs' (Lesko, 1995:177), which can never be entirely remedied or accounted for by the social reforms advanced in policy documents. Adolescents' bodies represent and are (mis)represented; whether they are 'rendered invisible, portrayed romantically, described with statistics, fear, propulsion or pity [...] [they] are inescapable and cannot be lost in a chain of reference' (Pillow, 2003: 148).

Inspirational texts

In analysing and presenting my research findings, I have taken inspiration from Ann Oakley's seminal text *Becoming a Mother* (Oakley, 1979[1986]), and Joan Cassell's absorbing ethnography *The Woman in the Surgeon's Body* (Cassell, 1998). These texts examine the embodied experiences of two very different groups of women, in England and the USA respectively: pregnant women and female surgeons. The female participants in these studies occupy opposite ends of the established hierarchy of the (medical) institution, and this positioning is reflected in their bodily attitudes and comportment: female surgeons 'do' power and authority; pregnant women 'do' deference and submission.

Ann Oakley's account of first-time motherhood, as experienced by a sample of sixty-six London-based women aged between nineteen and thirty-two years, departed from previous research in this area. By foregrounding her participants' embodied knowledge and expertise about their own (bodily) experiences, Oakley challenged prevailing 'expert' (medical) pronouncements on motherhood. Unusually, for the time, she also drew upon her own understanding of being pregnant and used insights she had gained from personal experience in her analysis. In taking a 'realist' view of maternity, Oakley rejected the 'bed of roses' (Oakley, 1979[1986]:6) approach hitherto adopted by many writers on this theme. Her report was initially viewed as an overly bleak, unrelentingly depressing portrayal of women's childbearing and childrearing experiences. Oakley argued, however, that her research was grounded in

her participants' lives and, as such, was a genuine attempt to challenge the 'sanctimonious whitewashing of the ragged vitality of one of the most powerful of human experiences' (Oakley, 1979[1986]:5). Arguing that the happinesses and contentments which women described were not camouflaged or otherwise denied by their references to episodes of grief and despondency, Oakley created a framework which enabled women to articulate deeply-held, but rarely voiced, ambivalences about motherhood.

Joan Cassell's study of women surgeons powerfully, and shockingly, exposes the extent to which embodiment 'seems to roughly parallel the prestige system amongst doctors' (Cassell, 1996:41), with less embodied specialities (psychiatry) disparaged by those whose sphere (surgery) requires them to make 'brutal' physical contact with the patient's body. Cassell's work makes explicit the 'penetrative' nature of the sexual hierarchy, and the degree to which this acts as a driver in the different specialities of medicine. Interesting parallels may be drawn here between midwifery and obstetric practices, and practitioners, and the hierarchies of prestige in which women's childbearing bodies are employed to service the different requirements of these two groups.

Many midwives, at least in the UK, generally view themselves as autonomous practitioners concerned with promoting intervention-free (or 'normal') childbirth; being *with* women is more highly regarded than doing *to* women. For these midwives, embodied practice is perhaps best portrayed as 'hands off' practice with practitioners facilitating women to follow their instincts, especially during labour. It is in the *non-doing,* achieved through *not* intervening in what is considered a normal process, that 'successful' childbirth outcomes are achieved. This is not to suggest that all midwives are sympathetic to this ideology. As will be evident in respondents' accounts over the following chapters, midwives did not always act in their client's best interests but sometimes prioritised their own interests, and advanced the agendas of obstetricians and employers, to the detriment of their clients. In comparison with midwifery, obstetric practice, and its practitioners, generally value technical prowess and embodied physical competency in interventionist tasks over the more facilitative roles adopted by midwives.

CHAPTER SEVEN: PREGNANCY REALISATION and DISCLOSURE

This chapter documents respondents' reactions to pregnancy, disclosure patterns, and early help-seeking behaviours. It examines how family and kinship networks, and relationships with health professionals, impacted on decision-making and young women's sense of personal agency, and how interpersonal relationships influenced young women's latent maternal identities. Finally, there is a brief discussion of abortion as a 'non-choice' for respondents. Throughout this, and the following four chapters, I make constant reference to institutional norms and demonstrate the multiple ways in which the bodies of maternal teenagers are both disciplined and mistreated for failing to comply with such norms: their bodies may thus be understood to 'bear their societies like stigmata' (Fay, 1987:154). By way of illustrating my analysis, I have included text in the form of verbatim, but anonymised, quotations derived from interview transcripts and fieldnotes. Where text has been removed for the purpose of condensing a quotation, this is indicated: [...]. I hope these chapters will serve to illustrate the myriad ways in which young women complied with, and attempted to subvert, the expectations of others, including their mothers and significant others, and health and allied professionals.

Doing sex, becoming pregnant: young women, eroticism and romance

> '(Falling in love was) an extraordinary self-awakening, especially if you have a romantic temperament as I do. [...] (Teenage sex) was so exciting, and without any of the baggage that comes later. It was connected with animal desire, which girls lose quickly. They're just as likely to want sex for its own sake but get tricked out of it.'
> Jeanette Winterson, The Saturday Guardian 29.05.2004

With the exceptions of Catrin and Elenor, all respondents had boyfriends with whom they sometimes had sex; most claimed to be in a 'love relationship' (de la Cuesta, 2001:181) at the time of conception. The duration of relationships varied: the majority of young women were 'courting' or 'going steady' for only a few months prior to conceiving; Lou and Pete, however, had been in a sexually active relationship for almost six years. Only one respondent, Bronwyn, stated from the outset that her pregnancy was planned, but she nonetheless reported being surprised when she 'fell' during the menstrual cycle after she ceased using oral contraception. Young women's self-reported references to being 'on the pill' were often a euphemism for engaging in sexual intercourse although, as Rhian explains, this was usually within an established relationship.

> I was on the pill for about a year before I got pregnant. It wasn't like, Oh I just had sex for the first time and then I got pregnant. I had sex for quite a long time before I fell.
> Rhian, thirty-seven weeks pregnant. W[83]

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[83] W = Wales; SY = South Yorkshire. See Appendix Seven for an explanation of other abbreviations used.

Although I did not explicitly ask respondents to describe their sexual experiences in any depth, we did talk about first sexual encounters and the sex which had immediately preceded pregnancy: the story of 'how it happened'. With some respondents I was able to engage in 'sex talk' more easily than with others, perhaps because I am too easily embarrassed. Discussing this issue with Alys and her mother was exceptional, in that the conversation felt relaxed and unconstrained; this seemed to mirror the relationship between them. Unlike other respondents, Alys was a confident communicator who initiated conversation on a range of sensitive topics which other respondents avoided, especially in front of their mothers.

HS	What was that [first experience of intercourse] like?
Alys	Mmm. It wasn't very nice at all. I was petrified.
Mum	Oh, she said it was awful. She came crying to me the first time. [...] We sat here in the kitchen next day and she cried it out all over me. We laugh about it now though don't we? *Both laugh.*
HS:	Can you remember what you were expecting?
Alys:	I think I expected it to hurt [...] Everybody said that for girls it hurts. But really it was crap. I mean it was really really crap. *Laughs.*
HS	In what way?
Alys	Oh he just wanted to get straight inside me. It was all over in two seconds. I was like, Oh, is that it then? I didn't feel anything. It didn't even really hurt. Now looking back I don't know why I was so upset about it.
HS	Did the sex get any better with that boyfriend?
Alys	No. No not with him it didn't. [...] But it was much better with [current BF]. Not giving him a big head or anything, but it was really a lot better. I was more best friends with him. [...] I was going out with him for three months before I'd even thought about sleeping with him.
HS	And he didn't pressure you?
Alys	No, he didn't. Not like the other one.

Alys, son aged two years. W

That young women experience sex, especially for the first time, as 'crap' is not altogether unexpected; that Alys anticipated it would also be painful, needs further research.

Considerable tensions were evident in some mother-daughter relationships, often focusing on the (un)suitability of boyfriends and young women's negotiation of a sexual identity. This caused some teenagers to decide against confiding in their mothers when they were in difficulty:

Since I hit my teens I haven't really gotten on with my mum. I don't sit down and talk to her if I've got a problem anymore. Susan, thirty weeks pregnant. SY

Some things I just wouldn't ever tell my mum. Like with this new boyfriend [father of her baby] I knew she wouldn't like him so there were no point in asking her opinion. She hasn't liked any of my boyfriends. Not really. That was when we stopped being so close. When I started going out with boys. Clare, thirty weeks pregnant. SY

In my conversations with mothers, it seemed that daughters' attempts to lay claim to a sexual identity were often problematic for all family members, especially for fathers and occasionally for older brothers.

This is perhaps not surprising; overt expressions of female sexuality in early adolescence are often denied the legitimacy afforded young men, and this creates particular difficulties for young women wishing to 'do' sex[84] . Accounts of sex education in school revealed that these sessions, 'about boring biology,' failed to equip respondents' with the necessary skills to negotiate the timing of, and the location for, sex, and many did not acquire the assertiveness they needed to discuss contraception. The 'technologies' (Stewart, 1999:375) governing young women's reputations are intricate and complex but it seemed to me that the young women in this study positioned themselves, and were positioned by others, as (hetero)sexual subjects in oppositional ways: as defiant and confrontational characters who earned themselves reputations as 'slags', 'sluts', or 'girls who'll go with anyone', or as 'sad mongs' (mongols) because their sexual explorations were mostly conducted furtively and secretively (if at all). None of these identities facilitated young women discovering what pleasured them before they were expected to be proficient in pleasuring others.

Almost all respondents were living at home and/or attending school when they first started sexual explorations, and most reported that their sex lives were constrained by pressures which reflected the spatial and temporal characteristics of domestic spaces:

HS   Before you actually fell pregnant had you been having a lot of sex with Carl or was it just like now and again?

Clare   It were quite a bit I'd say. *Laughs.* Yeah, a fair bit, weekends mainly. That were only time we could get by ourselves.

Clare, daughter aged nine days. SY

As I say elsewhere in this thesis, many respondents lived in crowded homes where privacy was rarely possible. Most shared bedrooms and some shared beds with younger siblings; one young woman rotated between the floor and a sofa when bed space was unavailable. Sex then, was perforce often in haste, with little time for romantic preludes; it is possible that time pressures were such that persuading (inexperienced) young men to don a condom reduced the already restricted opportunities for erotic pleasure.

That's life, accidents happen: sex, pregnancy, and contraception.

Most young women initially reported that pregnancy was 'an accident', that it 'just happened' and was unplanned and unexpected. This was in contrast to the attitudes they perceived midwives to hold:

I think they [midwives] just think I've gone out and done it on purpose [...] I didn't do it on purpose. It was an accident. Just like anyone can have an accident and not mean to get pregnant. Lowri, three weeks after the stillbirth of her daughter. W

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[84] Fine (1988) and Tolman (1994) provide discussion the theme of adolescent female desire in more depth.

Although pregnant teenagers are no longer punished 'in the old and cruel sense of the word' (Arney and Bergen, 1984:17) by being dispatched to homes for unwed mothers or forced to relinquish their babies for adoption, they are nonetheless disciplined. The moral discourse within which teenage pregnancy is framed in Western societies identifies female sexual desire that is acted on 'inappropriately' as a transgressive act requiring correction. Health professionals play important roles in shaping these discourses and, indeed, many respondents reported that interactions with maternity staff left them feeling humiliated and infantilised, or occasionally sexually harassed. Such attitudes may harm young women because they reinforce the perception of 'error in the *proper* timing and location of (their) sexual desire' (Arney and Bergen, 1984:17 emphasis added). Assumptions that pregnancy resulted from consensual sex may also prevent a midwife from exploring other possible scenarios, including rape, incest and prostitution, which arguably impact more negatively on young women's health and sense of well-being.

Official explanations for teen pregnancy suggest it results from failure to use contraception (effectively) or failure of a chosen contraceptive method. One feminist academic, however, interpreted her personal experience of teenage pregnancy in terms of 'body betrayal [...] the body that began this whole nonsense by conceiving without consent' (Pietsch, 2002a:5). Literary accounts of 'clever' girls who nonetheless become pregnant, confirm that teenagers are not necessarily protected by superior intellect. Sex happens and when it happens the experience may be uncontrollable and uncontainable, as the late Lorna Sage - formerly Professor of English at The University of East Anglia – attested when describing her first experience of teenage sex (which resulted in pregnancy):

> 'It's a hot, bright afternoon summer [...] we are trying to get inside each other's skins, but without taking our clothes off, and the parts that touch are swaddled in stringy rucked-up shirts, jeans, pants. There are no leisurely caresses, no long looks, it's a bruising kind of bliss mostly made of aches. [...] we're dissolving, eyes half shut, holding each other's hands at arm's length, crucified on each other, butting and squirming. Our kisses are like mouth-to-mouth resuscitation - you'd think we were dying it's so urgent, this childish mathematics of two into one won't go.' (Sage, 2001: 234-5).

Accounts of the humorous, and erotic, nature of teenage sexuality are uncommon in scholarly writings. Conventional narratives tend to locate teenage pregnancy as a matter of individual choice although in reality, when certain choices are acted upon they tend to be (re)constructed as personal pathologies. Hence, 'failure' to comply with the dominant (middle-class) social paradigm - which scripts young women as industrious, discreet and careful - may cast working-class teenagers as deviant and in need of correctional strategies to prevent future 'transgressions'. Echoing existing research (Tripp and Viner, 2005) on adolescent patterns of contraceptive knowledge and use, all respondents were aware that contraception was available and most reported using it, albeit not always consistently or appropriately:

> We'd been together for nearly a year. [...] Mostly we used condoms but sometimes we didn't. [...] We knew it were a bit risky but you think, Oh we'll be all right. *Laughs.*
>
> Clare, daughter aged nine days. SY

Many respondents admitted taking some sexual risks. Corporeal risk taking is normal behaviour during adolescence when many young people relate to their bodies as sites of unpredicatable 'otherness'; this is a time when desires may be most intensely felt and appetites most resistant to moderation. Using the body as a vehicle for risk taking is not uncommon during this time and, indeed, drug and alcohol experimentation, and the induction of extreme physical states through a variety of sport and 'leisure' activities, have been widely documented (Bloustein, 2003). With specific regard to teenage pregnancy, sexual risk taking has been noted as more prevalent in areas of social deprivation (SEU, 1999). Risk taking implied by non, or irregular, users of contraception should not be regarded as actively seeking pregnancy, however, as various factors militated against respondents accessing reliable information and suitable contraception. In this respect, my study affirmed earlier research findings (Free et al., 2002; SEU, 1999), namely: inaccessible Family Planning facilities which were not open 'after hours'; negative attitudes from health professionals; fear of parental disapproval; lack of confidentiality; a belief in their own or their partner's infertility; and a reduced sense of personal vulnerability. It is also not unreasonable to suggest that adolescents might choose immediate sexual gratification rather than spend precious time negotiating contraception use.

Mirroring previous research (Dudgeon and Inhorn, 2004), the young women in this study tended to assume responsibility for providing contraception, for ensuring its continued use, and for deciding 'how far you go'. This reaffirms the widely held belief that pregnancy is 'a risk that boys were not responsible for' (Chambers et al., 2004:401). Respondents whose narratives suggested they used contraception 'properly' cited burst condoms and pill failure as the most common reasons for pregnancy. As Clare reports in the following quotation, however, respondents were not necessarily aware when mishaps with contraception occurred and were therefore not well positioned to take remedial action, even when they knew emergency birth control (EBC) was available.

HS	Did you think about getting emergency contraception?
Clare	Yeah well I would have done but I didn't know it [condom] burst, did I?
HS	How did you figure out it had burst?
Clare	Well 'cos [BF] told me about six days later. [...] It were too late to do owt then.
HS	Why do you think he didn't tell you at the time?
Clare	I dunno. [...] He were scared as well 'cos I were only fourteen, like.
HS	And when he told you six days later, what did you do then?
Clare	I didn't really think nowt about it to be honest. I didn't think, oh my God, I could be pregnant. It sounds stupid now, but at time I weren't really thinking about it. I were just blanking it out, I think.

Clare, thirty-eight weeks pregnant. SY

Clare was not alone in volunteering that she was somewhat preoccupied when she first realised she might be pregnant. Whilst 'blanking' may be interpreted as a psychological defence, or disassociative, mechanism, it appeared to serve Clare as an effective coping mechanism, protecting her from attempts at rational discourse at a time when she felt very confused.

With the exceptions of Jade and April, all respondents agreed that intercourse resulting in conception had been consensual. As the research proceeded with the longitudinal (South Yorkshire) cohort, some respondents retold their conception stories in such a way as to suggest that events leading up to pregnancy were different than they had originally suggested. For example, Michelle was initially adamant that she and her boyfriend Ryan 'always' used condoms and that pregnancy had resulted from a burst condom. When her baby was six months old, however, she confided that 'Well, sometimes he were [wearing a condom] but that time he wouldn't and it were just that one time but one time's enough isn't it?' Susan also offered an alternative explanation to that which she had originally proposed: that she forgot to take her oral contraceptive pill when she went away on a school trip. Some months later she confided that she had planned the pregnancy and had 'tricked' her boyfriend into believing she was taking her oral contraception as prescribed.

The midwives I observed and/or interviewed mostly concurred with the premise that adolescent women, especially those at the lower end of the age range, do not deliberately engineer pregnancy. That said, some midwives were very aware of the harrowing home circumstances endured by selected clients and empathised with their attempts to use motherhood as a means to create better lives for themselves:

> The practice nurse was telling me she had a youngster in the surgery recently who said she was planning to get pregnant so she could leave her dreadful home conditions and get her own flat. It's very sad. She's only thirteen. I know the family and to be honest I can't blame her for wanting to get as far away from them as possible. Community midwife (CM4). SY

As I explained in Chapter Three, manipulating the system to improve one's personal circumstances is not new, especially in societies where dependency is viewed negatively. As the links between poverty, inequality and dependency have loosened, so the association between welfare and dependency has strengthened (Fraser and Gordon, 1994). Indeed, both issues tend to be conflated in current discourses such that - at least in the public imagination - the notion of dependency appears to be singularly applied to lone mothers who, if only they applied themselves, could also better themselves.

Welfare dependency is widely seen as a social problem because it is understood to undermine the drive to self-sufficiency, is corrosive of self-esteem, is stigmatising, isolating, and generative of an underclass group of marginalised citizens. Most of all, dependency is portrayed as a problem of *individuals*. In their genealogical analysis of dependency, however, Nancy Fraser and Linda Gordon (1994) argue that the assumptions and connotations currently applied to the term serve to privilege

dominant social groups at the expense of those who are subordinate, and that it is the relentlessness of such conditions which renders people disenfranchised and useless.

Disclosure stories: responses from significant others

Many young women reported having rehearsed disclosure scenarios a number of times before they enacted them and indeed, some failed in their first attempt. The time between pregnancy confirmation and disclosure varied, although the majority of respondents waited only a few days or weeks before confiding in someone, usually a boyfriend or mother. In addition to recognising that pregnancy was something of a calamity event, the 'WOW' factor was also clearly evident in some accounts, and these young women lamented the absence of a congratulatory response from others. Health professionals were singled out as the group least likely to recognise pregnancy as a positive and exciting event in respondents' lives:

> I felt stupid but I also felt, like, Wow, this big thing had happened and I was pregnant. That part was really exciting but they [health professionals] didn't want to know that. But I had my mam and [BF] for that. I was lucky I had them for that. Alys, thirty weeks pregnant. W

These positive feelings may in part be accounted for by respondents' relatively low social status and their restricted opportunities for engaging in occupations other than motherhood: 'the less social status women have in public in terms of work, the more likely they are to feel that pregnancy confers status' (Coward, 1992:49). Young women's mothers usually assumed the role of envoy, in transmitting news of the pregnancy to others. Most intimated that this was a delicate and difficult task, because conflicting feelings needed to be managed appropriately.

The majority of young women admitted to being pregnant during the first trimester. Clare however, was entering the third trimester when she finally agreed with her mother's assessment that her changed body shape reflected advanced pregnancy. One community midwife claimed that Clare had deliberately 'concealed' her pregnancy, and that this was unfortunate because it reduced midwifery contact time and, hence, 'educational' opportunities:

> HS That word 'concealed' - I know it's a word midwives use when they're talking about women who don't reveal that they're pregnant - but what's it mean to you? Can you unpick it a bit for me?
>
> CM7 Oh well a lot of the young girls conceal. You see it all the time. It's mostly with them that you do see it. The problem is when they do conceal you don't get much time with them, which is a shame really because there's so much they need to learn and then it's all crammed in. [...] Like with Clare, because she concealed [the midwife drops her voice to a whisper on word 'concealed'] so I didn't have all that much time with her. It all had to be squeezed into just a few weeks right at the end, so it wasn't ideal.

Later in the interview, the same midwife reflects on her relationship with her own children and frames Clare's relationship with her mother as aberrant by comparison:

Another thing I can't understand is when a mother does not realise that her daughter's pregnant. I cannot understand how it took so long for Clare's mother to realise. I think it's because I've got such a good relationship with my own daughter. Maybe that's why I find it so difficult. I think when you want to conceal, you can. If you want people not to know you're pregnant, they'll not know you're pregnant. But when you live at home, under your mum's roof that's when I can't understand why they don't know.
Interview with community midwife CM7 following a booking consultation with Clare when she was twenty-eight weeks pregnant. SY

The midwife failed to take due account of Clare's reasons for keeping such sensitive information private until such time as she had identified a trustworthy person in whom to confide. Whilst it may be advantageous that this person is a parent or another adult, some young people do not have this option. The ability to contain information, until the time for enlightening others feels individually appropriate, may be indicative of a mature, rather than an immature, personality and in this respect both disclosure and concealment may be regarded as communicative 'performances' which are context bound. Clare's persistent denial of her pregnant status, however, caused her mother to wonder whether there was something 'seriously wrong' with her physical health:

It were a case of wringing it outta her. [...] She'd not tell me straight. I did ask her. I asked her several times. [...] 'You don't think you could be pregnant do you?' She said, 'Don't be stupid, what d'ya think I am..?' [...] So then I started thinking, 'Oh God, what's wrong with her then? There's something wrong with her. She must be sick, like.' I thought there might have been something seriously wrong with her. It does goes through your mind. Chris (Clare's mum) SY

Clare's account of her decision to withhold disclosure of her pregnancy differed from the explanations offered by the midwife and her mother. Rather than offering a single rationale for her silence, in the following quotation Clare justifies her decision by invoking multiple factors, and hence keeps the discursive space wide open to alternative interpretations, including those which are both self, and other, generated. On the one hand she agrees that she has indeed 'concealed' her pregnancy, but she disagrees with the construction of this decision as 'bad'. Rather, she considers herself 'lucky' because, by continuing to wear the same clothing, she avoids 'showing' and thus inviting unwanted questions; by not 'thinking' she is able to continue inhabiting her 'dream' world and thus resists pressure to consider an abortion which, like most young respondents, she 'doesn't believe in':

HS   When the midwife was here the other day she said you concealed your pregnancy – that you hid it. Was that a fair comment? Did you hide it?

Clare   Yeah, I did hide it. [...] I were lucky I didn't show much. *Laughs.* My jeans were really close fitting so you couldn't really tell. Not early on you couldn't 'n that's how I could keep it from my mum as well. *Smiles* I were lucky in that way. [...] She (midwife) made out it were really bad that I hid it but I don't see what difference it makes. [...] I weren't going to have an abortion anyway.

HS   What was it like in those early months when you first realised you were pregnant?

> Clare   I weren't really thinking about it. It were like I were in a dream or something. [...] I just
> blanked it.
> Clare, thirty-eight weeks pregnant. SY

'Concealment' may be considered a normal aspect of adolescent development, in that young people generally do hide (parts of) their bodies and their activities from others, especially from authoritative elders. As Carole Satyamurti eloquently describes in the poem which prefaces this thesis, teenage girls 'do' adolescence in all manner of ways which may appear strange, irritating and/or offensive, especially to parents and other adults. Adolescents also tend to commandeer domestic spaces, especially bathrooms; take refuge in sleeping; communicate in grunts and monosyllables; and engage in a variety of behaviours designed to protect the spaces and places they consider private. All this is normal.

o   Mothers' responses to sexual development in daughters and to pregnancy disclosures

Some mothers reported that they responded to pregnancy disclosure with anger and that this effectively deterred daughters from elaborating further. As mothers were generally the first sources of comfort in times of trouble, their lack of availability reinforced daughters' feelings of distress and isolation.

> When I first got pregnant, I really wanted to tell her [mother]. But I couldn't... I were too
> frightened of what she'd do. Then when I did tell her, it were so bad I had to stay out of the
> house for two days. She's so angry I can't tell her things. There's no-one to talk to about
> pregnancy. There's no-one I can really pour my heart out to. I were crying last week 'cos there
> were so much pressure. Susan, sixteen weeks pregnant. SY

My own interactions with mothers during early interviews confirmed that some were indeed very angry with their daughters, especially when news of the pregnancy had been withheld from them until it was too late to consider abortion. Whilst displays of maternal anger heightened young women's sense of loneliness, this was mostly a temporary phase. When trust between mother and daughter was well established, and pre-existed pregnancy, it did not jeopardise long-term relationships.

Some mothers volunteered that they 'instinctively' recognised that something was amiss with their daughters, often before the news of pregnancy was divulged.

> On the Sunday night I came home and she was in bed. She called out, 'Mum'. I said, 'What's
> the matter?' but I just knew. I don't know how, I suppose it's instinct. I knew what she was
> going to say... Anwen (Megan's mum) W

Mothers occasionally mistook changes in their daughter's general demeanour and behaviour as indicative of 'growing pains', whilst others considered that increased weight and changing body shape reflected the accumulation of 'puppy fat'. Mothers' everyday performances of housekeeping roles, and daughters' departures from normal dress codes, however, eventually signalled that 'something was up':

> I do all the shopping and the washing and I empty the bins so you do notice things. [...] I knew there were something up with her. I mean, you could tell. Especially over the last few weeks when she were just wearing her tracksuit bottoms all the time. Chris (Clare's mum). SY

As pregnancy progressed, maternal support was generally forthcoming and enduring – which is not to understate the period of intense turmoil which enveloped all the study families following pregnancy disclosure. Even the young women who had been accustomed to a warm and loving relationship with their mothers reported that the announcement of pregnancy 'was like a brick wall coming between us'. Many daughters volunteered words to the effect that their mothers would generally have preferred to see them 'married and a bit older' before they embarked on motherhood.

o   Men's responses to female adolescent sexuality and pregnancy disclosures

Some adolescents refrained from early disclosure of pregnancy, because they sought to avoid becoming the focus of parental, especially paternal, disappointment. Many parents had hoped that their children would enjoy the career opportunities they themselves had been denied and early pregnancy was perceived as jeopardising these aspirations. Girls tended to assume disclosure responsibility on behalf of boyfriends and to position themselves as morally culpable for interrupting their educational and career progression:

> He [BF] didn't tell his family till five months. He was scared his parents would go mad. [...] He's like in his second year of university. Nia, son aged six weeks. W

Interestingly, Nia was also in her first year of university studies and did not tell her own parents until she was around six months pregnant. Alys also expressed concern about her boyfriend's future but initially failed to mention her own future career plans:

> They're fine with me now. [...] But in the beginning it was terrible. [...] like we've done all this for him, given him good schools and he's got all his exams and now this. [...] it's all for nothing now. Alys, son aged two years. W

Negative reactions from fathers (and stepfathers) were widely anticipated by female family members. Irate, sometimes violent, outbursts were usually followed by indefinite periods of cold and aloof behaviour as fathers struggled to come to terms with their daughters as sexual beings:

> [...] my husband can't look at her, doesn't want her in the house. Anwen (Megan's mum) W

> He [Michelle's father] took it very badly. [...] He was gutted really. He wanted the best for his girls. He wanted them all to have the best education. He wouldn't speak to her for weeks after she told him. [...] My brother's a bit the same. He's been very hard on me about Michelle's pregnancy. He told me I'm soft in the head to let her get away with it. He's got a twelve year-

old daughter himself and he told me that if she ever gets pregnant as a teenager, she'll be out on her ear. [...] He said I'd never support her the way you've done with Stacey [Michelle's older sister who was also a teenage mum] and Michelle. Polly (Michelle's mum) SY

With the possible exception of Jade's mother, men tended to be the most hostile recipients of pregnancy announcements and many young women looked to their mothers to intercede, as far as the actual timing of disclosure was concerned. Mothers tended to adopt a placatory and pragmatic role within the family, soothing tensions between fathers and daughters. Although some fathers were considered 'very open-minded', and were liked and admired by daughters, none enjoyed the intimacy and ease of communication which characterised relationships between some mother-daughter dyads. Within the home, intimate talk was gendered and spatially specific. When it occurred, it was in rooms which afforded a high degree of privacy: bedrooms and bathrooms – where a locked door restricted entry - were the most frequently mentioned locations. Fathers were excluded from these domains:

> I would never have talked about sex and boyfriends and stuff like that with my dad [...] Like my dad wouldn't come in [to the bathroom] on me and my brother wouldn't either, but my mum would. And my dad wouldn't go in on my brother and my brother wouldn't go in on my dad. [...] My dad's very open minded as well though, and if I needed to speak to him I would, but my mum's way more easy to talk to than my dad is. Especially about things like my periods and contraception and what I do with my boyfriend. Beca, fourteen weeks pregnant. W

For some young women, pregnancy and motherhood provided the impetus to develop new relations with previously estranged family members, especially fathers, and this provided an additional, and much-needed, resource. Boyfriends' responses to the news of pregnancy varied. Many were not only shocked but also alarmed, especially if their female partners were under the legal age of consent. Half of the young women (n=8) were underage when they conceived, although there was no suggestion that they, or their parents, intended to pursue criminal proceedings. For their part, it seemed that young men's cognisance of the seriousness of their actions initially deterred some from maintaining contact with their female partners, and with the young woman's mother:

> Mum   Well, he's breaking the law for starters isn't he?
> HS   Was that an issue for you, the fact that your daughter was under age? Was the legal side of it an issue?
> Mum   Not really. Not with us it wasn't. With him it was so because he was afraid to come here and see her. [...] They've been seeing each other for about eighteen months and I know it sounds bizarre because they're so young, but when I look at some of the girls her age and the way they are and what they're up to, obviously it's not the immaculate conception and she's done the deed, but it takes two to tango and all that doesn't it? So even though Megan's only fourteen I can't only blame him.
> Anwen (Megan's mum) W

Her boyfriend was too scared to come here and then later I found out he'd been on the

phone to the Samaritans. I said, 'What did you do that for?' He said he could go to jail. I said, 'Yes you could but then again you've got to be sensible, you didn't jump out of the bushes and rape her did you?' Marg (Susan's mum) SY

Hence, some couples stayed away from the young woman's family home, in order to avoid inflaming an already difficult situation. This was particularly the case where the young woman's mother had previously expressed disapproval of her daughter's choice of boyfriend, whose baby she was now carrying:

> We haven't been here [at home] much because I don't know if she [mum] wants us to be here, 'cos obviously wherever I am he's [BF] coming as well and well, she's not rude to him or anything, but you can tell she doesn't like him. [...] She's never liked him. She don't like the family either. Clare, sixteen weeks pregnant. SY

Young women themselves tended to differentiate their intimate relationships with young men on the basis of whether they thought it was likely to be 'cas'(ual) or whether it constituted a 'friendship' with potential for future development. When intimate relationships were sustained throughout the upheaval effected by pregnancy, young women generally referred to their boyfriends in affectionate terms, which suggested deepening attachment and an intention to co-operate in parenting. Announcements of pregnancy were more positive when boyfriends were already regular, and welcome, visitors to the family home:

> HS   So your mum's been OK about you getting pregnant?
> Beca   Yeah, she's been fine about it. She would have been upset if me and [BF] hadn't been together. Like if it had been a one-night stand or somebody who I'd already split up with, then she would've been upset.
> Beca, fourteen weeks pregnant. W

Mothers were often quite forthright in voicing their expectations that young men would act with integrity and become involved in childbearing and rearing activities. Although such matters might be presented in a humorous light, the threat that action would follow if paternal responsibilities were avoided, was clearly evident in some mothers' responses:

> HS   So [BF's] sticking by Alys then?
> Mum   He's got no choice, he's not going anywhere now! *Laughs.* I told him, I've got a shot-gun upstairs if he tries to get away now! No, he's not going anywhere! [...] No, he's going to stick with her if I have anything to say about it. *Laughs.* [...] He's been very good though...
> Angharad (Alys's mum) W

As will become apparent in the following chapters, the majority of young men did 'stick with' their female partners and most assumed some level of parental responsibility.

Many young women drew on abortion narratives from within their social networks to illustrate the power that young men wielded to influence decision-making in this regard. Some young women delayed disclosure for fear their boyfriends would leave them, or coerce them into having an abortion:

> His [BF's] best mate's girlfriend, she fell pregnant and she got rid of it and then he says to me if you ever fell pregnant I'd make you have an abortion. I mean he were only joking when he said it, but how do I know that? [...] So then he says, 'Oh, I wouldn't make you do anything you didn't want to.' [...] He says to me other day, 'Oh, I don't hate you for not telling me or anything.' 'n I says, 'Well that's good, 'cos it's too late now.' *Laughs.*
> Susan, son aged six months. SY

Two respondents reported being *dumped* by the fathers of their babies and three experienced relationship difficulties and/or relationship breakdown at a later date. Young women, including Clare, whose relationship had already ended before she realised she was pregnant (but which she later resumed), were unsure about whether to disclose to ex-boyfriends:

> I'd like, I'd already finished off wi' [BF]. [...] I mean [BF] says to me now, 'If you'd have told me I wouldn't have left you', and obviously he's still here now, but you don't know that at time do you? You don't know what they're gonna do. [...] Clare, daughter aged three months. SY

Some mothers intimated that although pregnancy in a teenage daughter was an unwelcome event, it was something of a biological inevitability; that it was simply a matter of time before early childbearing manifested as an actual, rather than as a potential, event:

> When you have daughters I think you're always preparing yourself for them to come home one day and say 'Mum I'm pregnant.' [...] It's always going to be a shock, but with girls, well it's always there in the back of your mind isn't it? [...] Girls you worry about more I think than boys.
> Polly (Michelle's mum) SY

The bond between some mother-daughter dyads appeared especially strong and this enabled them to resist male pressures, especially from young women's fathers, to conform to a (masculine) modelling of 'appropriate' femininity. Occasionally, mothers reported colluding with their daughter's need to 'go out and have some fun', although such conspiratorial behaviour was potentially threatening to parental harmony.

> Mum   Oh, it was nothing to go upstairs and fluff a pillow up and make it look as if she were in bed, so she could go out with her friends and have some fun. *Laughs.*
>
> HS   And would you do that for her?
>
> Mum   Oh, yes, I'd do that for her. I had to. I couldn't stand the misery of it. Her locked in and all her friends out having fun. It didn't seem right. It wasn't as if she weren't sensible. She had a good head on her, even then. Even when she were quite young. And my husband would put his head through her door and say, 'Oh good, she's not gone out, she's asleep!' He'd look in and see the hump in the bed and think she's in bed, she's all right... So then he'd go to bed... If he'd have gone in and shook her, Oh then, there would have been hell. *Laughs.* [...] He wouldn't think twice about the boys going off

> mind. First time she went away with the school, before she could go, he wanted phone numbers and a list of who she was with and would the teachers be there all the time...
>
> Angharad (Alys's mum) W

Limitations on freedom of movement, and hence on an individual's social life and the ongoing project of self-construction, have been described in relation to pregnancy (Longhurst, 1996), childbirth (Sharpe, 1999), and the transition to parenthood (Aitken, 1999). Parents in this study employed different strategies to protect their teenagers from what they understood to be unsuitable company and/or dangerous environments, and the first line of defence typically involved setting (different) restrictions for sons and daughters. Girls were generally required to be more explicit about where they were going and with whom; unlike their brothers they could not just go where they liked, when they liked. Girls were less able to negotiate going out alone after dark and hence night-time worlds were less accessible to them. Restrictions on certain activities limited girls' interactions with others, although this is of less significance than for previous generations, when the demarcation between behaviours considered 'girlish' and 'boyish' was more rigid. Nonetheless, girls were more likely to be restricted in their social contacts because parents preferred their daughters to associate with 'nice girls' rather than with 'slags'. This protected their reputations from being corrupted by others (Fox, 1977). That Angharad was willing to collude with her daughter, in deceiving her father, demonstrates an unusually high degree of mutuality and trust in their relationship.

o   Regret

Previous research suggests that many young women subsequently express regret for early and unplanned intercourse, particularly when this results in an unwanted pregnancy (Dickson et al., 1998; Wight et al., 2000). A small number of respondents in this study anticipated the restrictions imposed by early parenting and lamented the decline in opportunities for socialising with their peer group:

> I'm still gutted really. When I first found out, I was, like, oh no, I can't do anything now. My life is finished. I can't go out any more. Things like that. I used to go out with my friends all the time. We were a big gang. [...] I can't go out to pubs any more. I can't drink any more. I mean I can go out and socialise, but it's not the same seeing everyone else having a good time and you're just sitting there with a coke. It's not my idea of fun. [...] I get depressed thinking about it. I think, oh, I hate this. I think my life's finished. I've got twenty years of this.
>
> Alys, thirty weeks pregnant. W

Two years later, Alys confirmed her prediction that the quality of some aspects of her life has indeed diminished as a result of motherhood:

> HS   How would you describe your life now?
>
> Alys   To be honest, if I could go back, I would have waited to have him. I would have, because my life is not my own now. I don't get to do the things I want to do, like

before I used to go out all the time, you wouldn't see me for hours on end. I'd go out with my friends and have a laugh. But now I've got to work around him. [...] Like if I want to go out, I have to ask my mam to watch him or get somebody else to watch him or take him with me. I haven't got the option of just putting my coat on and going out any more.

Alys, son aged two years. W

Only very rarely, however, and usually only in response to particularly stressful events, did young women voice regrets about being a mother to their particular child:

She's been a right pain in arse. Yeah, she has. [...] I told her I don't want to be 'er mum if she carries on like that. *Laughs.* Lou, daughter aged nine months. SY

I told [ex BF] he'd have to take her [youngest daughter] 'cos I can't look after her. I have to get m'self sorted. I can't look after both of 'em. Not now I can't.
Jade, daughters aged sixteen and two months respectively. SY

Jade and Lou were amongst the poorest, most isolated, and most marginalised of all the young women. They had few friends and little access to the sources of support which might have alleviated some of the hardships they faced in their respective transitions to motherhood. In Chapter Eleven, I describe the circumstances surrounding Jade's decision to temporarily abdicate parenting responsibility for her younger child.

o   Disclosure and help-seeking: responses from maternity staff

Respondents who were not using contraception generally recognised the possibility of pregnancy when they failed to 'come on' with their monthly period. Contraception failure was more likely to delay help seeking behaviour because, believing they were protected, young women failed to notice the early signs of pregnancy. Lack of knowledge about the circumstances in which conception is possible was evident from accounts of events preceding pregnancy, for example, a belief that being 'due on' was protective against pregnancy was widespread:

At first I wasn't sure 'cos well, I had my period a few days after we had sex [using a condom, which burst] so it's like, oh well I thought, I won't be pregnant then [...] so I thought, well, there's no need to worry, but like obviously you can still get pregnant if you're due on [a period] can't you? Clare, thirty-eight weeks pregnant. SY

Delayed help-seeking reinforced negative stereotypes of pregnant teenagers and had consequences for antenatal screening and termination options.

I was on the pill. Then my periods started going a bit funny. I was bleeding at the wrong time, between my periods. I asked my mum and she said I should go to the GP. [...] I did a pregnancy test and it was positive. [...] Two weeks later the midwife feels my tummy and she

> says, 'No you're not ten or twelve weeks, I think you're twenty-four weeks. [...] You're too late now for any of the tests'. Lowri, three weeks after the stillbirth of her daughter. W

Confirmation of pregnancy was generally sought through established channels, including GPs and family planning clinics. Those who could afford to do so purchased over-the-counter pregnancy testing kits for self-testing. Making an appointment with a GP required young women to exercise considerable initiative, as most respondents were not in the habit of arranging their own diaries and nor did they usually instigate meetings with adults. Although most young women acknowledged the gravity of their situation, many reported they were nonetheless censured by health professionals and were made to feel 'stupid' when consulting them:

> At the doctors it was all, 'Oh dear, you're pregnant. You stupid girl.' That's how they made you feel. Lowri, three weeks after the stillbirth of her daughter. W

Dilys, Lowri's mother, was pregnant at the same time as her daughter. In the following excerpt she articulates her more positive experience of conferring with maternity staff and suggests the differences were age-related:

> The midwife sat down with me. She explained everything. She obviously felt she needed to explain and then I asked questions afterwards. I was given an opportunity to discuss anything that I wanted to discuss so there were no problems there at all. It was a very, very different experience from [Lowri]. It couldn't have been more different. It was a different midwife but I don't think that was the reason. I think it's because she's a teenager and I'm obviously older. Dilys (Lowri's mum), twenty weeks pregnant. W

Young women's mothers were ideally positioned to criticise the maternity care their daughters received, as their own maternity experiences were relatively recent and hence their knowledge about local childbearing norms could be said to accurately reflect local service provision. As I have explained in Chapter Four, the provision of maternity care has changed dramatically in recent years, with fragmented care, increased technological intervention, greater policing of women's bodies and lifestyles, shorter hospital stays, and reduced midwifery support being the norm. Midwives in contemporary practice are expected to have a more extensive knowledge base, to question pregnant women about an ever-increasing range of topics, and to maintain stringent records of their interactions with clients. Most importantly, they must provide their clients with sufficient information to ensure that they, and their employers, are maximally protected against potential litigious threat.

Respondents often complained that interactions with maternity staff, throughout their childbearing trajectories, left them feeling belittled and upset. The quality of communication in clinical settings has been shown to be related to positive health outcomes (Di Blasi et al., 2001) and in a changing NHS, patients are increasingly encouraged to air their views and to participate in clinical decision-making. This level of interaction is only possible, however, when the relationship between clinician and patient is based upon mutual respect and egalitarian principles. Indeed, 'successful'

doctor-patient relationships are those in which the patient is perceived as the expert on their own condition (Coulter and Dunn, 2002).

As I have previously suggested, respondents frequently suggested that (young) age was the reason for discriminatory treatment from maternity staff, although occasionally surprises were reported:

> So I took her to the surgery and she saw the GP. She wasn't chastised in any way because of her age. *Laughs.* I thought it would be an issue, but it's like if you're twenty-five these days you seem old. Anwen (Megan's mum) W

If all childbearing women were subjected to less rigid categorising by maternity professionals (for example on the basis of 'risk' factors including age, and individual perceptions of 'good' v ''bad' mothers), the process of deconstructing adolescent motherhood as particularly problematic might be made easier . It might also enable the circumstances (the 'how', 'why' and 'for whom' questions) surrounding an individual's pregnancy to be disentangled and taken-for-granted associations unpacked. For example, is young motherhood problematic because of premature childbearing, low educational attainment, or unmarried status? Or declining family values or individual female sexual transgression? Furthermore, is the 'problem' located with the teen mother herself, her child/ren, her family and kinship group, or the wider society in which she lives, and is this is an issue only when the teenager is still attending school, or when she is deemed irresponsible and incapable by virtue of her class, race and/or social standing? (Pillow, 2003).

Young women's narratives suggested that midwives were often dismissive of their relationships with male partners. Indeed, a small number of midwives were reported as refusing to include boyfriends' details in maternity records, and occasionally making inaccurate and unwarranted predictions about their clients' romantic relationships:

> What really got to me was that she [midwife] wouldn't put down that he was my boyfriend. She wouldn't put it down that I had a steady boyfriend. She told me it wasn't worth it 'cos I'd be split up with him before baby was born. She said, 'Oh they all do it, you'll be no different.' [...] Well [two years on] we're not split up. He's still my boyfriend. [...] We're engaged and we're going to get married. Alys, son aged two years. W

Midwives' projections concerning the longevity of adolescents' relationships were more transparent when they disapproved of partner choice. In this regard, they helped, however unintentionally, to shape stereotypes of young parents-to-be as feckless and fickle. The quasi-parental role many adopted in relation to their clients may also be considered inappropriate.

Young women, decision-making and personal agency: to keep, or terminate, the pregnancy?
A recent study of UK teenage pregnancies (Lee et al., 2004) revealed that more than 40% end in abortion, but that these statistics disguise wide variations amongst local populations, with very young

teenagers and those from affluent backgrounds, most likely to access this option (Dennison and Coleman, 1998). Abortion rates tend to be lower in disadvantaged areas, even though they have the highest rates of teenage conception. Abortion tends to be higher in areas where there is more extensive family planning provision, where the proportion of female GPs is higher, and where there is easy access to independent abortion services (Lee et al., 2004).

A number of respondents had friends and acquaintances who had undergone a termination, either voluntarily (and sometimes secretively) or in response to external pressure. Few studies have examined the long-term affect of abortion on young women, although the results of an early study (Sharpe, 1987) suggested that coercive decision-making may engender subsequent guilt and regret, and may also effect a 'rebound' repeat pregnancy at a later date – as reported by a more recent study (Seamark, 2001). Additional research in this area suggests that termination of adolescent pregnancy has a stigmatising effect (Lee et al., 2004) and may be linked to depressive illness in married adolescent females (Reardon and Cougle, 2002). The majority of teenage respondents and their close kin indicated that they were averse to both the prospect of abortion, and to considering adoption:

> You've got to have balls of steel to give up a baby up for adoption, or have an abortion. [...] You know that keeping the baby is a really, really hard thing to do, and you know your life is going to change completely, but to have an abortion, or to have to give the baby away to be adopted... Oh I couldn't. Alys, thirty weeks pregnant. W

Although the majority of respondents initially denied that they would consider termination, some suggested they might reconsider this option in the event of the baby being identified as having a problem for which there was no known medical cure:

> HS   So you think you if the baby was affected by Down's syndrome or Spina bifida you might have considered a termination?
> Alys   Yes, I would have had to, 'cos it wouldn't be fair on the baby if I kept it.
> Mum   Mmm. It's like, well, you can't carry this baby now, but, you know, she's young enough to have more, isn't it Alys?
> Alys and Angharad (her mum). W

Moral responsibility is thus repositioned, to take account of the baby's future and anticipated (poor) quality of life, alongside the teenager's youthfulness and the ease with which a (healthy) replacement baby might be conceived. References to potential fertility status were well received when they came from young women or their close kin; when health professionals made such comments, they were generally considered hurtful and/or offensive. Perhaps because of widespread antipathy to abortion, respondents expressed disappointment when this was the first, and sometimes the only, option suggested by GPs:

> I went to the GP for a pregnancy test. [...] She just said, 'It's positive.' That's all she said.

> There were no congratulations or anything. There was nothing. It was just, 'Well, do you want an abortion?' Beca, fourteen weeks pregnant. W

Young women's low expectations of health professionals may influence their (un)willingness to seek help in early pregnancy (Tabberer et al., 2000), although research has not specifically linked such reluctance to concerns about pressures to abort. As Elenor intimates in the following excerpt, negative attitudes towards adolescents may prevent some from hearing, and/or heeding, medical advice. It also makes it more difficult for them to decide the most appropriate course of action for themselves:

> The GP was horrible. [...] She told me straightaway I should have a termination. She said I was too young to be a mother. She said I'd ruin my life if I kept the baby. Then she said I'd be better having it adopted. [...] She put more on not having the baby than she did about actually keeping the baby. She was really terrible. [...] I know it's stupid but when they're like that with you it just makes you want to do the opposite. *Laughs.*
> Elenor, twenty-three weeks pregnant. W

A significant number of young women received incorrect information from health professionals about abortion. Some were misinformed about the upper legal time limit (twenty-four weeks), some were told they were too young, whilst others were told they required parental consent. Recent research revealed that clinicians particularly dislike requests for abortion beyond the first trimester of pregnancy (Lee et al., 2004), but this is problematic for adolescents who may be unaware of, or unable to admit to, the possibility of pregnancy at this early stage. Young women occasionally reported difficulties with doctors whose religious beliefs prohibited them from furnishing them with the information they needed to make an informed decision:

> I didn't like the GP. She said she can't discuss abortions because she's Catholic. I thought that wasn't very professional of her. It's her job isn't it? Rhian, thirty-seven weeks pregnant. W

It appeared that respondents whose doctors objected to abortion on moral grounds were not necessarily referred to another practitioner.

Some respondents were unwilling to consider abortion because of concerns that such interventions 'muck with your brain', and are potentially spoiling of sexual identity. As Alys indicates in the following quotation, the spectre of the post-abortion teenage 'tart' may pose a significant threat to the integrity of young woman's future sexual reputation:

> They tell you to have an abortion like it the easiest thing to do. It's like, 'Oh you made a mistake, you can get rid of it. You can have another one'. They don't tell you that it's going to muck with your brain. My mother's friend, her daughter's, fourteen. She got pregnant and she had a termination. And now she's a right tart. [...] Anything in trousers she'll sleep with.
> Alys, son aged two years. W

Most respondents recalled someone in their peer group who had been 'forced' to have a termination, or relinquish their baby for adoption, when they would have preferred to keep it. Narratives suggested that

some individuals were unable to 'move on' from these experiences, but retained an imaginative link with the aborted foetus (or adopted baby) and continued to seek information about its developmental milestones. As previously mentioned, rebound pregnancy following abortion was not uncommon:

> A girl I was at school with she had a termination. Her parents made her. [...] She's not moved on from it. It's sad really. All the time she says things like, 'If I'd have kept it now, it would be, how old would it be now? It would be about so many months old, it would be twelve months old by now...' She says that sort of thing all the time. Susan, six months pregnant. SY

> You see them on the telly, twenty years later and they're still upset about it and they want to find their children and things like that. It's something you can't let go of. [...] They give up the baby for adoption and then you find they've had four more kids, and then you think, but she left that kid go for adoption but then she had another four. You think why did she do that? Why didn't she just keep the first one? Alys, son aged two years. W

Whilst young women's mothers were influential in their daughter's decisions, most supported their preferences. Regarding abortion, both parties expressed concern for their future relationship in the event of a mother acting coercively:

> I told her she had options. I'm against abortion but that isn't my choice to make. [...] I think I could have put her off having an abortion because she will listen to me and be influenced by me, but I don't think that's fair. I think in years down the line she would have blamed me. [...] So it had to be her decision. Polly (Michelle's mum) SY

> You would never forgive your parents for forcing you to do it [have an abortion] would you? There's a rift then between you that's always going to be there. [...]
> Nia, son aged six weeks. W

Luci was the only respondent who volunteered that she initially intended to have a termination. When an ultrasound scan at ten weeks revealed she was carrying twins, however, she changed her mind and decided to go ahead with the pregnancy:

> It was a helluva shock when we found it was twins I was carrying, but then we thought we just couldn't not keep them. Luci, fifteen weeks pregnant. W

It is possible that young women resist the pressures to undergo a termination of an unplanned pregnancy as an alternative way of 'doing' femininity. That said, for many women of childbearing age the timing of pregnancy is rarely precise; it seems there is seldom a perfect moment to embark upon this life-changing, mind-altering, experience. Teenagers are no different. Rather than delaying motherhood on the off-chance that their circumstances might improve, poorer, and some ethnic minority, teenagers tend to embark upon their maternal careers earlier: there is perceived to be little

advantage in waiting (Ermisch and Pevalin, 2003a). What is more, at least some of these young women actually end up doing rather well (Furstenberg et al., 1987).

Family dynamics: interactions with, and between, adolescents' families

Whilst most young women's parents played a central role in the young couple's transition to parenthood, prior to the baby's birth the parents of young men tended to be background figures, uninvolved in day-to-day events. It may be that the absence of the young men's families reflects the orientation of my study, which did not seek their direct involvement (although individual family members occasionally contributed to data generation). However, parents of young couples, although sometimes familiar with one another by reputation, had often not met prior to the pregnancy. Some parents were unaware that their sons and daughters were in a relationship, and, indeed, one young couple became formally engaged but withheld this information from the young man's parents for some months:

> [...] me, and [BF], we've been engaged since Christmas day and he didn't tell her [mother] about that at all, but then she found out last month and she wasn't happy at all. Alys, thirty weeks pregnant. W

Mothers displayed a range of responses to the young men with whom their daughters consorted. Some welcomed them, regarded them as 'family' and encouraged them to take a full and active role in domestic life. Sometimes, however, the young man's family was regarded as 'other', as unacceptably different. When such differences were explained, they tended to be ascribed to disparities in class and (higher) parental expectations regarding the young man's future:

> He's the only boy. [...] His father's a headmaster. [...] But they're not better than us. They're not. You know what I mean. You see [BF] and you see his parents and you wouldn't think they were from the same family. You wouldn't think he was from that family... [BF] is more ordinary. They're a bit... They're a bit stuck up... Alys, thirty weeks pregnant. W

> They've just got different ideas haven't they? They've got different ways, different opinions like. They're a different lot from us. Glenys (Beca's mum) W

Differences in family status were most remarked upon by the Wales cohort. Mothers of young women sometimes (unfavourably) compared the relationship they had with their daughters with that between young men and their mothers; exposure to the young woman's family was seen to had a maturing effect on the young man:

> Mum   He [Alys's BF] hasn't got the sort of relationship with his mother that she's got with me...
>
> Alys   His mother's of the old school. From what I know she babies him. [...] She won't let him grow up. [...] I think she likes keeping him a baby. He's very quiet. [...] He's a bit more rugged now mind, after being round us... *Both laugh*

Angharad (Alys's mum) W

During pregnancy, male partners generally spent more time in the young woman's home than the reverse. Once the baby was born, however, the newly constituted family spent increasing periods of time in the young man's household. The majority of young men's parents showed an interest in their grandchildren's development and some became very involved, providing childcare and supporting the young family in other ways.

Kinship networks, especially between female relatives, played a pivotal role in the lives of most respondents, providing them with ongoing practical, financial, social, and emotional, support. For those without access to this resource, life was grim indeed. The absence of female kin during pregnancy and the early years of children's lives worked against young women's early assumption of a competent maternal identity. The historical significance of mother-daughter bonds, and the support provided by these connections, has been well documented (Bourke, 1994; Roberts, 1984), as has the importance of extended kinship networks, and their 'ordinariness' in the lives of previous generations of working-class people (Young and Wilmot, 1957). Research within areas of the UK with traditionally high rates of teenage pregnancy contradicts the stereotype of single, socially isolated schoolgirl mothers, concluding instead that young mothers are generally well supported within these (working-class) communities (Ibbotson, 1993; MacLeod and Weaver, 2003). Where such support is not available from family networks, 'the main conclusion to be drawn [...] is that offering socially disadvantaged "at risk" mothers additional support during pregnancy has a positive impact on measures of children's health status and family well-being seven years later' (Oakley et al., 1996:20). Hence, the presence of good social support throughout the transition to motherhood has long been associated with a reduction in many of the more negative outcomes associated with early childbearing (Barth et al., 1983). For the young mothers in this study, kinship networks and discourses of childbearing were grounded in class, gender, and locality-based relationships (Mitchell and Green, 2002), which generally promoted affirmative, and adaptive, responses to unexpected pregnancy.

CHAPTER EIGHT: THROUGH PREGNANCY

This chapter documents young women's embodied experiences of pregnancy, including the early, physically experienced, signals that something was awry. It explores respondents' perceptions of maternity care, the operational boundaries of inclusion and exclusion, and the more overtly 'performative' aspects of teenagers' encounters with maternity staff and institutional regimes.

The physicality of pregnancy: daughters' and mothers' interconnected experiences

Adolescent status afforded little protection from the physical discomforts of pregnancy, particularly morning sickness and tiredness. Although physical indicators were generally accepted with the pragmatism I came to associate with teenagers, many were nonetheless surprised by the intensity of symptoms:

> I had it [morning sickness] quite bad [...] it was terrible. I'd be going down the street but then I'd have to come back home and lay down. I felt sick all the time. I couldn't eat anything. I couldn't bear the smell of food. It was terrible. Elenor, twenty-three weeks pregnant. W

> I was just feeling tired and whatever all the time and it just got worse really. I was feeling more and more tired. Eventually I stopped going to work because I couldn't get up to go to work. Lowri, three weeks after the stillbirth of her daughter. W

One sign of pregnancy, which respondents viewed with a mixture of irritation and amusement, was food cravings. Jade referred to herself as 'mad keen on pickled onions' whilst Alys 'couldn't stop eating liquorice allsorts'.

Some mothers reported feeling physically connected with their daughters through the pregnancy-related sensations that they themselves experienced. These feelings were unexpected and did not seem to mirror previous childbearing experiences:

> I feel like I'm having this baby as well. *Laughs.* It's like every little niggle she [daughter] has she tells me and I know what she's feeling. It's like I feel it with her. [...] It's really weird. When I had mine I didn't feel like this. [...] When you're pregnant yourself, you're pregnant and that's that. [...] But this baby [...] It's really weird. It's a really nice feeling. *Laughs.*
> Anwen (Megan's mum) W

> Chris   Every time she says, I'm feeling this or that, I think well, yes, I've been feeling that as well. *Laughs.*
>
> HS   Would you say it's the same sort of feeling as when you were pregnant yourself?
>
> Chris   No. No not at all. I think when I were pregnant I knew I were pregnant, so I were sort of expecting to feel things. But with her, it's like I know it's her that's pregnant but then I'm feeing it like I were. *Laughs.* It's more like, it's like it's an all-over thing. I can't explain it any better than that. *Laughs.*
>
> Chris (Clare's mum) SY

The embodied sensations mothers reported seemed different from the more commonly described masculine experiences known as 'couvade' (from the French *couver*, to 'brood' or 'hatch'). Albert Doja (Doja, 2005), quoting the early works of Edward Tylor (1889:254) describes the couvade thus: 'the father, on the birth of his child, makes a ceremonial pretence of being the mother, being nursed and taken care of, and performing other rites such as fasting and abstaining from certain kinds of food or occupation, lest the new-born should suffer thereby' (Doja, 2005:918-9). Whilst couvade has a long anthropological history, only recently has it been considered a stress response manifested by men when exposed to the events of maternity (Thomas and Upton, 2000); more recent research proposes a physiological basis (Bartlett, 2004). Couvade, or 'sympathetic pregnancy syndrome', is a relatively common, but poorly understood, phenomenon whereby the expectant father experiences somatic symptoms during his partner's pregnancy, which typically resolve once the baby is born. Unlike expectant fathers, however, teenagers' mothers in this study did not report a match in pregnancy-related 'symptoms' with their daughters, but, rather, a more global feeling of 'connectedness' which anticipated the baby's future presence.

Observing their daughters' progression through pregnancy prompted many mothers to reflect on their own childbearing experiences and relationships with their mothers, a generation for whom reproductive talk was generally proscribed. As Angharad explains in the following excerpt, her uninhibited relationship with her daughter bore no comparison to what she had experienced with her own mother:

HS   What kind of relationship did you have with your mum, Angharad? Would you've been talking to her like you do with Alys, you know, sharing stories about sex, having babies and stuff like that?

Angharad My God no. Oh no... *Laughs.* You couldn't talk with her about sex. You didn't even talk then about having babies. You just had them and that was that. [...] The sex word I never ever heard mentioned in our house. It was forbidden. You didn't talk like that. [...] I remember when I first started my period. I was about twelve and a half. I was at the comprehensive school. I couldn't go to my mother. I was terrified. I went to my sister-in-law but she just laughed at me and then she marched me straight to my mother. I'm cryin' like and sayin' to my mother, 'I'm sorry, I'm sorry...' I didn't know what for like. Stupid now, isn't it... But I didn't know... It wasn't told to you then. [...] Not like with Alys. *Laughs.* Oh, she knew all about it [menstruation]. All excited she was when it happened, wasn't it Alys? *Laughs.*

Angharad (Alys's mum) W

Ignorance about sex and reproduction, and communication taboos, made it difficult for many women in previous generations to access appropriate help and support when they suspected pregnancy. In the following excerpt, Michelle's mother describes attitudes prevalent in her adolescent years, when the chaperoning of daughters by fathers was common practice, and sex outside marriage was unthinkable:

I were scared to death. We all were 'cos it were all illegal then. Only married people had sex then. [...] And if you ever got pregnant - look out! You'd end up in workhouse. That were the end of you. *Laughs.* [...] If you went anywhere your dad went with you just to be sure like. *Laughs.* Polly (Michelle's mum) W

Liberated from the etiquette norms of their forebears, many mothers in my study re-lived their childbearing experiences through their daughter's emergent maternal identities.

Respondents and maternity staff 'doing' antenatal care

At the time I started this research none of the maternity units attended by respondents made special provision for teenage clients. Most young women encountered a different professional at each antenatal consultation and, in labour, the majority were attended by unfamiliar midwives. At the conclusion of my study, a consultant midwife with a specific remit for teenage pregnancy was appointed in one of the research areas and anecdotal information suggests that her presence rapidly became a much valued and sought-after resource. Indeed, two respondents, whose older sisters became pregnant after they themselves were mothers, spoke enviously about the 'better deal' their sisters received. This created tensions because older sisters were perceived to have less need of additional support.

Fragmented maternity care was problematic for the most marginalised young women because they tended not to be consulted about changes to arrangements in care provision.

HS   So it wasn't your choice to switch to X [another community midwife]?
Tracey No. I didn't have nowt to say about it. I'd have rather stayed with [community midwife
        with whom Tracey had originally booked] but she said she were too busy. [...] She
        told me she were changing me to other midwife. She just crossed her name off my
        folder and wrote in other lady's name. I didn't like it. I didn't think she could do that but
        she did. She didn't even say sorry or nowt - like it weren't nothing to her...
Tracey, twenty-nine weeks pregnant. SY

During my follow-up interview with midwife X, it became apparent that she had not been consulted about managerial decisions to rearrange her caseload and she was unaware that Tracey preferred to stay in her care. This mirrored how midwives themselves were made vulnerable by practices within their employing organisations, where their opinions were rarely sought, or were largely discounted, by more powerful others. Meanwhile Tracey, who had hitherto not missed one antenatal consultation, started to skip appointments and by late pregnancy was referred to as a 'non-attender'. The Department of Health's clinical guidelines (Department of Health, 2003) currently suggest that staff offer pregnant women seven to ten consultations over the course of pregnancy, according to individual need. This represents a steady reduction in contact time between midwives and pregnant women and fails to take account of the increased volume and complexity of information to be disseminated (Stapleton et al., 2002a). The 'Informed Choice' study (Kirkham and Stapleton, 2001) indicated that the more pronounced the hierarchical distance between staff and client, as measured by variables including age, ethnicity and social class, the greater the tendency for staff to withhold information and to talk 'over' clients as if they

were non-existent. I was particularly alert to this behaviour when it occurred between childbearing women and midwives, because of my expectation that women-to-women[85] encounters would be less influenced by gendered power relations and, hence, would be qualitatively different. When mothers accompanied their teenage daughters to clinic appointments, I observed midwives conducting their conversation exclusively with the older women. When young women's mothers were unable to attend appointments with their daughters, midwives tended to direct their questions to me. This was despite in-depth explanations about the purpose of my study, including my observer role. The following excerpt from my field notes typifies these interactions:

CM1   Oh dear, she's got her hands full hasn't she? *[The midwife looks in my direction and addresses her comments to me]* With two to look after now it's not going to be easy for her is it? [...] Has a social worker been allocated do you know?

HS   I don't know. You could try asking Jade herself. *Laughs.*

CM1   Do you have a social worker then, petal?

Jade   Mmm. Yeah. Its same one I had before.

CM1   Good, 'cos I just need to get a referral off to health visitor as well. Do you know where she'll be living after she's had the baby? [Once again, the midwife looks in my direction and addresses her question to me.]

Community midwife and Jade, thirty-eight weeks pregnant with her second baby. SY

Midwives were not alone in their tendency to usurp teenagers' agency and hence limit their potential contribution to maternity care proceedings. With the possible exception of social workers, with whom some young women had a previously established relationship, many health professionals were observed, or were reported as, acting in a manner many respondents interpreted as punitive and judgemental. Whilst health professionals may not have intended to cause offence, their behaviour nonetheless upset respondents. Repeated experiences of being ignored also diminished young women's willingness to engage actively in decision-making processes, with a potentially negative impact on maternity outcomes.

Aneez Esmail, quoting from Vikram Seth's novel 'A Suitable Boy', makes the point that it is not so much the prejudices of 'bad' people that are problematic in the health services but rather the intolerances shown by individuals deemed to be 'good' on account of their education, accent, and other such markers of elevated social status: 'what [such] people *think* is not what matters – what they *do* is what matters, and in that respect the [medical profession] in the United Kingdom has a long way to go' (Esmail, 2004:1449 emphasis added). I would extend Esmail's comments to include midwives, whose negative behaviour has been attributed to working conditions where they are 'ruthlessly manipulated' (Mason, 2000:247) by the demands of general management. Whilst all NHS staff might argue that they suffer the incursions of management into their respective spheres of practice, doctors are arguably better protected than all other professional groups because, at the point of entry into the NHS, they

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[85] Whilst I acknowledge that there are a small number of male midwives in clinical practice, I did not encounter any during my study.

negotiated contractual arrangements which continue to ensure their professional autonomy and to protect their privileged status.

Mothers were widely appreciated as important sources of embodied childbearing knowledge. For their part, daughters were valued translators of technical knowledge:

HS   And did you read any of this information, Polly?
Polly   Oh yes. *Laughs.* I had to. I was told to read it, by miss [Michelle] here! *Laughs.* I didn't have an option. She told me I had to. *All laugh.*
HS   So why is it important for your mum to read it Michelle?
Michelle Umm... So she can understand. I know lots of things have changed from when she had us. Like scans and machines, things she never had when she were having us. I know it's all different now, but I just want her to understand what's going on now and how things are different, so she can help me. So she knows what to expect.
Polly and her daughter, Michelle. SY

There's still a lot that's the same as when I had mine. They use some different words now but soon as she [Alys] explains it to me, I can say 'Oh, but that happened to me, too.' [...] She takes the logic out for me. I can understand it if it's put in common-sense.
Angharad (Alys's mum) W

Rephrasing technical concepts in the language of 'common sense' enabled some mothers to re-interpret their own childbearing experiences in the light of current practices. For daughters, the process of dismantling and re-presenting the 'logic' of maternity events in light of their unfolding experiences, provided them with opportunities to breach the discursive space of rational thought and conventional childbearing wisdoms. Some young women were observed breaching communication conventions by initiating conversation, soliciting information, and/or questioning a health professional's viewpoint. Such contraventions, although relatively rare amongst pregnant teenagers, tended to be (mis)interpreted by staff as challenges to their authority:

I think with your first baby, with health professionals, you do tend to feel intimidated. If they tell you something, you're not supposed to turn round and say, 'Well I disagree with you'. Especially when you're young, that's not an easy thing to say, not really.
Lowri, three weeks after the stillbirth of her daughter. W

You're not a baby any more but that's how they [midwives] make you feel. They should just be telling us, look, this is what we think you should be doing, but it's up to you if you do it. If you don't want to do it, well, that's your problem. But they don't. They make you feel like you're a baby. Like you're not a grown up at sixteen.   Susan, thirty-six weeks pregnant. SY

Most respondents were very sensitive to the unspoken rules of conversation etiquette which characterises institutional exchanges. Rather than risk possible censure, however, teenagers tended not to question staff but turned to their mothers for advice and information. When mothers were unable to provide answers, the more literate and confident young women consulted alternative sources, including other females, books, and the media.

Staff appeared limited in their imaginations, regarding age-appropriate treatment of maternity clientele, occasionally confusing mother-daughter identities:

> Some of them you can see they think. Oh, who's that old woman with her then? Must be her gran she's brought along with her! *Laughs.* And they're probably saying the same about her [Susan]. You know, 'Look at her now, don't she look young!' Stupid isn't it that they can't just treat you as normal. Margaret (Susan's mum) SY

The word 'normal' has been described as a 'faithful retainer, a voice from the past [...] one of the most powerful ideological tools of the 20th century' (Hacking, 1990:161-169), serving as a yardstick against which previous experience may be compared. The concept of 'normal' is a relatively recent invention, which assumes that a person has a basic repertoire of 'cognitive, psychological, emotional, and social skills' (Wong, 1997:278). To be read as 'normal' requires the individual to subscribe to normative values, at least on a superficial level, because this protects them from being mistaken for deviant or atypical. To be normal then, is to be 'good' (Wong, 1997:278) although the term tends to obfuscate the 'fact/value distinction' (Hacking, 1990:161) and hence to effectively mask power relations.

Although young women often appeared unresponsive when faced with the stereotyping behaviours of maternity care providers, they were not unaffected. Subjectively, to be labelled in ways which diminish one's sense of agency is to be personally discounted; it is as if one's history and experience have no value. Whilst such experiences are not peculiar to adolescent women, they appeared to have fewer coping strategies. At different times throughout this study I asked young women what it felt like to be young and pregnant, and to access maternity services. The following responses are typical and reinforce what is a recurring theme in this thesis, that it was the relational, not the physical, aspects of childbearing which most respondents experienced as problematic:

> Yeah. Well... It wasn't very friendly at all. It wasn't a very good experience really. Pregnancy was easy. I found that part really easy. [...] It was the midwives and the doctors that made it not a very good experience. They looked at me like I wasn't old enough to have sex. They were like 'Oh, you shouldn't be having sex anyway! You shouldn't be pregnant!' It's all your own fault sort of thing. Alys, son aged two years. W

> They [staff] look down on you. You can see 'em thinking, 'Oh, she's just a slut. She's a right slapper she is.' Tracey, thirty weeks pregnant. SY

The accents of maternity staff, and the technical language they used, were also problematic, especially for young respondents. Doctors' accents were described as particularly challenging and the problems some teenagers experienced were compounded by their low educational attainment, and in the case of one respondent, mild hearing loss. Although I observed the difficulties teenagers experienced trying to communicate with doctors who spoke heavily accented English, and indeed I had experienced similar

difficulties myself, it was not easy to engage young women in discussions on this issue. It was Megan who alerted me to concerns about such talk being (mis)construed as racist:

> I couldn't understand anything 'cos he, like, mumbled all the time and then he had this awful accent. I mean, don't get me wrong, I'm not racist or anything, but he was so hard to understand. I was trying to listen really hard but I still couldn't understand him.
> Megan, thirty-six weeks pregnant. W

Asking staff to repeat themselves was not a favoured tactic, not least because teenagers wished to avoid being constructed as 'rude' or 'stupid' with perhaps further erosion of an already fragile identity:

> HS   Some of the other teenagers said they've had problems with not understanding maternity staff 'cos of their accents. Has that been a problem for you?
> Clare   Yeah I'll say it has, big time. *Laughs.*The doctor I saw last time, her accent was so strong I couldn't understand a word she were saying. I kept saying, 'Pardon, pardon...' [...] You think afterwards, 'Well I didn't get half of that', but then you don't like to ask them to repeat themselves all the time 'cos then it sounds like you're being rude, or you're just stupid or something. .
> Clare, daughter aged three weeks. SY

Additionally, respondents were concerned about the implications of failing to grasp information considered essential to 'knowing what's going off':

> I felt a bit cheeky saying all the time, 'What? Sorry I can't understand you, could you repeat that please?' I think you can only say it once, then you feel a bit ignorant, like they'll think, 'Oh she's not paying attention.' [...] It's really hard, 'cos when you can't understand then you don't know what's going off, do you? Rhian, thirty-seven weeks pregnant. W

I judged the majority of interactions I observed between young women and midwives to be mediocre in terms of the overall quality of exchanges - an assessment which was repeatedly confirmed by respondents. Occasional exceptions were noted. Exceptional staff did not judge respondents on the basis of age or appearance, but focused on pregnancy-related matters. They assumed teenagers might feel nervous and perhaps frightened to be facing both an unplanned pregnancy and an unknown health professional, and attempted to put them at their ease by: keeping to scheduled appointment times; making eye, and sometimes physical, contact; offering them a drink where facilities permitted; asking whether, rather than assuming that, young women would want their mothers and/or boyfriends present at consultations; directing questions at young women themselves rather than at others; providing good quality information and following this up by asking questions and actively soliciting responses; and exercising restraint when requesting sensitive information. I observed one such midwife undertaking a

booking consultation[86] with a young couple; the following excerpt is taken from my fieldnotes:

> The community midwife greets the young couple by name, shows them into the consultation room, invites them to sit down and then asks if they'd like a coffee(!). They accept her invitation. As I am familiar with the layout of the building I offer to make the drinks. The midwife suggests that I also fetch the tin of biscuits she keeps for special occasions. When I return, the midwife has started the consultation. She is very focused on the young couple and barely acknowledges my re-entry. I distribute the drinks, leave the biscuit tin open in front of the threesome and retire to my chair in the far corner of the room. The midwife has moved her chair round from behind the desk and sits alongside her clients; she makes a lot of eye contact with them, smiles frequently and encourages them to participate in discussions by making openings for them and waiting for them to speak. She leans back in her chair and acts as if she has all the time in the world (although I know she is extremely busy and has a large caseload of women in her care). Each time she makes an entry in the maternity record she explains what she is doing and uses the opportunity to translate medical terminology - for example *primigravida*. She frequently reminds the young couple to tell her if there are words they don't understand. Towards the end of the consultation both young people are spontaneously asking questions: the young man asks what *foetal* means; his partner asks about *mongol* babies and this leads into a discussion about the pros and cons of antenatal screening. The midwife reiterates the need to 'read everything we write in your notes and if you don't understand it, or if you think we've got it wrong, then you must tell us.' She introduces the topic of blood tests by saying that all tests are offered, that the majority of these are 'what we call routine, for things like your blood group, iron count, to see if you're immune to German measles, and to see it you've ever had illnesses like hepatitis'. She adds that 'most pregnant women have all of them but that doesn't mean you <u>have</u> to have them.' Before the midwife delivers each package of information, she invites the young couple to tell her what they already know about the subject. The midwife closes the consultation by congratulating the young couple, telling them how 'good' they look together and what 'marvellous parents' she thinks they will make. Later that evening, as I am writing up my fieldnotes, I regret having not told this midwife how marvellous I thought <u>she</u> was and that if I were pregnant, I would want her as my midwife.
> Fieldnotes, observation with community midwife CM18. W

I accompanied this midwife for two days and observed her interacting with clients and championing their rights to articulate their needs and to assert their rights. Unlike other midwives who 'protect' clients by avoiding truth-telling, or lying[87] outright to facilitate, or block, their preferred choices, this midwife confronted obstetricians and powerful others on the occasions she considered that their actions or

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[86] This generally takes place between ten to twelve weeks of pregnancy. In addition to taking a medical and reproductive history, the location of this visit, within the private sphere of the women's homes, permits midwives to make moral judgements about their client's domestic circumstances and hence their 'fitness' for motherhood. The time required to complete this consultation is significantly greater than for subsequent consultations due to the (ever-increasing) amount of information midwives are required to collect from, and disseminate to, pregnant women.

[87] Examples I observed, or were reported to me anecdotally, included midwives recording lower than measured blood pressures; advancing the time labour commenced; inflating, or understating, the rate of cervical dilatation; advising clients to refuse to comply with management directives, for example to leave the bath for routine vaginal examinations, or indeed to give birth. I also observed midwives lying and colluding with medical management in order to protect their own interests, for example by reporting blood pressures, temperatures and foetal heart measurements as elevated when in fact, recordings were within the normal range. Colluding with management against a client's best interests most commonly occurred when a midwife anticipated that a particular client might require her to practise outside her clinical 'comfort' zone.

decisions were unreasonable, their practice was not based on credible evidence, or their rules and regulations were detrimental to her clients' best interests.

The literature describing the midwife-client relationship focuses on the 'femaleness' of women's interactions, and, indeed, the formation of a 'partnership' between women and female midwives is a cornerstone of New Zealand midwifery (Freeman et al., 2003), a country where practice is acknowledged as extremely progressive. Male partners tend to be peripherally positioned and then only in relationship to their female partners, rather than to midwives. The community midwife I described in the previous excerpt was unusual in that she welcomed male partners by name and actively encouraged their participation. She did not permit them to dominate proceedings, but rather acted as if she *expected* to form a relationship with them and that this would be reciprocated. Young fathers are largely invisible in statistics on teenage pregnancy: 'there are no population-based data on the age at which fatherhood starts, compared with the voluminous statistics on motherhood and female fertility' (Quinton et al., 2001:2). With respect to maternity care, whilst the presence of middle-class men has become increasingly prominent, the opposite is true for working class men, particularly adolescents (Tan and Quinlivan, 2006), and those from black and ethnic minority groups (Higginbottom et al., 2006). For these groups, the maternity environment is generally experienced as unfriendly and intimidating.

Economic barriers, employment demands, lack of public transport, and constraints imposed by living separately from their girlfriends, meant few young men were able to accompany their partners to antenatal consultations. Exclusion from maternity proceedings angered and frustrated some male partners:

Gavin   I've never even seen the midwife. I don't think she knows I even exist. *Laughs.*
HS   Is that because you're at work when Luci goes to see her?
Gavin   Yes and I can't take time off to go to the hospital. [...] I haven't been told anything. [...] I think the partner should be involved [...] I've not been to any meetings or anything. All the meetings are when I'm at work and they won't give me time off so how the fuckin hell can I go?
Gavin (Luci's boyfriend) W

Us dads are in minority, right, but we're still here, some of us. We've still got something to fucking count for haven't we? [...] It's like we don't exist. [...] Dads get completely ignored, they're just not seen as part of the picture. Fade out. That's us. Pete (Lou's boyfriend) SY

They think we're tossers 'cos we're at work aren't we, when they're with 'em [their girlfriends]. [...] We're nowt but worthless dross for 'em. On the dole, laying about, that's what they think. You can see it way they look at you, like you're scum. Ryan (Michelle's BF) SY

Although I did not specifically seek young men's views, on the occasions they were at home when I called to interview their female partners, I encouraged their participation. A proxy version of their views was also available through the discourses provided by their female partners. I could find no research

which explicitly addressed young men's experiences of antenatal encounters with health professionals, but studies which have examined transitions to fatherhood generally conclude it is a negative experience (Lupton and Barclay, 1997; Bradley et al., 2004), with men generally taking a 'backseat' in proceedings. In particular, the fathers of teenage mothers' babies have been noted as 'shadowy figures' (Lawson and Rhode, 1993). Professional guidelines reinforce the centrality of women in all phases of parenthood transition, rarely portraying fathers in nurturing or supportive roles (Carpenter, 2002). This is problematic for young men, many of whom have previous experience of being excluded by, and from, mainstream services. Although most young men voiced intentions to 'stick around' and assume a parental role, the transition to fatherhood was never going to be easy for the most marginalised. Experiences of the maternity care system appeared to reinforce their limitations in this respect.

Young women complained when the inflexible scheduling of antenatal appointments precluded boyfriends from accompanying them, not least because it encouraged speculation that 'unaccompanied' equalled 'single' status:

> There's lots of young girls round here that have babies without fathers and they [maternity staff] just assumed that would be me too. But my boyfriend, he's going steady with me. He works [...] The only time he's ever come with me, when I've seen the midwife, is when I was in hospital having the baby [which had died *in utero* @ thirty-three weeks]. He had a day off from work without pay for that but before then no-one ever saw him so they just assumed I didn't have anybody. Lowri, three weeks after the stillbirth of her daughter. W

Some young women intimated that boyfriends' absences during antenatal consultations increased relationship tensions, with male partners becoming 'right suspicious' when they were unable to control disclosures about what they considered to be confidential information.

Technological imperatives: antenatal screening and estimating the expected date of birth

Routine antenatal screening for all pregnant women had only recently been introduced in some study areas, hence respondents, and indeed some staff, were unfamiliar with what this entailed. Suggestions that the foetus might be damaged, and thus considered by staff as appropriate for termination, generated significant anxiety amongst respondents, not least because termination was negatively regarded across the sample. As no baby was diagnosed *in utero* with a congenital or other life-threatening/limiting abnormality, however, it is difficult to predict whether respondents' attitudes to abortion might have changed in response to such a threat. Attitude to abortion is not necessarily related to screening uptake (Green and Statham, 1996[1999]) and, with the exception of two young women, all respondents consented to antenatal screening.

Teenagers' mothers commented that they were only able to relax when their daughter's pregnancy proceeded beyond the 'worry stage', when screening for foetal abnormalities had returned a low risk result and an ultrasound scan revealed a healthy and viable foetus:

> I'm just glad she's got past the worry stage now... We can both settle down. [...] I'm enjoying it now. *Laughs.* The first four months were a real worry for me. She was coming to me all the time asking me things. She hadn't felt it wiggle so she says to me, 'When did you feel yours move ma...?' [...] And then there were all these tests they do now to see if the baby's all right. They didn't do them when I were having mine, so that's all new isn't it?
> Angharad (Aly's mum) W

Indeed, it was through talking to mothers that I realised the degree to which worry and fearfulness have become embodied aspects of how women in contemporary societies 'do' childbearing:

> I think I had two scans and four babies. But I didn't have the worry. That was the good thing. I carried those babies without the worry. [...] You didn't have a clue in those days what they [maternity staff] were talking about. No-one told you anything and if they did it went right over your head. *Laughs.* I think it were more relaxin' in my time. [...] With her [Alys] she's supposed to be understanding it all, and I think it's quite a strain on them, especially when they're young.
> Angharad (Alys's mum) W

For some respondents, participation in screening programmes generated doubts about the baby's well-being and viability before they had had such thoughts themselves. More importantly perhaps, it introduced them to medically derived conceptualisations of risk. In the following excerpt, Alys draws attention to a change in the midwife's attitude after her screening results assigned her a 'low risk' status:

> It's like you're a guinea pig. You <u>could</u> be carrying one of these babies but in their eyes, you <u>are</u> carrying one until they find out you aren't, but until then, until they tell you that you aren't, they treat you like you are carrying one. After they told me I was a low risk, they changed then. The midwives started to tell me about other things then, but before it was just all about whether my baby might have Down's syndrome or Spina bifida. Alys, thirty weeks pregnant. W

In the event of concerns being raised about the baby's viability and/or health, to the degree that the pregnancy was temporarily re-categorised as 'high risk', respondents tended to remain worried for the remainder of pregnancy even when such concerns were subsequently found to be spurious[88]. As something of an antidote to the anxiety generated by screening procedures, undergoing an ultrasound scan was generally regarded as a pleasurable, and positive, experience. This was especially the case for young men, who perforce relied on 'second hand' impressions to compensate for the embodied knowledge afforded their female partners. The ultrasound scan generated 'visual knowledge' (Draper,

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[88] It is now more than two decades since Fearn and colleagues (1982) illustrated the persistence of maternal anxiety once aroused. The current litigious climate is such, however, that health professionals practise defensively even though this may provoke unnecessary anxiety and increase intervention rates. It is no longer acceptable practice to convey information to pregnant women without also conveying an approximation of the attendant risks but as there is no standard definition by which maternity-related risk is assessed, and because childbearing women are vulnerable to suggestions that they might be exposing their babies to risk, it is unsurprising that discussions about antenatal screening are likely to provoke anxiety. This issue is further complicated by research (Teixeira et. al., 1999) which suggests a negative association between maternal anxiety and foetal outcome. Given the earlier work of Helen Statham and colleagues (Statham et al., 1997) which revealed that anxiety about something being wrong with the baby is very common amongst pregnant women, introducing additional notions of risk could reasonably be expected to accentuate the anxiety spiral.

2002:771) in the form of real-time, and photographic, images which seemed to help young men absorb the physical actuality of pregnancy and better locate themselves on the father-to-be trajectory.

Most respondents regarded ultrasound scans as social, rather than medical, events. The air of excitement which accompanied the 'first viewing', together with the purchase of the ultrasound photo - framed and printed with the baby's chosen name - confirmed this as a significant aspect of contemporary antenatal care packages:

> The first time we saw it, it was amazing. To see it on the screen like that. Ooh, it's so exciting the first time you see it. *Laughs.* I thought Oh my God, God, look at it...! Look at my baby...! Brilliant! It was brilliant. After it was finished she asked us if we wanted a photo. Which of course we did. *Laughs.* Alys, twenty weeks pregnant. W

The emphasis on the social aspects of scanning has implications for staff undertaking antenatal screening procedures because, unlike pregnant women and their families, staff understand these occasions to be diagnostic opportunities. Service users and their families, however, generally understand initial scans as benign and routine interventions; as opportunities to see the baby and confirm its health and well-being, rather than to identify potential problems (Green and Statham, 1996[1999]).

o Estimating the expected date of birth

Although many young women were able to cite the first day of their last menstrual period - information which dates conception with reasonable accuracy - this tended to be discounted by maternity staff. The greatly increased reliance on ultrasonography for ascertaining information about women's childbearing bodies has resulted in a gradual erosion of other ways of knowing; women's experiential knowledge has thus been largely superseded by the authoritative knowledge derived from reproductive technologies (Jordan, 1997). Respondents were frustrated when staff changed the expected 'due date' (of birth) without apparent reason and in the absence of consultation:.

> ...they kept giving me different dates. First of all it was the seventeenth and then it was the nineteenth [of May] when it was going to be born and then it was the twenty first and then it went straight to sixth [of June]. They told me different dates, every person I've seen. [...] I've had three different scans and they still don't know. [...] I still think I'm going to have it at the end of May. Beca, fourteen weeks pregnant. W

Luci	Yeah, and then they gave me a different date.
Gavin	Yeah, but there was a month's difference. A whole month! I thought that was quite a lot seeing as the whole pregnancy is only nine and a bit months.
Luci	Yeah, fifth of January I was given and now I've been given December the fifth.
HS	And what did you make of that?
Gavin	Stupid, that's what I think.
Luci	What they did finally was, they said 'Well, it's in-between the two'.

Gavin   It doesn't seem like they know a lot really. If you ask me, it's like the left hand doesn't
        know what the right hand's doing.
Luci, fifteen weeks pregnant, and Gavin (BF). W

Whilst early ultrasound scanning for pregnancy screening and dating purposes is now not only widely
accepted but also acknowledged as good practice, it cannot take account of the (wide) variation in
women's menstrual dates and hence 'actual gestational age tends to be overestimated' (Shennan and
Bewley, 2006:939). Indeed, earlier research suggests that as many as 25% of babies diagnosed as
already pre-term are found to be an additional week younger at birth than their scan-based gestational
age (Gardosi and Francis, 1999). In other words, despite the supposedly 'hard' evidence of maturity
provided by ultrasound scanning, approximately a quarter of babies are identified, at birth, as being at
least a week less mature than their predicted age (by ultrasound). Besides health and related
implications for the infants concerned - many of whom are already classed as 'vulnerable' - this has
serious resource implications for the NHS.

Resisting norms and conventions: antenatal 'education'

During pregnancy, many women attend NHS/private sector antenatal education ('parentcraft') classes,
which typically provide information about labour and the care of the newborn infant. Such classes play
an important role in the construction of (certain kinds of) mothers. Adolescent women, particularly those
who are single and unmarried are generally under-represented at these events (Cliff and Deery, 1997).
Mirroring the findings of earlier research (Howie and Carlisle, 2005; Rozette et al., 2002), most
respondents in this study expressed negative views about parentcraft classes and those who attended
on one occasion generally failed to repeat the experience. Some teenagers demonstrated considerable
skill at resisting midwives' attempts to include them.

Classes were dismissed as an irrelevance, because many young women had sisters or friends
who had recently experienced childbirth, from whom they sought 'no bullshit' information. Young
women's mothers were an additional source of advice which was generally considered more
appropriate and responsive to individual needs. Finally, many teenagers had been very involved with
bringing up younger siblings and/or other kin, and, hence, were well-versed in the practical skills of
childcare:

I think they're a waste of time to be honest. [...] I've looked after both my younger brothers and
I've fed my sister's baby right from the start. I've winded him, changed his nappies and
everything, so I know all that. Elenor, twenty-three weeks pregnant. W

One midwife was observed colluding with April's prediction that classes would not benefit her because

she was already a mother:

Well, as your baby's only nine months old, I'd say the classes would be a waste of your time, really. You'll know it all. It'll all be still pretty fresh in your mind, so I'd say it's not worth your while. Community midwife (CM15). W

Although the community midwife's stance could be interpreted as a giving credence to April's embodied and experiential maternal knowledge, her response undermines the value of classes as a potential vehicle for social networking, which might support vulnerable young women in the longer term (MacLeod and Weaver, 2003). Classes were often discounted because they focused on the forthcoming labour, an event from which many young women were more concerned to distance themselves:

HS Tell me more about what you think goes on at parentcraft classes?
Alys Parentcraft class is... Well, you go there 'n you drink tea and you talk about labour and things. But I didn't want to go and talk about it. Uggh... No way. I didn't want to think about it happening. Yuck! I knew it was going to happen. That was enough. *Laughs.*
Alys, thirty weeks pregnant. W

Teenagers identified breathing techniques, emphasised by staff as an appropriate method for managing labour pains, as particularly irrelevant, because such practices emphasised corporeal aspects of childbearing, which teenagers were seeking to avoid:

It's just the vision of how stupid you look. [...] like you're lying there on floor and you're doing all this breathing and looking really stupid 'n stuff like that. [...] It were nothing for me. It were just stupid things. *Laughs.* Jade, thirty-eight weeks pregnant. SY

The focus on physiological aspects of childbirth also detracted from the emotional and psychological support identified by earlier research as central to young women's needs (Coombes and Schonveld, 1992). Indeed, respondents themselves, especially those with minimal access to support, emphasised the importance of humour and the significance of social context in their lives:

I just wanted a laugh. There was one woman, she only had a day to go and I was just thinking, 'Oooh what if she dropped the baby here. That would be a laugh wouldn't it?' *Laughs.*
April, ten weeks pregnant with her second baby. W

HS If there'd been classes for younger girls might you have gone?
Jade Yeah, that would've been different. [...] If it were all youngsters you could have a laugh. Jade, daughter aged five months. SY

Many young women complained that staff attitudes made them feel 'stupid' although they themselves strove to avoid looking stupid. Maintaining a 'cool' appearance, considered essential in contemporary adolescent culture, was an important consideration for participants and hence activities which focused explicitly on the physicality of pregnancy, and which emphasised physical limitations, were not well

received. Stigmatising, threatening, or coercive staff attitudes were identified as particularly problematic; they also acted as a barrier to future participation:

> She [midwife] said 'Well I think fifteen and sixteen year olds shouldn't be having children' and then she just sort of looked at me. I thought, well I'm not going to say anything in the middle of a class but if that's what she thinks I'm not coming back.
> Lowri, three weeks after the stillbirth of her daughter. W

> Susan   She [midwife] tried loads of times to get me to go. [...] She were on and on about the classes this and the classes that. I said I didn't want to go but then she said she'd come and get me. [...] She said, 'If you don't come I'll come and get you.'
> Mum   Yes and she was right scared after that. *Laughs.* She'd not answer the door or the phone or nowt for ages after that. *Laughs.*
> Marg (Susan's mum) SY

Subtle forms of peer pressure also acted as a significant deterrent:

> I don't know anybody my age that's been to them. I don't think anybody ever said 'don't go', so I don't really know why I didn't go. Nobody I knew had ever been.
> Elenor, twenty-three weeks pregnant. W

Appreciating that antenatal classes suffered from an 'image' problem, a small group of midwives in one area created a teenage-friendly alternative. In the following excerpt, Nia's praise may be read as a eulogy to their success:

> ...the ante natal classes were brilliant, I was really impressed. I thought they'd be a bit old fashioned [...] [but] they were really interesting. They did games and stuff, they made them good fun. You could ask as many questions as you wanted, you could talk about anything.
> Nia, son aged six weeks. W

The publication of the Teenage Pregnancy Strategy (SEU, 1999) was instrumental in highlighting the need to create responsive, and appropriate, maternity services for young women and, to that end, a national midwifery network was established in 2001. With over five hundred current members, this group aims to establish a teen-focused maternity agenda for all childbearing adolescents in the UK.

    o   Aquanatal classes

In some areas, aquanatal, or water-based, exercises were available as an additional resource for pregnant women. Whilst such classes are generally highly regarded, and tend to be in great demand, the corporeal emphasis created difficulties for teenagers because such classes were only available in late pregnancy, at a time when self-esteem was fragile and body image in flux:

> There were those something she [midwife] said I could do at the swimming pool – 'aka' something *Laughs.* Oooh, but then she said you had to wear your swimsuit. [...] No way am I going. Not looking like this. I'm so fat. *Laughs.* Alys, thirty weeks pregnant. W

Given the significance of the body and its potential for (re)presentation during adolescence, image was a prime concern for most respondents. Many young women resented their inability to control their weight gain and the changes in body shape induced by pregnancy, and looked forward to birth as an opportunity to regain a sense of self. Being read as 'fat', rather than pregnant, was a particular worry and most respondents reported being 'pleased' not to have gained excessive weight. Unlike research undertaken with older pregnant women (Stapleton, 2006), the teenagers in this study did not report a sense of relaxation over the monitoring of their shape and body image during pregnancy but neither did they appear to engage in disordered eating practices to control weight and/or size. Although most respondents considered female fatness to be generally abhorrent, a range of understandings about size and body image were advanced by individual respondents, both for themselves and for other young mothers. For example, a considerable number of young women had figures which I would call 'solidly built' or 'well endowed', although this was not necessarily how they perceived themselves, as I realised when I was walking through a supermarket car park with Susan, twenty weeks pregnant and just beginning to 'show'. Susan stopped for a brief exchange with an average sized ex-school friend who was leaving the supermarket with bags of shopping and a toddler in tow. As we walked away, Susan shuddered and commented that she'd 'rather die' than end up looking like her friend whom she denounced as having 'gone to fat' following childbirth. Susan added that if hadn't known her friend was definitely not pregnant she might think, from her figure (which looked within normal parameters to me), that she was. Like many other young women, Susan wore crop tops and low-cut jeans which exposed both her pregnant belly and the 'handles' of flesh around her hips and midriff. Regardless of the weather or the time of the year, most teenagers in both localities dressed in this way, changing only for antenatal consultations or late in pregnancy, when a degree of relaxation over the self-management project permitted tracksuit bottoms and loose jumpers to be worn.

Respondents also expressed concerns about fatness/'overweightness' in relation to the side-effects of contraception, and during the early postnatal period, when body shape, size and 'texture' was perhaps more suggestive of pregnancy than of motherhood. These issues are discussed in more depth in the following chapter.

Corporeal events in pregnancy: threatened miscarriage, ill-health and self-harming behaviours

Many respondents articulated concerns about threatened miscarriage in relation to episodes of vaginal bleeding or abdominal pain, or when maternity staff initially failed to locate the foetal heart. Young women's mothers sometimes intuited when things were 'not quite right' before health professionals suspected anything was amiss. Young women who experienced pregnancy 'scares' tended to seek their mother's advice and reassurance before consulting a health professional:

> [...] I started bleeding at half three in the morning and I phoned her [mum] straight up and she said to me, 'Don't worry about it. I did the same thing when I was having you. Don't worry about it, we'll get you to the doctor's tomorrow morning'. Beca, fourteen weeks pregnant. W

Vaginal bleeding, which was generally considered 'out of place' in pregnancy, was viewed by young women's mothers as a particularly ominous sign, suggestive of imminent miscarriage:

> I know it's a long time ago, but when I was pregnant they always used to say, the sight of blood you must take seriously. They said you should always go straight away to be checked. But then here, with her [Rhian], they're not bothering with her at all. Why aren't they bothering? That's what I want to know. Gwyneth (Rhian's mum). W

> My mum was really freaking out because I started having like a period. I went to the doctors but they weren't that bothered so then my mum rang up the hospital.
> Michelle, seventeen weeks pregnant. SY

Vaginal blood loss was especially worrying for Michelle, because, prior to the onset of menstruation, she experienced an episode of heavy vaginal bleeding. Subsequent screening confirmed that Michelle, and all the female members in her family, were carriers for Trisomy 13. After Down's syndrome, these are one of the most common autosomal trisomies[89]. Staff attitudes to threatened pregnancy loss did not reassure respondents; they were framed as individuals with countless future reproductive opportunities:

> Every time I were bleeding I were panicking, thinking something's wrong and nobody's telling me. [...] We were all worried sick, in case I were going to lose it. I think the doctors didn't care if I did. They probably thought, 'Oh well, she's young anyway, she probably didn't mean to get pregnant so it doesn't matter if she loses it. She can have another one, sort of thing.'
> Michelle, thirty-seven weeks pregnant. SY

Fears about the baby's well-being were sometimes inadvertently generated through technical incompetence or technological failure:

> They couldn't hear the heartbeat and they were all standing there looking at each other, but then the nurse said the machine wasn't turned on. Then they were all smiling at me, all cheesy like, when they got the scanner working. They found it, but for a while I thought, oh, it's dead.
> Michelle, son aged three months. SY

As previously noted, once concerns had been raised about foetal well-being, respondents experienced difficultly quelling future anxieties. Daughters' experiences of pregnancy-related events often prompted mothers to articulate their own experiences of childbirth, and some reported this was the first time they had reflected on these traumatic events in any detail. Mothers who had experienced difficulties themselves worried that their daughters might suffer similar experiences and a small number reported that they attempted to shield themselves from further distress by suggesting that their daughters seek alternative sources of labour support. Such suggestions were often misinterpreted by staff and they invariably upset daughters. In the event of labour, however, most mothers were present and the majority

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[89] See http://www.soft.org.uk/index.htm

reported being overwhelmed with relief and happiness that they had been able to put aside unpleasant personal memories and support their daughters.

When problems did arise during pregnancy, some young women reported being 'palmed off' or made to feel 'stupid' by staff who pre-empted discussion by refusing to answer questions. This was particularly difficult when information was required about illnesses which threatened the continuation of pregnancy, for example, acute cystitis:

> I was in hospital [because of acute cystitis] and I was waiting for a scan and this didn't happen for three days. I was being wound up with people not telling me anything. [...] I don't think the Sister liked me. I think she thought I was just another stupid teenager that doesn't know which end of the packet the pill comes out. They never treat you like you're going to be a mother, just like a stupid teenager. Rhian, thirty-seven weeks pregnant. W

Being excluded from discussions about their own health and well-being was particularly difficult for unsupported young women because they had no-one to intercede for them and hence were generally unable to fully appreciate the implications of decisions which were made on their behalf, but without their involvement.

o   Differentiating symptoms of ill-health from those associated with pregnancy

The concerns mothers raised about their daughter's health were generally dismissed by health professionals as the inevitable, and inconsequential, results of pregnancy:

> HS   So you suspected there was something wrong?
> Dilys   Yes I did. It wasn't anything I could put my finger on. I just knew something wasn't quite right. In fact I was convinced something was wrong even though she'd [Lowri] just come out of hospital and they'd [maternity staff] said there was nothing wrong.
> Lowri   She [Dilys] kept telling me that I needed to go to the doctors again. I went to the surgery quite a few times, but then one doctor he said, 'Well you must just be having a bad pregnancy', so after that I didn't go back. [...] In the end I started thinking as well, oh well it [the vague feeling of unwellness] must be because I was pregnant. [...] In the hospital the doctors [...] they told me it was because I was pregnant. But then she [Dilys] kept saying, 'No, something's not right'.
> Dilys   If she hadn't been pregnant and she'd just gone to the doctor's with those symptoms something would have been done about it. It would have been investigated. It was just assumed that it was pregnancy [but] you know when your own child is ill. [...] It's that instinct, being a mother I suppose. [...] I'm a woman and to me what she was having was an illness. It wasn't pregnancy.
> Lowri and her mum Dilys. W

The results of an autopsy following the birth of her stillborn baby confirmed Dilys's suspicions: her daughter had contracted cytomegalovirus, a viral illness which her baby had also contracted, resulting in its death.

Teenage pregnancy is associated with a number of adverse medical outcomes (Cunnington, 2001; SEU, 1999; Tripp and Viner, 2005), but research about staff failing to take seriously the health concerns raised by pregnant young women, and their significant others, is lacking. It is possible that reproductive outcomes for this vulnerable group might be improved if service providers could be persuaded to listen more attentively, and respond more rapidly, to their complaints of ill-health during pregnancy.

o Changing habits: smoking, drinking, disordered eating, and self-harming

In contemporary Western societies the responsibility for maintaining a healthy pregnancy, and for ensuring a positive pregnancy outcome, is increasingly understood to be the sole responsibility of the mother. On her rests the duty to abstain from harmful activities and to prioritise the health and well-being of her baby-to-be at all times and indeed, over her own needs. Maternal liability for reproductive outcomes has become more pronounced following research linking the interuterine environment with health in adult life (Barker, 1992) and one obvious consequence of this research has been the tendency to shift attention ever further back in the life course so as to encapsulate the mother-foetus dyad. Hence, pregnant women must now strive to achieve optimal health status not only for themselves but also for those conceived, but as yet unborn. The bodies of pregnant women are thus 'acted upon', which is in keeping with their medicalised 'condition' (of pregnancy-as-illness), and their perceived role as mere containers or vessels for the foetus.

Smoking in pregnancy is known to be associated with poverty-related indicators, including an early exit from full-time education, unemployment, single or divorced status, and living in rented accommodation (D'Souza and Garcia, 2003). A number of respondents in this study were heavy smokers and, prior to pregnancy, were also regular and/or binge drinkers, although most abstained from drinking alcohol throughout the maternity episode. Few respondents were aware of the link between alcohol consumption in pregnancy and foetal alcohol syndrome (RCOG, 1999).

Respondents' efforts to stop smoking were largely unsuccessful, although most were aware of the deleterious effects, including increased risk of prematurity, low birth weight and stillbirth (Penn and Owen, 2002). Despite government targets for reducing smoking amongst disadvantaged pregnant women, there is a dearth of qualitative research on the smoking-related behaviours of *young* pregnant women. This evidence gap raises questions about the basis for current policies, especially smoking-cessation interventions (Graham and McDermott, 2006). Respondents who had commenced smoking in childhood experienced greatest difficulty in reducing their intake and/or ceasing altogether.

April   I don't drink much now anyway. Not now I have her [first baby]. [...] Before I had her I just used to sit in my room and drink and drink and smoke and smoke. [...] [If] I had the money I'd go down the pub with my mates and get as drunk as an idiot [...] we used to hold each other up like a pair of crutches. I used to drink eight double rums

and about three pints of cider. If I could afford it I'd drink Malibu as well. [...] I'd be totally legless by end of an evening. [...] We'd all just get totalled.

HS   And when you realised you were pregnant did you just go off alcohol or did you have to make a real effort to stop drinking?

April Oh no I had to make a really big effort. It was really hard. I love the drink. It's the thing that keeps me going. It's the same with smoking. I try and forget them but wherever I go there's an ashtray or a lighter or there's someone smoking outside and I'm away. I'm always craving one. I was eleven when I started smoking. It was my father's fault. He said, 'Go on have a puff of this. If you don't like it that's all right'. He said, 'Go on I won't tell your mother'. So I had a puff on his cig. Ever since then I've smoked. [...] Other people have the willpower, but I haven't got that. Drinking, that's not a problem, I can stop that. But stop smoking? I don't think I could do that. I haven't got the willpower.

HS   When it's really hard to give something up like smoking, how does it make you feel when the midwives and doctors go on and on at you to give it up?

April It depends on my mood. *Laughs*. [...] Sometimes I lie just to get them off my back. Before I got pregnant I was on like over forty a day, now it's like thirty a day. He [doctor] said, 'You could give up'. I said to him, 'Do you smoke?' He said no, and I said, 'Well you don't know what I'm going through'. He said, 'Well other people haven't got a problem giving up'. I said, 'Well I have, I can't give up'. I gave up for ten hours once [...] at the end of it I was, I was like... *Growls*.

April, ten weeks pregnant with second baby. W

April was not alone in admitting she lied to maternity staff, to 'get them off my back', a strategy which was often adopted when young women anticipated being rebuked or humiliated for 'bad' habits which they were unable to forego. This is not to suggest that respondents were unaware of the link between smoking and the negative consequences for their own health and that of their children, but, as Hilary Graham concluded from research over a decade ago, 'it was how women lived rather than what they knew which was the stronger predictor of their smoking status' (Graham, 1993a:101).

Respondents who smoked heavily experienced considerable distress on the occasions that they were hospitalised. The period immediately following delivery was often a critical time for nicotine-addicted teenagers, when their desire for a cigarette was overwhelming, especially following a long and physically gruelling labour. In the following excerpt, Lou attempts to persuade staff that a 'drag' is quantitatively different from a 'fag', and, when this ruse fails, she expresses an intention to resort to more devious tactics:

HS   How're you doing with the stress of not having had a fag for nearly twenty-four hours?

Lou   That's killin me that is! *Laughs*. All I want is like, two drags... But, like, when doctor come in, he said no fags. He didn't say I couldn't have three drags though. *Laughs*. He said a fag, 'cos you know with some people, you know a fag means different things, dunnitt? You could say, oh three drags ain't done nowt to you, but with t'other person it would be same as having whole fag... So I asked midwife if I could go for three drags and she says, no, you can't smoke at all. Your lungs are too bad. So I says to her, why can't I just go to smokers' room for three drags...? I think I'll go and hope she's not lookin'. I can't wait no more. It's killin me...

Pete I wouldn't. I don't think you should risk it. Not from what doctor said.

HS   What would you be risking?

Lou   He says... Doctor says if I have a fag I'm gonna be in intensive care by tomorrow morning. It's me asthma that's got so bad with me smokin 'n all. It's getting worse all the time... He says, I'm like, I'm sixteen years old and I've got lungs like I'm eighty years old.

Lou, first day following caesarean section. SY

When I interviewed maternity staff providing in-patient care for teenagers who smoked, I asked if they had ever considered whether the 'disruptive' behaviour some reported might be linked to nicotine withdrawal. I also enquired whether therapeutic initiatives, including nicotine patches, had been considered, at least for the duration of hospitalisation. Although some staff appeared interested in my proposal, none of those interviewed had previously considered this issue.

I did not make comprehensive enquiries about the prevalence of smoking by young women's male partners, although my own observations, and anecdotal reportage, suggested that the majority were also moderate to heavy smokers. Despite the increasing evidence that passive smoking is injurious to the respiratory health of infants and children (Cook and Strachan, 1997), expectant fathers are not generally targeted for smoking cessation interventions. This is despite the fact that parturition is widely viewed as a time 'when discontinuities in everyday life associated with the transition to fatherhood and the presence of a new baby provide opportunities for establishing new routines' (Bottorff et al., 2006). The gendered nature of smoking cessation programmes may thus be interpreted as an attempt to regulate and sanitise the pregnant female body, as much as a public health initiative to promote infant well-being. By characterising the consumption of alcohol and cigarettes as activities unsuited to 'responsible' childbearing, pregnant women are pressured to conform to a moral understanding of motherhood which privileges the child's future health and well-being over the mother's, but not the father's, continued indulgence in sensual and pleasurable activities.

Some boyfriends, and family members on both sides, regularly engaged in drug-related activities and indeed, a number had criminal convictions. There was no evidence, however, that young women in this study were involved in the 'dark play' (Schechner, 1993: 36) which posed serious threats to social status, and/or well-being. Indeed, most respondents voiced strong disapproval of such behaviours, and those with drug-dependent family members spoke passionately about the damaging effects of drugs on the lives of individual family members and on family cohesion.

Some young women reported having become progressively more dissatisfied with their body image, following the transition to adolescence. Whilst some teenagers admitted to having dieted, and others had engaged in brief episodes of self-induced vomiting to achieve desired weight loss, - which was never much more than a few pounds less than their current weight - no respondent volunteered information suggestive of an entrenched eating disorder. Tracey and Jade's self-harming behaviours however, were of a different order. Tracey had been hospitalised on numerous occasions, each time undergoing examinations and intrusive interventions for which no cause had ever been identified. Prior

to pregnancy she had made two attempts at suicide by overdosing on paracetamol. On two occasions during pregnancy she threatened to 'top' herself.

In times of stress, Jade severely restricted her food intake and had begun self-harming (cutting) when her abusive relationship with the father of her first baby ended abruptly, after he began an affair with another young woman. Following pregnancy disclosure, Jade was made homeless by her mother and at this point her disordered eating and self-harming behaviours worsened significantly. Improvement occurred only when she was re-housed and was able to access support from her landlady and landlord, and when she realised the potential consequences of her behaviour for her future relationship with her child:

Jade   When I first come here I hardly ate anything 'n I was hurting [self-harming] myself all
        the time but now [landlady and landlord] helped me talk about things. [...] They said
        it's not good for bubba if I don't eat 'n if I keep hurting myself, 'cos the Social
        [Services] can take bubba off me. [...] They just keep sayin' you have to think of
        bubba now. So that's what I'm tryin' to do.
HS   Is that hard for you?
Jade   Yeah. It is. There's so many things going off round ya, but what I try and do is just
        think about bubba. Yeah. That's helpin' me.
Jade, twenty-six weeks pregnant with first baby. SY

Social Services were invested with significant power in the minds of the most vulnerable respondents. Jade, April, Tracey and Lou all volunteered anxieties about their babies being removed from their care. This potential-for-action was independently verified by maternity staff.

The most marginalised young women in my study had tended to turn distress provoked by situations over which they had little or no control (eviction from home, abuse, inappropriate housing, insufficient money), against themselves. Their stories support the claim that 'anger directed against the self or others is always a central problem in the life of people who have been violated [although] "acting out" is seldom understood by either victims or clinicians as being a repetitive re-enactment of real events from the past' (van der Kolk, 1989: 391). There appeared to be few resources available within local communities to assist young women to manage the aftermath of the psychologically damaging experiences they had endured, sometimes over a period of many years. For example, two young mothers were referred to mental health services for psychological assessment and were subsequently identified as needing ongoing therapeutic help. The support they so desperately needed, however, could only be accessed on a short-term basis, and at an institution which provided neither transport nor childcare facilities.

Socio-spatial exclusion and maternity environments

Boundaries, as represented by the location and timing of consultations, for example, reinforce divisions between service users and providers. Within hospital settings, especially within labour wards, such divisions operate along spatial, class, and hierarchical lines. That certain places are freely accessible

only to certain categories of people (Sibley, 1995a), and that identities are spatialised and politicised through the operations of power and 'territorialisation' techniques (Skeggs, 1999:228), suggests that maternity environments, and the populations passing through these locations, may be similarly regarded. David Sibley's (1995a) research examined shopping malls (including Meadowhall, a highly regarded and much visited haunt by the South Yorkshire respondents), and the ways in which space is ambiguously presented as 'public' although organised as 'private', through the presence of security guards and surveillance cameras restricting 'undesirables'. Hence, adolescents' hanging about in shopping malls 'doing nothing', or at least nothing which costs money, come to be viewed as 'trouble'; as 'matter out of place' (Douglas, 1999:109) because they do not conform to the normative model of the urban shopper. Non-consumption, and 'hanging out', are construed as forms of deviance because these 'activities' are undertaken in spaces designed for other purposes and for other people. Shopping malls are for shopping; for purchasing; for consuming. Above all they are family spaces, and the presence of non-conforming 'others' in such spaces is discrepant and threatening.

Respondents' narratives suggested that many maternity care professionals viewed the institutional spaces in which they worked as 'adult' spaces which properly belonged to 'respectable' people who, by definition, are not youngsters and not working class (Skeggs, 1997). Young women were admitted to these 'adult' spaces only because they had transgressed social norms. Hence they could justifiably be classed as 'other' and undeserving of civil treatment:

Angharad Some of them, you see 'em thinking, 'Why am I bothering? Why am I wasting my time with ones like you? Why am I bothering with you? You shouldn't be in this condition anyway...'
Alys Yes. It's like, instead of it just being well, all sorts of people get pregnant and I'm just one of those sorts, you can see they're thinking, 'Oh you shouldn't be havin' sex at your age. You shouldn't be goin' out with boys at your age.' Laughs.
Alys and her mum, Angharad. W

Shopping malls and maternity environments may appear to have little in common, but they are both locations in which certain individuals, especially those who are obviously working class, are likely to be regarded as outsiders:

It's her [midwife] disapproval is the worst thing isn't it? [...] If she [Michelle] were older and she were married it would help her. [...] They're more polite to older ones aren't they, but because she's just a slip of a kid... That's what they think... You're only a teenager... You shouldn't be here... You're far too young to be here. Polly (Michelle's mother). SY

Health professionals' stereotyping practices and attitudes had an alienating and/or muting effect on young women, many of whom reported being treated very differently from their older counterparts. Most respondents reported feeling unwelcome and unwanted in maternity environments.

o   The presentation of self in the antenatal clinic: dressing up for the midwife

During observation sessions, I often heard midwives commenting on the dress sense and bodily adornments worn by their young clients. Such comments were occasionally made during the consultation and hence were available for interpretation by the teenagers concerned; more disparaging remarks were generally withheld until the consultation concluded and the young woman had left the room. Although I had expected that teenagers would be well versed in contemporary fashion trends - as identity statements and/or as vehicles for rebellion - I had not anticipated midwives would show much interest in this aspect of their client's personal management. That they did so reflects early research which suggested that circulating discourses of both adolescence and femininity are often shaped by professionals and articulated through 'a hierarchy of authority' (Hudson, 1984:33). In this instance, it was midwives who assumed an authoritative stance and whose opinions influenced how pregnant young women were portrayed and perceived. The attitudes of professional groups, especially those involved in the lives of vulnerable young people, play an important role in media constructions of adolescence. Their opinions carry weight and are read as authoritative. As such, they may be purloined by the media and re-presented as stereotypical images for consumption in the public arena.

In order to deflect possible criticism by midwives, considerable numbers of young women reported changing from their normal clothing, to clothes 'I'd not be seen dead in' before they attended antenatal appointments. This midwife-induced pressure to dress differently caused some young women considerable distress, especially those who possessed very few clothes and who had no money to buy new outfits. Whilst some young women were fortunate, in having accommodating mothers who encouraged them to borrow their clothes for clinic visits, most young women rarely shared the same size and taste in fashion as their mothers. Dressing for an antenatal appointment, then, provoked anxiety and assumed an inflated importance, as young women strove to adjust their embodied appearance to the 'appropriate' dress code. There is a considerable literature on the links between female corporeality and clothing, whether as a practice of female consumption (Colls, 2004), as an ingredient in identity construction (Green, 2001), and/or as fashionable lived experience (Entwistle, 2001). Discourses on dressing as a social practice in the context of pregnancy (Beale, 2002; Longhurst, 2000) have highlighted the importance of appearance for all women, including those previously considered to be removed from such concerns. The teenagers in this study suggested they were more likely to be governed by dress codes than were older pregnant women:

> When I went to antenatal I did dress tidily. [...] There were some [pregnant women] there in leggings and t-shirts, but they were older so they could get away with it. *Laughs.* I wasn't comfy in half the clothes I was in, but you put up with it. Mmm, even if I was killing myself with the clothes being really uncomfortable, I still wore them. *Laughs.* It was hard, 'cos I didn't have many clothes that I could wear, but my mum let me borrow some of hers. *Laughs.*
> Lowri, three weeks after the stillbirth of her daughter. W

The efforts young women made to dress in accordance with perceived 'proper' norms of maternity attire were not necessarily successful. As Alys describes in the following excerpt, clothing must not only be deemed 'appropriate', it must also comply with an ideology which privileges foetal welfare:

> I bought some really good jeans and I wore them to the clinic. They were really really expensive and the midwife told me off. *Laughs.* She said, you're not supposed to wear jeans when you're pregnant. *Laughs.* [...] She told me I shouldn't wear them 'cos I'd crush the baby. I did wear them anyway, 'cos I felt like really comfy in them. They weren't tight around my stomach or anything, they were just really comfy. [...] She said you shouldn't wear high heels either, because they're bad for your posture 'n everything. Alys, thirty weeks pregnant. W

Midwives responded similarly to teenagers with tattoos and pierced navels, claiming these were also potentially injurious to foetal well-being. Tattoos were potential sites of infection, and pierced navels, in particular, were thought to impede the expansion of the young woman's belly and hence to compromise foetal growth. A focus on the external surfaces of young women's bodies thus emphasised the power of the techno-medical gaze in mapping foeto-maternal corporeality. It also emphasised the pursuit of ever more precise parameters by which to measure foetal status and, if deemed necessary, introduce correctional strategies.

Young women's mothers described the efforts their daughters made to look 'presentable' before attending antenatal appointments. They hoped that such efforts would deflect attention away from staff perceptions of their 'inappropriate' youth and, with it, the negative connotations generated by being teenaged in maternity environments.

> She [Beca] always dressed up and made herself really presentable. Rather than be comfy and go down there [to the clinic] in a little t-shirt, or something she'd wear round the house, she always made sure she looked all right. She was really worried about looking tidy, so they wouldn't think badly of her because she was young. Glenys (Beca's mum) W

Realigning dress codes in accordance with midwives' expectations may be understood as another aspect of the totalising processes of 'confinement' to which pregnant women are routinely subjected. As Robyn Longhust (Longhurst, 2001) has noted, the word 'confinement' – meaning limit or boundary – is a recurring image and experience in women's lives. It is also one which comes early and forcefully in pregnancy, restricting access to public spaces, sometimes limiting indulgence in alcohol and tobacco, and curbing a range of other previously taken-for-granted pleasures and freedoms. Gillian Rose (Rose, 1993), quoting an earlier piece of research (Frye, 1983), contextualises the notion of 'confinement' within a classed environment:

> '[...] if I have to think of one word that can work as a motif for this experience [of being a white working-class woman], it is confinement - the shrinking of horizons, the confinements of space, of physical and assertive movements within institutions, the servility that masqueraded as civility, the subjugation of my body, emotions and psyche' (Rose, 1993:27).

White working-class women, then, are increasingly 'marked as the national constitutive limit to propriety' (Skeggs, 2005:968). This is even more so if they are teenaged and pregnant.

Pregnant adolescents were seldom read by maternity staff as 'normal' and, as a result, tended to be positioned as marginal, at least as far as their evolving maternal identities were concerned. Such positioning complicated an already difficult transitional period and reaffirmed the negative scripting and stereotypes of young motherhood. It is not unusual for adults to feel uncomfortable when faced with the physicality of adolescents' bodies, their distinctive dress codes and body modifications, and particular behaviours. In middle age, when our own bodies may be sagging into shapelessness and years of pleasurable, but ultimately self-abusive, practices have taken their toll, the adolescent body may serve as the perfect *tabula rasa* upon which to project our personal, but unacknowledged, envies and dissatisfactions. Thus, midwives, many of whom are middle-aged, may be unsettled when confronted with teenagers presenting ('flaunting'?) their maternal selves within institutional settings and may react by trying to suppress the adolescent's (sexual) self-expression.

The (re)enactment of an assigned role, and the importance of maintaining a consistent, and appropriate, 'front' during individual role performance, was remarked upon by Erving Goffman (Goffman, 1959 [1969]). Goffman employed the metaphor of the stage and the language of theatre to describe the 'dramaturgical' aspects of social encounters. It was Goffman's contention that if we can understand the archetypal interactions presented by actors working within the contrived and imperfect environment of the stage, then we may be better placed to recognise when these archetypes are at play in everyday social interactions. Goffman also appreciated the operations of social mobility within stratified societies and the pressures on individuals to maintain progress from lower to higher status. Such progression is not without costs, however, as 'upward mobility involves the presentation of proper performances and efforts to move upward and efforts to keep from moving downward are expressed in terms of sacrifices made for the maintenance of front' (Goffman, 1959 [1969]:31). Many young women in this study strove to present an acceptable 'front' within (maternity) environments which were, by and large, hostile to unconventional representations of maternity. Their efforts to create an acceptable identity were generally not appreciated by midwives, however, and, hence, could not work to advance the teenagers' status.

CHAPTER NINE: LABOUR AND BIRTH NARRATIVES

Birth, whatever its origins and associations, is normally a celebratory event, which, in ideal circumstances, could serve to counterbalance critical responses to non-normative childbearing. That *young* motherhood is seldom understood as an event to celebrate has been noted (Baker, 1999); indeed, narratives of labour and birth presented in Chapters Seven to Eleven of this thesis suggest that, to the contrary, these events appear to be particularly troubling for maternity staff. Once the charged family atmosphere which accompanied pregnancy disclosure had subsided, most of the teenagers looked forward to becoming mothers and stated an intention to do the best they could regarding their child's welfare. As I have illustrated in the previous two chapters, the journey through pregnancy for most respondents was made more difficult by the stigmatising attitudes they faced, not least from health professionals. Any young women approached labour with a mounting sense of dread. Mothers were also anxious, especially when the prospect of this event reactivated painful memories of their own labours and the cruel treatment some had received from maternity staff.

The majority of teenagers articulated fears about the anticipated pain of labour. When I repeated these concerns to midwives, a common response was that such fears might have been reduced had respondents attended 'parentcraft' classes, 'learning for themselves that there's nothing to be frightened about. It's ignorance that's their main enemy'. In the minds of midwives then, it was education – in a very particular form - which they perceived as the route to an easier labour. Relational elements, which would require midwives to consciously engage with their young clients, were not mentioned. This was in contrast to respondents' narratives, which highlighted negative staff attitudes, including their refusal to allow young women the company of loved ones in labour:

> I were really frightened. [...] They wouldn't let Pete [BF] stay with me "cos they said I weren't in proper labour. Then they put me in a room all on my own 'cos they said I were making too much noise, 'cos I were getting loads of contractions and I was just falling off the bed I were in so much pain. [...] I were so tired'n all I just cried and cried. Lou, daughter aged eighteen months. SY

> You tend to forget the horrible bits if the people around you were nice. But I remember the nurses were not very nice with me [...] *Labour was horrible because they were horrible.* Alys, son aged two years. W (emphasis added)

Evidence has been available for some time to suggest that although women may forget the physical pain of labour, they never forget things which were said and done at the time (Leap and Hunter, 1993; Simpkin, 1991). The abandonments, the rejections, and the refusals, which respondents from both study cohorts described, appeared so ordinary that they must be considered routine. These practices magnified the pain of contractions and fore-grounded the 'sensational' and corporeal elements of labour.

Space and power in the birthing environment

All the young women laboured and gave birth in hospitals. This location emphasised the separation between the familiar and the unfamiliar, between kin and strangers. Teenagers were adamant that hospital was the most appropriate place to labour and birth. Mothers expressed greater ambivalence with one who had enjoyed a home birth and another who had considered this option, offering alternative understandings, particularly with respect to privacy, risk and safety:

> I said to her, 'Well you can always have it here at home'. She said, 'Oh no mum, I couldn't'. I said to her, 'Yes, you could, you could have it in your bedroom, it's private if that's what you're worried about', but then she said, 'Oh no, all that mess, all that blood 'n stuff, imagine that'. *Laughs.* Then I said she could have it in the bath but she won't have anything like that. To her, it's like if you're having a baby it's the hospital is where you go. Chris (Clare's mum) SY

Prior to labour, some mothers voiced their scepticism about the (poor) quality of maternity care they anticipated staff would provide for their daughters. Low expectations reinforced their opinion that labouring and birthing at home was the better option:

> Mmm, yes, everything's there but can you actually get it when you need it? Most of the time midwives are just sat there chatting and having cups of coffee at their desk. They're just sat there doing nothing for you. Part of me is thinking, they're there and they're not there. So I think well, what's the point of going to hospital. Why doesn't she just have it at home, like I had her at home. Anwen (Megan's mum) W

Space affects our 'feelings about others' (Sibley, 1995a:xiv); this became very apparent after Lou gave birth. The combination of her existing poor health status, and her prolonged labour and surgical delivery, required that she remain under medical observation, on the labour ward, for twenty-four hours following her caesarean section. During this time she was nursed in a pleasant single room to which her boyfriend, Pete, had unrestricted access. At the end of this period she was judged sufficiently recovered to transfer to the postnatal ward. Both Lou and Pete expressed reservations about the proposed move. Lou was worried that her appearance would make her an object of derision and pity, because she had no 'nice maternity clothes' to wear but only her (smelly) trainers, ill-fitting track suit bottoms and grubby tee-shirts. She also worried that her constant coughing and noisy expectoration (a result of chronic asthma exacerbated by tobacco consumption) would annoy other mothers and generate anxiety about whether she was potentially 'infectious'. Pete was concerned that the combination of restrictive visiting hours and poor public transport meant that he would have little time with Lou and his baby daughter; the cost of transport was an additional worry. During labour, Pete discovered that a number of single rooms were available on the maternity unit, and Lou asked a midwife she considered 'friendly' whether she might be transferred to such a facility. The following excerpt, taken from my fieldnotes, graphically illustrates Lou's 'unworthiness' and her lack of bargaining power to access NHS spaces reserved for the exclusive use of privileged others.

The midwife who had apparently told Lou she would be transferring to the post-natal ward visits Lou just as I am about to leave. She neither knocks at the door nor, on entering the room, does she wait for Pete to complete his sentence. The midwife takes up position at the foot of Lou's bed, glares at Lou, and demands to know, 'If it's true what I've heard, that you're after a single room?' Lou hesitantly replies that yes, she had asked a midwife if that might be possible. The midwife then launches into a vitriolic tirade, which is delivered too rapidly and too furiously for me to make precise notes. She informs the young couple that, 'There are only 2 single rooms and they're reserved for special cases and anyway they're both occupied'. The midwife reiterates the details of the imminent transfer to the postnatal ward, and reminds Lou and Pete that, regarding visiting hours, 'Rules are rules, you'll have to stick to visiting hours and that's all there is to it. There's no exceptions.' She then leaves the room. I am shocked at this unprovoked attack on these two vulnerable young people; I also feel embarrassed and upset. Later I feel angry and my anger intensifies when I discover that both of the single rooms were in fact, vacant and, indeed, had been for the past week, after the last 'special case' - an older mother, the wife of a hospital consultant who had given birth to twins as a result of IVF treatment – had been discharged. Fieldnotes, Lou, first day following c/s. SY

Lou was so distressed by the midwife's attitude that, against medical advice, she discharged herself from hospital shortly afterwards. This excerpt demonstrates how individual 'worthiness' is evaluated and the ways in which idividual identity may be 'mapped onto public space' (Jenkins, 2004:168).

Labour and birth were perhaps the most obvious times in pregnancy when power relations between maternity professionals and respondents were most visible. Initially I found myself stumbling over the application of the term 'abuse' within a midwifery context. During readings of transcripts, I had to constantly remind myself that abusive acts are not concerned with the intentionality of the perpetrator but, rather, with how they are experienced. Conceptualised thus, the term fits the maternity context. Indeed, some scenarios described in this chapter suggest that, for some young women at least, the birthing environment must be considered a 'terrain of power' (Hagan and Smail, 1997a:260), in which oppressive, and abusive, acts are repeatedly visited upon defenceless women.

Anticipating labour: knowing signs

Although most respondents expressed anxieties about labour, they were generally pragmatic about its inevitability and about their capacity to endure it, although this is not to imply that they were fatalistic:

HS   How're you feeling about labour - are you worrying about it?

Clare   No. I haven't really thought about it. My mum's been on and on about it. *Laughs.* [...] (it) just goes in one ear and out other. *Laughs.* What's point in thinking about it? It's gonna happen anyway, nowt I can do is there? [...] I mean, if summat's gonna happen it's gonna happen, so no point worrying about it 'n getting m'self all stressed out.

Clare, thirty-eight weeks pregnant. SY

HS   So…labour could happen any day now. Are you ready for it?

Jade   No. *Laughs.* But I'll be all right. It's only gonna be for a day, or two days, then it'll be over and I'll have a babba.

Jade, thirty-nine weeks pregnant with first baby. SY

Perhaps the most dreaded scenario young women anticipated was the amniotic fluid sac suddenly releasing in a public setting. Mothers reported on strategies that their daughters devised to normalise this event:

> She [Anwen] said to me, 'I'm going to take a bottle of water out with me from now on mum'. I said, 'Why?' She said, 'Cos all the girls have been telling me if my waters go in the street I can pretend I've tipped this [water bottle] down me'. I said, 'You'll look more stupid doing that, it's a natural thing it is when that happens'. *Laughs.* Anwen (Megan's mum) W

Somatic concerns appeared to be more pronounced within maternity environments, perhaps because it was here that young women felt most constrained and self-conscious.

The majority of respondents knew someone who had recently laboured and birthed, and their experiences carried significant influence. Nonetheless most young women tended to seek their mother's advice about the 'right' time to transfer to hospital. Teenagers often interpreted advice literally and disguised their anxieties with humour:

> HS   And what about when labour starts. Do you think you'll know when it's time to go to hospital?
> Clare   Mmm. My mum said you have to phone up when you go into labour, but then the midwife, she said you're not supposed to go in to hospital until your contractions are coming about every three minutes, something like that. *Laughs.* [...] She said your womb has to be so much open inside, as well, or they send you back home. Six inches or something I think it were. *Laughs.* I don't know how you know it's six inches without a ruler stuck up inside you all time. *Laughs.*
> Clare, thirty-nine weeks pregnant. SY

Mothers' own childbirthing histories also influenced young women's expectations:

> HS   How long do you think your labour might last Clare?
> Clare   I dunno. *Laughs.* Haven't got a clue. Could be anything couldn't it? Midwife said for first baby it might be about nine hours. Something like that. [...] My mum said she were in nine hours with me. [...] She were ages with [younger sister]. She were about thirty-six hours with her, I think.
> Clare, thirty-eight weeks pregnant. SY

In the event, Clare was induced, because of perceived postmaturity, although, as she had first consulted with her GP late in pregnancy and could not recall her last menstrual period with any degree of accuracy, estimating her 'due' date was always speculative. Her labour lasted a very typical twenty-two hours (see Table A for more details).

Labour and technologies of management

Most young women learned about labour from their mothers and female relatives, including how to

determine the onset, and how to manage pain. Concern about labour pain, and the (in)ability to cope with it, has been identified as a 'worrying trend [...] one of the indicators of a lack of confidence to cope with the forthcoming birth' (Green et al., 2003:25). The same study reported significant increases in childbearing women, especially first-time mothers, stating that they felt 'very worried' about labour pain, whilst an earlier study by the same researchers (Green et al., 1998) reported greater numbers of women expressing a desire to have an epidural during labour. The later study reported a dramatic fall in unassisted vaginal delivery[90], especially for first-time mothers.

Determining the quality of contractions is considered an essential element of monitoring labour progress. Maternity staff define 'effective' contractions as those which dilate a labouring woman's cervix at an approved rate whilst simultaneously exerting pressure on the presenting part of the baby, moving it progressively down the birth canal. Once the onset of labour has been confirmed, 'ineffective' contractions are not well tolerated by staff because they are associated with problematic labours:

> I were getting contractions all day, but they said they weren't good ones 'cos they weren't making me open fast enough like, so then they said they'd have to give me something to make it open faster. Clare, daughter aged nine days. SY

Defining the constituents of 'good' contractions was an important preoccupation for both midwives and respondents. 'Good' contractions meant admission to hospital and, if young women had been induced, 'good' contractions were an important criterion for admission to labour ward and consideration for pain relief, particularly epidural anaesthesia. Not for these young women the glories of 'natural' childbirth; pain-free childbirth was what they sought, although this preference met with considerable resistance from maternity staff:

> HS   So did you have anything for the pain in the end?
> Clare   I were having gas and air for a while, then [...] later on, I think it were about half ten, eleven, I had injection [...] then eventually I had an epidural. [...] I wanted the epidural right from the start, like, but she were like, oh, no, you don't need that, you're fine. You'll have the baby soon. [...] It were ages before I had her.
> Clare, daughter aged nine days. SY

When contractions are considered 'ineffective', i.e. deemed by the attending professional as insufficiently powerful to dilate the cervix according to a pre-determined time-frame, it is routine practice to 'give something' to accelerate labour. Most often this 'something' takes the form of an internal examination, as a prelude to puncturing the amniotic sac, and/or the insertion of an intravenous infusion containing 'syntocinon', a preparation which stimulates the womb/uterus to contract[91]. Before pain relief

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[90] For some time now, assisted vaginal delivery has been associated with the increased use of epidural anaesthesia.
[91] Prior to discussing medical interventions, midwives may advise relaxation in a warm bath. In some maternity units the provision of purpose-designed birthing pools enables women to labour and/or give birth in water. Although the maternity unit accessed by the South Yorkshire cohort had installed this facility, none of the young

is administered (apart from 'gas and air'), it is common practice for staff to 'objectively' assess labour progress by performing a vaginal examination, colloquially referred to as an 'internal'.

o   Induction of labour

Of the total number (n=17) of young women who participated in the study, labour and birth details are available for nine, including all six of the South Yorkshire cohort and three from the Wales-based cohort (see Table A for further details). Five of the six South Yorkshire teenagers were induced; Jade was the only respondent in either cohort to experience a spontaneous onset of labour, which she managed with both her children. Tracey was induced at a little over thirty-five weeks with her first baby, because of premature rupture of membranes and concerns about foetal exposure to maternal genital infection (chlamydia and gonorrhoea). The remaining teenagers were induced at forty-one weeks because of post-maturity[92]. When I first discussed induction, most respondents intimated they had willingly acceded to the advice of maternity staff and accepted this intervention. It was during the postnatal period, and sometimes long after the events of birth, that some teenagers reconsidered their 'decisions'. Others voiced discontent about the quality and the amount of information they had received, and criticised the lack of emphasis maternity staff placed on the 'down side' of the induction process:

> With the induction no-one told me the side effects. No-one followed the argument through. They just cut to the bit and say, 'It's for your benefit if you get him out. The quicker you get him out, it's for your benefit.' But they didn't tell me other side of it. Alys, son aged two years. W

> They [maternity staff] don't put so much of the down side to you. [...] I don't think it's [induction] a good thing to do. Not when you know all the things that can go wrong. When you know all the side effects you think, well, why didn't I wait a bit longer then?
> Michelle, son aged six months. SY

Research in the UK (Green et al., 1998) revealed that most childbearing women perceive themselves to be well-informed about induction of labour. The same study, however, also found that many women do not differentiate between a labour which is induced and one which is 'accelerated' with oxytocic (uterine stimulating) drugs. When reflecting on the circumstances of their induction, a significant number of teenagers expressed a desire to avoid this intervention in a future pregnancy:

> HS   Is there anything you'd like to change [about labour or birth]?

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women in this study were invited to use it. The majority of unit midwives lacked experience in caring for women labouring in water and women who wanted to use the pool were required to book in advance and to pay a £20 fee to cover the cost of a disposable liner. These factors deterred all but the most determined and affluent women from using water to reduce the painfulness of contractions.

[92] Seven days beyond the estimated date of birth was the maximum permitted by the consultant obstetricians on the study sites. A pregnancy is considered to have reached 'term' between 37 and 42 weeks. Babies born before the 37th week are considered premature, while babies born after the 42rd week are considered postmature.

Clare   Erm, [...] I wouldn't ever want to be induced again.
HS   Why is that?
Clare   'cos it were awful, I hated it. [...] It were really really painful. I were screamin' in agony and then they wouldn't give me an epidural. [...] I weren't expecting that. [...] Nobody told me what they were doing or anything. I just went into hospital and then they woke me up about half five in morning to start me off. [...] If I ever have another one I'm never gonna let 'em near me. *Laughs.*

Clare, daughter aged twelve months. SY

All respondents experienced induction as extremely painful. It was also generally associated with a cascade of iatrogenic interventions, including the need for an epidural to control pain and 'assistance' (forceps, ventouse, and/or caesarean section) to deliver the baby. Teenagers' accounts of induction were often conflated with the difficulties they experienced obtaining an epidural. As Clare describes in the previous excerpt, a labour which is artificially produced, and which rapidly increases in intensity without time to adjust, is usually agonising. A number of teenagers in this study were in their early years of adolescence and had little previous experience of menstruation and the pain which can be a regular feature of this event. Hence, most were unprepared for the breathtakingly painful experience, and the gruelling work, of labour.

Although some degree of labour management is now widely regarded as routine by both users and providers of maternity services, the escalation of technological intervention in all aspects of childbirth, but especially in labour, has led to the formation of a global counter-culture in recent years. The central aim of the movement is to keep birth 'normal'; this involves re-educating childbearing women and professionals about, for example the dangers of routine induction and the value of pain in labour, stressing that requests for pain relief may be constitutive of the abnormal and the pathological.

o   Vaginal examinations in labour: a violation of selfhood?

When I explored the topic of labour pain with respondents, it was not just the physical sensations associated with contractions which respondents commented on, but also the pain and embarrassment incurred through being subjected to regular vaginal examinations. In some maternity units, vaginal examinations are no longer performed routinely, although nor are they discussed in any detail with women antenatally (Stewart, 2005). This may be one reason why some women, especially first-time mothers to be, enter labour unprepared for the (painful) reality of what these examinations entail.

The complexities involved in negotiating informed consent for intrapartum procedures have been previously documented (Marshall, 2000), although I would suggest that consent processes may be more complicated when adolescents are involved. The difficulties of midwives ensuring clients provide fully informed consent in advance of a vaginal examination may be exacerbated by training which stresses the importance of accurately assessing cervical dilatation, considered essential for predicting the course and duration of labour. A focus on physiology may encourage midwives to emotionally 'distance' themselves from their clients, which, in turn, may shield them from acknowledging the

unsettling effects of the penetrative acts they perform. Such a focus is at odds, however, with the raw physicality of women's seeping, fluid-filled, (labouring) bodies.

Being required to present their 'private parts' for examination by strangers was a deeply unpleasant experience for young women. In the following excerpt, Clare provides a disturbing account of the everyday, taken-for-granted, violence embedded in contemporary midwifery practices, and which appeared to be enacted by the midwives 'caring' for her in labour.

Clare   I had to have it [vaginal examination] again and I didn't want to have it done again. Not with that midwife 'cos she really hurt me. She were right horrible with me. Yeah she were just, I don't know, I think she had like a bad attitude [...] She got t'other midwife to hold me down so she could do it, so that put me off even more.

HS   How did she hold you down?

Clare   She got my legs and she made my mum hold one hand and she made me sit on other one, on other hand. Then she did it [vaginal exam]. [...] I were cryin out. I think I were screamin. It were so painful. [...] I did think if I were older they wouldn't have done it. It's because I were only young they did it. Silly girl, like, that's what they were thinking, silly girl, we'll teach her a lesson.

Clare, daughter aged five months. SY

Midwives' narratives confirmed respondents' accounts of the force some applied when undertaking vaginal examinations. They tended to justify their actions as a response to young women's physicality and a perceived need to restrain their 'hysterical' and 'tense' labouring bodies:

Midwife   I couldn't do it [vaginal examination] because Lou was so tense [...] She became quite hysterical actually, which was a shame for her. [...] Especially when we had to do [vaginal] examinations on her. [...] She wouldn't let us do them. She became too tensed up and in the end I had to get another midwife in to help me.

HS   How did the other midwife help you?

Midwife   Oh, well one held Lou's hand and she talked to her. The other one, we had a leg each, we had to hold her open so I could do the internal.

Labour Ward midwife (LW8) SY

The image of three midwives applying their collective physical strength to subdue a teenager's labouring body may be compared to the surgeons described by Joan Cassell (1996), and the pride they take in practising 'body contact sport' (ibid:41). Surgery not only involves patients' bodies, it also involves the surgeons' bodies in the practice of a 'uniquely physical, distinctively embodied medical specialism' (ibid:41), and, in this respect, midwifery and surgery have much in common. The fact that physical violence was a routine event in the lives of many respondents may have made it less likely that such behaviour would be identified as problematic when it occurred in labour.

    o   Epidural anaesthesia

During the antenatal period young women were divided in their opinions about the pros and cons of epidurals. Arguments for this intervention came from respondents desirous of a pain-free labour; those

against expressed concerns about side–effects, including headaches, paralysis, and immobility in labour. Seven of the nine young women whose labour narratives were available to me, had an epidural during labour.

When reflecting on their labours, many young women spoke about the difficulties they experienced when attempting to secure effective pain relief, particularly with respect to epidural anaesthesia. Midwives were identified as the group most likely to obstruct respondents wishes in this regard, by either denying requests outright, or resorting to delaying tactics, for example by failing to contact an anaesthetist, or falsely stating that labour was too far advanced and that birth was imminent. Predicting of the timing of the baby's arrival is notoriously difficult, however, and many respondents reported that they birthed occurred considerably earlier, or later, than predicted by staff:

> As soon as I went in, I asked her [midwife], 'Can I have an epidural now?' She said, 'No, you're too far gone. You're ten centimetres, that's too far. You've gone too far. You can't have an epidural now.' [...] Alys, son aged two years. W

Even Lowri, whose baby was known to have died prior to the onset of labour, was initially refused an epidural, despite the fact that this had been previously agreed by her consultant obstetrician:

> I'd been promised I could have an epidural. My mum was going 'Do you want an epidural?', so I said, 'Yes', because the pain was really bad. My mother asked for an epidural and basically I didn't get one. Lowri, three weeks after the stillbirth of her daughter. W

Because midwives played a very small role in data generation, and because those who were interviewed did not necessarily contribute material of relevance to this particular discussion, it would be inappropriate for me to speculate about their reasons for withholding epidurals from their young clients. It is also possible that respondents were inaccurate in assessing the time lag between making a request for an epidural and this being available.

Midwives seemed more willing to arrange for the speedy insertion of an epidural when they encountered young women who they perceived to be 'hysterical' or 'panicking'. The need to impose control, especially on those who are perceived to be out of control, may be particularly important for midwives, because their inferior positioning in the institutional hierarchy accentuates their own relative powerlessness. In addition, most maternity units had insufficient staff to provide one-to-one care for women in labour, and the fragmented nature of antenatal care meant that few respondents had previously met midwives looking after them in labour.

Whilst there is evidence (Allen et al., 1997) to suggest that continuity of maternity *carer* is not necessarily associated with an increase in negative outcomes, the need for consistency in care has nonetheless been emphasised (Green et al., 1999). Whilst research findings have highlighted the importance of differentiating between the organisational elements of maternity care and the content of that care, the characteristics and requirements of particular client groups must also be considered.

Many teenagers encountered midwives during their labours who lacked knowledge about the (sometimes extremely challenging) circumstances of their lives and this lack of understanding hindered their attempts to make informed assessments about the responses young women might make to the stresses of labour. The epidural thus became a mechanism for rendering 'hysterical' young women compliant and silent:

> She'd [Lou] become so hysterical after the [vaginal] examination, I decided she ought to have an epidural. She was totally panicking really. I suppose you could say I persuaded her to have one. *Laughs.* She had it done but she went absolutely hysterical while the anaesthetist was putting it in. We thought she'd react badly, but not that bad. *Laughs.* But the anaesthetist was very good with her, really. She was good for him as well. She did lie still eventually.
> Labour Ward midwife (LW8) SY

The insertion of an epidural not only requires labouring women to lie very still, it also requires them to assume, and maintain, the 'correct' (left lateral, foetal-like) posture for the duration of the procedure. Regardless of age and previous childbearing experience, labouring women generally find these requirements extremely difficult to accommodate. Midwives' narratives regarding this event generally emphasised their collusion with anaesthetists, rather than any sense of empathy with young women in their care.

  o 'Support' in labour

Midwives assumed a central role both in supporting, and subverting, institutional arrangements for the care of childbearing women. This became apparent when I analysed respondents' narratives on the theme of support in labour. Most young women experienced varying degrees of difficulty in having their chosen companions with them throughout labour. This was particularly evident when labour was protracted, or when they were admitted to hospital before it was 'properly' established. Maternity units enforced strict regulations on visitors, including labour supporters, with generally no more than two people permitted at each bedside. Unsurprisingly perhaps, rowdy, intoxicated, and abusive visitors were referred to as 'nuisance factors' and their presence caused staff considerable anxiety. Whilst there were no facilities for partners and significant others to stay overnight on antenatal wards, once women had been transferred to the labour ward staff did not impose time limits on visitors (although 'number' limits were generally adhered to). Restricting the presence of loved ones caused respondents considerable distress:

> It was half past eight in evening. We wanted to stay [...] She [midwife] wouldn't let us stay. She told us we had to leave. I hated leaving her [Alys]. It broke my heart. She was only just turned sixteen. She'd never spent the night on her own. Not with strangers. She told us, 'You've got to go now, she'll be ages yet.' *[Angharad's voice distressed and high pitched]* I said to her, 'Please, can't we stay? We don't mind staying.' I told her we didn't have a car to get back in a hurry. [...] I could have left [BF] there. He said he'd sit in the waiting room all night, he didn't care. He just didn't want to miss it. [...] He didn't want to not be there, if she was needing

comfort like. But no, you can't do that she says, you've got to go. [BF] was cryin his eyes out he were so upset. I thought, well, if I've got to miss it, but don't let him miss it, because he was so looking forward to it. If we'd had a car, we wouldn't have minded so much. It would've been hard leaving her there all alone with strangers, like, but we'd have been able to get back if we were needed in a hurry. We got the last bus home. Last bus goes at half eight. In the end, we had to call my friend out of work as soon as we got home to come straight back.
Angharad (Alys's mum) W

More than twenty-five years ago Sara Ruddick suggested 'that the most liberating change we can make in institutions of motherhood is to include men equally in every aspect of maternal care. [...] to prevent or excuse men from maternal practice is to encourage them to separate public action from private affection' (Ruddick, 1980:360).

Differences in working practices and staff attitudes between maternity and hospice settings may be relevant to this discussion. Although there have been significant changes with respect to humanising birth in recent years, I suggest that such changes have been less dramatic than those affecting the care of the terminally ill and dying. For instance, it is now considered normal practice in hospices for loved ones to remain at the bedside throughout the entire process of dying, but for a woman giving birth, similar freedoms are only possible if she chooses to labour and give birth at home.

Some young women spoke of being abandoned and/or ignored at crucial times during their labours, for example when birth was imminent. As is suggested by the following excerpt, even the tragedy of giving birth to a dead baby did not shield teenagers from uncivil and callous treatment by maternity staff:

It was half four when I got there and the midwife who took me over said, 'Oh there we are, gas and air, have that'. Then she left me. One midwife, I don't know who she was, she came in to take the chairs out of the room for somebody else. She didn't even look at me. She just said 'Oh can I take these chairs?' Nobody else came in until just before I had her [baby]. Nobody came back in the room. [...] The only time the midwife came in was after somebody had gone and asked her to bring me something. [...] The midwife just left us, so then my mum took over. [...] She'd had babies as well as lost babies, so she knew what it's like from both sides. [...] I did think they'd pay me more attention, with me being so young, but I suppose they thought, 'Oh, well, the baby's already dead so nothing we can do'.
Lowri, three weeks after the stillbirth of her daughter. W

That midwives often seemed unaware that their actions might be construed as transgressing the norms of professional conduct echoes an earlier observation: that whilst those who are marginalised and oppressed may be 'acutely aware of discrimination against them [...] exclusion is much less likely to impinge on the consciousness of conforming adults' (Sibley, 1995a:pxiii).

Jade, who was perhaps the most isolated and angry of the South Yorkshire cohort, was atypical, in that she appeared unconcerned about who would accompany her to hospital in labour. That said, I found it difficult to assess whether the 'front' she presented was, in fact, a genuine lack of

concern, or whether her anxieties were well disguised by the extravagant displays of bravado in which she regularly engaged. In any event, her labours were the most uncomplicated of both cohorts:

HS   Have you thought that far ahead - to labour and who you'd like to have helping you?

Jade   Nah, not really. I'm not bothered. *Laughs.* Bev [landlady and surrogate mother] says she'll come in with me, and then my sister's said she'll come if she can make it. I told her I'm going to ring her up and say, 'Get here! I'm in labour', so then she'll have to come. *Laughs.*

Jade, thirty-six weeks pregnant with her first baby. SY

Pete, Lou's boyfriend, was alone among male partners in expressing ambivalence about providing labour support. Unlike other young men, Pete was generally at home when I called, and he often stayed for the duration of my visits. Although he contributed a significant amount to our conversations, and his presence counterbalanced Lou's tendency to introspection, he had an aggressive disposition and tended to dominate proceedings. It was not until some months after her baby was born that Lou admitted that Pete physically (and sexually) abused her. Despite his belligerent stance, and his abuse of Lou, I eventually warmed to Pete. One day, shortly before the baby was due, I challenged him about his lack of commitment to accompanying Lou to hospital and supporting her through labour. I was unprepared for his reply:

HS   Do you think you'll be able to be with Lou when she's in labour 'cos, you know, she's really scared of being by herself.

Pete pauses for a long time. Then looks me straight in the eye and says:

Thing I'm most worried about is if I see her in pain and they're not doing nowt about it. I think if that happens I'll just flip out. That's what I'm worryin about. It's making an idiot of meself. Embarrassing meself. Fainting'n all. Or getting in fight with doctors when they're not doing nowt for her. I know I've got violence inside me. Everyone says sooner or later, and I'll be sent down for it big time. It'll be just my luck it'll happen on day the babba's born... Just my luck I'll get done for smackin doctor or summat... Better for Lou I'm out of it. She'll do all right by herself. The nurses'll see to her... Nothin I can do they can't. Pete (Lou's boyfriend). SY

It is ironic that men such as Pete might dread being made to feel helpless and frightened by seeing their partners in pain, when they themselves are often perpetrators of another ordering of pain, for example, in the form of sexual and/or domestic abuse. Nonetheless, it is less than three decades ago since it was suggested that fathers who are unappreciated, who are poor or declassed or otherwise seen as 'failing', will 'know the pain of introducing their children to a world in which they do not figure. Sometimes their powerlessness is visited directly upon the mothers' (Ruddick, 1980:363). In this sense, witnessing labour is likely to be provocative because Pete could be forced (publicly) to confront his own violent self, with potential repercussions for Lou and their baby.

Giving birth

Of the nine young women whose birthing outcomes are known to me (see Table A), one experienced a ventouse delivery and four underwent caesarean sections, of which two were undertaken as emergency procedures and two were planned in advance. Although the remaining five teenagers would be defined, for statistical purposes, has having experienced 'normal' births, most nonetheless experienced varying degrees of intervention, including artificial rupture of membranes, episiotomy, oxytocic drugs to hasten labour and/or deliver the placenta, and instructions regarding the consumption of food and drink, and physical movement during labour. Additionally, midwives attempted to control the emergence of the baby, sometimes by denying women's somatic messages that birth was imminent, and/or by issuing instructions about pushing.

There has been considerable debate recently about an association between the increased use of epidural anaesthesia and caesarean section rates. This trend is apparent even in countries such as New Zealand, where midwives have considerably more autonomy and are less pressured by a medicalised birthing agenda (Bulger et al., 1998). Although a recent review of the evidence proposed a number of strategies for reducing caesarean rates, the authors conclude that implementation of these plans is dependent upon 'the social and cultural milieu and on associated beliefs and practices' (Walker et al., 2002:28). Enmeshed within these discourses are issues of control over the birthing agenda and over women's childbearing bodies.

There are tensions between those supporting 'technocratic' (Davis-Floyd and Mather, 2002), and 'normal' (Downe, 2006) approaches to childbirth. It may be useful in this context to consider childbirth as a 'performative' (Butler, 1990) act, in which birthing audiences have vested, but often opposing, interests. Hence, the experience of childbirth does not belong solely to the mother, but rather becomes a collective and shared experience of importance to all who are present in the labour room at a particular moment. Audience participation in the woman's labour may thus be used as a justification for epidural anaesthesia, because freedom from pain 'makes women nicer to be with [...] is akin to "sexual liberation" in placing women more squarely at men's disposal while in no way curing their estrangement from their bodies' (Oakley, 1979[1986]: 21-22). Whilst relief from pain might be welcome, the sudden loss of bodily sensations and control is complex and confusing, all the more so for young women whose relationship to their changing adolescent bodies has been recently acquired and is therefore more likely to be experienced as both tentative and as a 'work in progress'.

Within the paradigm of medicalised childbirth, labour is divided into discrete stages which reflect key physiological events[93]. The second stage, during which the baby is born, is confirmed by a fully dilated cervix (10cms) and descent and rotation of the baby's head (or bottom). Notwithstanding the effects of an epidural and a supine position, the labouring woman is then declared ready to give birth.

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[93] The first stage of labour includes descent of the baby in the birth canal and progressive cervical dilatation (0-10cm); the second stage includes the birth of the baby; the third stage is completed by the delivery of the placenta (afterbirth) and membranes. The addition of a fourth stage, which includes the first few hours following birth, is currently under consideration.

Pushing in labour has been something of a debated issue in recent years (Bloom et al., 2006; Byrom and Downe, 2005), with discussions focusing on the pros of cons of directed (active), versus non-directed (spontaneous), maternal effort to birth the baby. Many teenagers in this study reported being instructed to push when they had no urge to do so, and as Jade and Michelle describe in the following excerpts, they were also requested to refrain from pushing when the urge was overpowering:

> ...with Gemma [Jade's second baby] they kept telling me, 'Don't push, don't push.' But I were just pushing anyway. Couldn't help it. I were in agony. You can't control it when it's like that. They kept saying, 'No, no, don't push yet!' I says, 'Why, why not? I can't help it, I have to push. I can't help it.' I were screamin at 'em. I were saying like, I'm not pushing, it's not me pushing. It's my body is! It's not me that's pushing.
> Jade, four months after the birth of her second daughter. SY

> When I said, 'Baby's coming', I were told, 'Shut up and close your legs'. [...] I said, 'I can feel baby coming'. She said, 'Don't be stupid, it's not coming, it's not.' I said, 'It is'. I could feel it. She said, 'Don't be so stupid, shut up and close your legs'. Well my legs didn't want to be closed. [...] I were going mad. [...] They were telling me it weren't coming but I knew it were and then she said, 'Do you think I should have a look?', and the other one said, 'No, she's all right, she's all right'. Then the anaesthetist said, 'Well I think you should have a look'. Then the other midwife said, 'Oh, it's OK love, the baby's coming'. That were it then.
> Michelle, son aged six months. SY

A small number of respondents were unable to recall the experience of giving birth, because of the effects of the pain relieving drugs they had received. In the following excerpt, April recalls her first labour and compares the experience with being 'smashed', with all the connotations of recreational drug use:

> HS: You said earlier that when you went into labour that you didn't know what was going on?
>
> April: Yeah. That's right. [...] I had two bottles of gas and air, and then I fell asleep about half eleven. The baby was born at one minute past one. I woke up then, and she was on my stomach. [BF's] brother was standing by the side of me and there was this baby on me. I didn't know where it came from. I'd had way too much gas and air to remember anything. And they gave me an injection as well. I was well out of it. I hadn't been that smashed in a long time, and it wasn't my fault this time! *Laughs.* Next day I felt like I'd been on a real bender. I felt terrible.
>
> April, ten weeks pregnant with her second baby. W

Substantial numbers of young women reported that staff disagreed with their interpretations of embodied, labour-related, events. Even when teenagers reported sensations which suggested to them that birth was imminent, their appeals for help often failed. Not being listened to, or not having one's viewpoint regarded seriously, was a recurring theme in the narratives from women contributing to the 'Informed Choice' study (Kirkham and Stapleton, 2001). The same study also demonstrated that it was the voices of the most marginalised women which were most likely to be ignored.

Culturally inscribed rituals: skin to skin contact

Unlike their middle-class counterparts, many young women expressed ambivalence about immediate (skin-to-skin) contact with their newborn babies.

> HS   When Chloe was first born, what was she like?
> Clare   She were just laid there on bed. She didn't do anything...
> HS   Did she cry?
> Clare   No. She didn't cry for ages. She were just looking around. Midwife were telling me to pick her up, she were saying, 'Oh your baby's out now, your baby's born, you can pick her up now', but I didn't want to. I were just looking at her.
> HS   And did you pick her up?
> Clare   No, midwife did. She gave her to my mum. I didn't want to hold her then. I were too tired. And anyway she were still all slimy. *Laughs.*
> Clare, daughter aged nine days. SY

Current expectations are that all mothers will respond immediately and positively to the birth of their baby; absent, or delayed, maternal responses risk being interpreted by maternity professionals as a sign of incipient maternal pathology. Hence, respondents were prevented by maternity staff from acting as they saw fit and it was the norms of the institution which were the important arbiters in regulating individual performances. Insisting that mothers have immediate contact with their new-borns is now normative in Western birthing environments, because such contact is understood to facilitate maternal-infant bonding and to promote breastfeeding initiation (Anderson et al., 2003; Hodnett, 2002; Mikiel-Kostyra et al., 2002).

That there is a 'right' (professionally-defined) way and a 'wrong' (teenager-defined) way of doing things was never in doubt for respondents. Throughout pregnancy, and after, teenagers were closely scrutinised by professionals, and were often identified as lacking in skills, judgement, or both. There was little encouragement for respondents to use their own initiative and even less recognition that 'mistakes' are an inevitable consequence of embarking on a parenting career, regardless of age.

Death and loss in pregnancy

Two respondents suffered pregnancy losses during the research period. Luci, who was carrying twins, was informed in her fourteenth week of pregnancy that one baby had died. Lowri suffered a sudden, and unexpected, intrauterine death at thirty-two weeks gestation. The phrase 'pregnancy loss' is something of an anomalous term, but one which is usually taken to mean the unanticipated demise of the 'baby'[94], at some point between conception and the early post-partum period. Like other bodies, a baby's body 'is always imbued with social significance, not the least when it is a dead body [...] what the body becomes – what it means – is tied up with one's way of approaching it' (Radley, 2000:299). Loss of a baby, by any means and at any age, is now inextricably linked with bereavement rituals. But this

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[94] The use of parentheses draws attention to the fact that biomedical 'advances' permit the confirmation of pregnancy at an ever earlier gestation, when the appearance of the foetus is embryonic in appearance.

was not always so. Historically, and indeed in contemporary non-Western cultures, the spontaneous loss of a baby in pregnancy, for example through miscarriage, is a routine event[95]. It is also one for which women may make pragmatic allowances, by having many children over the course of a childbearing career, in order to replace babies 'born to die' (Cecil, 1996:7).

'New' reproductive technologies and significant changes to socio-economic patterns and structures have resulted in women in contemporary Western societies conceiving, and giving birth to, an ever decreasing number of children. It has been suggested that 'these demographic changes, wherever they occur, affect perceptions of human life, personhood, life stages (including the modern 'invention' of childhood and adolescence), and family roles and social sentiments (including mother love). They also alter perceptions concerning the relative value of the individual as measured against the collectivity (whether nuclear or extended family, lineage or community)' (Scheper-Hughes, 1992:401). One consequence of a reduced fertility rate (and greater access to material wealth), is the tendency to invest more heavily (materially and emotionally) in fewer children. Hence, every child becomes an ever more 'precious' child, not least because there is neither the time, the inclination, nor indeed the financial resources in the case of privately funded fertility treatment, to replace it.

Reproductive technologies to diagnose pregnancy are now available much earlier in the conception trajectory and this makes it possible to actively construct the sexed personhood of the child well in advance of its birth. And whilst every person confided in about the impending birth, every cigarette and alcoholic beverage abstained from, and every item purchased for the baby-to-be, increases its sense of 'realness', paradoxically it also magnifies 'the realness problem of pregnancy loss' (Layne, 2000:323). When a baby dies, parents-in-the-making are confronted with social taboos and awkward questions about the baby that 'was', and when there is no baby to welcome, the support previously offered may be withdrawn and replaced by rejection and awkwardness. It has been suggested that the collective denial of pregnancy loss seriously 'challenges the validity of the cultural and biological work already undertaken in constructing that child and belittles the importance of the loss' (Layne, 2000:323).

o   Losing a twin

Luci had first consulted her GP shortly after she had missed a period. She suspected she might be pregnant, as the last time she and her boyfriend had had sex, she was mid-cycle and the condom had burst. Initially, Luci had considered a termination, but then decided to proceed with the pregnancy, after an early ultrasound scan confirmed she was carrying twins. A further routine scan at fourteen weeks revealed that one twin had died.

Luci's aunt had accompanied her to the hospital for the routine scan, to confirm the expected date of delivery. Neither Luci's boyfriend nor her mother had been able to attend the appointment,

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[95] One of the most poignant accounts of impoverished and powerless women's 'everyday' losses in childbirth is that written by American anthropologist Nancy Scheper-Hughes (1992).

because neither employer would grant the necessary leave from work. The way in which Luci was informed about the death of one of her twins caused her, and her family, considerable distress:

Luci	When I had the scan, they just checked over the baby that was still there. [...] They weren't very nice. They just said, 'Well one of them's dead but the other one's still there.'
Gavin	She had no counselling. She had nothing. They should have tried to comfort her but she had nothing. [...] To her she's lost a child. To everybody else she's lost a child. It's part of us isn't it? It's not just a piece of bloody garbage you can chuck away. It's part of her body. It's the baby we both made. *Starts crying.*
Luci	When they told me one of the babies was dead, they took me into a room all by myself to tell me. They left my aunty outside and they took me in and they asked me if I still wanted to go ahead with the pregnancy, or if I wanted to have a termination.
Mum	She had no comfort at all. [...] They told her one baby was dead and then they left her aunty in the corridor and they took her into a room all by herself and one of them asked her if she wanted to continue with the pregnancy or, seeing as one was dead, did she just want to have a termination with the other one? She was all by herself and they took her inside this room and asked her that. [...] What right have they to do that, to take a young girl like her inside a room all by herself when she's just lost a baby without anyone to comfort her?

Luci, fifteen weeks pregnant. W

The conflation of life and death in this narrative is heightened by the insinuation that, because one baby has died, Luci might want to reconsider her decision to proceed with the pregnancy. Although Luci told me she had not discussed her earlier deliberations regarding termination with maternity staff, they may have inferred this possibility. The absence of comfort in 'bad birth stories'(Murphy-Lawless, 1998: 246), highlights the lack of agency[96] experienced by recipients of maternity services, especially when they are poor, young, or otherwise marginalised.

o   Sudden death in late pregnancy:

Lowri had decided from the outset she was keeping her baby. She had left school and had just been accepted for an apprenticeship, training as a chef, when she realised she was pregnant. Lowri had periodically complained about feeling unwell throughout pregnancy but health professionals ascribed her symptoms to the fact she was pregnant, rather than poorly. However, a post-mortem on her baby revealed that Lowri had contracted Cytomegalovirus, a type of herpes virus associated with miscarriage, congenital deafness, premature labour and/or stillbirth. The following narrative focuses on the events of labour and birth:

| Lowri | I had my second pessary [to induce labour] and that was the only time anyone had looked at me down there. That was five hours and nobody had even looked at me. [...] My mother and [boyfriend's mother] were sent out of the room for me to have the epidural. After they put the injection in I said, 'No I can still feel it'. The midwife said to |

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[96]By agency here I mean the individual's capacity to actually command influence, as opposed to having any intention(s) in this regard.

me, 'Oh, don't be so stupid'. Then the other one, she was like, 'No, no, don't take any nonsense with her.' [...] I mean all right, fair enough, they've got a job to do, but like I say, if I had something to look forward to at the end of it then maybe they'd have been different. But I didn't have anything to look forward to and after I delivered I was in a bit of a state, obviously. When I knew the baby was coming I was asking, 'Can my mum come back in with me?' 'cos I was on my own. But the midwife said, 'No, no, you can do it on your own. You'll be all right love.' She said, 'You can do this on your own.' But in the end I told her to shut up and get my mum. [...]

HS   What happened after your baby was born. Did you see her?

Lowri   No, I didn't want to. It was offered. The midwives had been saying to me all day, 'We think it's best if you do (see the baby)' [...] I had my eyes shut and she [midwife] said, 'Do you want to see her' and I said, 'No'. So she took her away. She didn't say whether it was a girl or boy, she just said, 'Do you want to see the baby?' She came back in then, after she weighed her and everything, and told me everything. She asked me again, and then she kept on asking me all the time, but I kept on saying 'No'. [...] They did put a lot of pressure on me to see it.

Dilys   Yes they did, and they were asking her questions about what she wanted to do with the baby, and afterwards, about the funeral and things but she was just too shocked to think straight. If you asked her a question it was, 'I don't know, I don't know'. She didn't know anything. She was just so shocked. She didn't know herself. She didn't know what she wanted, but the hospital was trying to get her to make decisions all the time. She couldn't. She was just too shocked. I do think if it had been me going through that experience they'd have been more understanding, just on account of me being older. I do think the younger ones don't get the same care, and that's a real problem when it all goes wrong, because it can stay in their minds forever, and it might even put them off having children forever. The feeling you get from them is like, oh, you're young, you'll get over it, you can have another one.

Lowri   Afterwards they wanted to have a look, to check that everything was all right,and I really just wanted to be left alone. She [midwife] said, 'Oh let me just have a look, can you lift up your legs for me', and all that. But the other one was just so heartless, really. She said, 'Well love, I'll tell you, the only good news you'll hear today is that you haven't got to have any stitches'. That just finished me off. [...] She just made me so mad. I thought, 'Oh you are so heartless.'

Lowri and Dilys (her mum), W

The 'heartlessness' of midwives, which Lowri's mother attributes to the fact of her daughter's youth, is a recurring theme in respondents' narratives. Varying degrees of 'heartlessness' also characterised interactions between other care providers and study respondents, although perhaps never quite to the extent where practitioners might be described as adopting the 'totalizing emotional defence against suffering or death' (Radley, 2000:300), so evident in Lowri's and Luci's accounts. Lowri also draws attention to the normative processes of 'doing' bereavement in contemporary institutionalised maternity settings. This typically involves care providers paying due attention to particular memorialziing practices: the bereaved mother is expected to hold her baby, to allow photographs and perhaps a lock of hair to be taken, and to have her dead baby's foot and handprints recorded. There is also an autopsy to be agreed and a funeral to be to be arranged. The bereft mother then makes her way into the world without a baby, but with a collection of mementos. From Lowri's account, it seemed that these aspects of the bereavement ritual assumed greater significance for the midwives than did her labour and birth. Or, perhaps, it was because these aspects were more clearly defined, and midwives were more

comfortable dealing with the physicality of death, rather than the emotional aftermath. It is also possible that Lowri had lost all trust in the midwives and her refusal to conform to their expectations may be read as an expression of her displeasure and disappointment.

CHAPTER TEN: MOTHERING IN THE EARLY POSTNATAL PERIOD

This chapter examines health professionals' attitudes and contributions to young women's lives at the point where they became mothers, mostly for the first time. I discuss how respondents and their kin 'made' and 'did' family, including naming and registering the baby. Finally, I examine discourses underpinning infant feeding practices and how they shaped (adolescent) maternal identities.

Learning to mother: the significance of place and the influence of others

Many teenagers reported that their initiation into motherhood was marred by the critical and unhelpful attitudes of maternity staff and older females. Criticism was voiced in the first instance by midwives, and subsequently by health visitors and some mothers and mothers-in-law. Most young women had already accumulated considerable previous experience of caring for older infants through their involvement with siblings and other young relatives. Familiarity with childrearing practices is relatively rare for new mothers in late modernity, as the socio-cultural context in which these informal knowledges and skills are acquired is generally not available outside working-class and minority ethic communities (Miller, 2005). In this sense, adolescent mothers may be perceived as having an advantage, although this is rarely acknowledged. Whilst they were in hospital, young women's embodied childrearing knowledges were rendered inaccessible by competing institutional norms. The short periods (between one and three days) spent on postnatal wards were mostly recalled as unpleasant experiences and narratives confirmed that most teenagers felt 'chucked in the deep end' with respect to caring for their newborn babies:

> I was chucked in the deep end [...] She [midwife] said, 'He needs a feed,' and she gave me this bottle and this teat. You have to take the top off the teat and put it on the bottle but she didn't tell me that. And it was cold milk as well, which I didn't like. So I used to [...] warm it up. It wasn't totally warm but it wasn't cold cold. It was like luke-ish. So I used to give him his feed and I used to think, 'He's only taken that much, he's going to starve.' I tried to get him to drink all his bottle, but he wouldn't. He would only take a tiny bit and she said, 'Don't feed him again with the same bottle, you have to chuck it away.' I was thinking well that's a real waste, why do they give you such a big bottle when he's only going to take such a little bit? That bottle was that big and he was only having that much. [Alys indicates with her fingers] And then she said, 'You have to change him.' So I changed him. I knew what to do, 'cos I'd done it loads of times with [younger brother]. I was changing him on the bed, and she came and said, 'Don't change him on the bed, that's where you get an infection. You must change him in the cot.' I was thinking, 'But the cot's only that big!' *All laugh.* Alys, son aged two years. W

As well as feeling judged by midwives, many young mothers felt disapproved of by older mothers on the postnatal wards. A general sense of being expected to get it wrong, which most teenagers reported, has been echoed elsewhere (Dykes and Moran, 2003).

> You just knew whatever you did it was going to be wrong. You know, 'Oh you don't put the nappy on like *that* and Oh, is he *still* crying?' It really got on my nerves.
> Michelle, son aged two weeks. SY

During a conversation about this incident, some months later, Michelle agreed with my suggestion that the pressures on young mothers were similar to those induced by examination conditions. Indeed, the anxieties generated in anticipation of (in)adequate performance, stimulated negative memories of being back at school again:

> Michelle When I'd had [baby] I remember her [midwife] saying, 'Now I'm going to show you how to bath him', so she showed me and the next day I had to do it in front of her. Oooh, the sweat were dripping off me! *Laughs.* It were awful. I were completely panicked. I'd never done it in front of anybody before. I remember thinking, 'Oh, shit, I wish I'd gone to them [parentcraft] classes so I'd have known something'. *Laughs.*
> HS   Mmm, yeah, but it also sounds a bit like you were doing like a test or something?
> Michelle Yeah it were a bit like that. *Laughs.* It were like I were back at school again. *Laughs.* It were really awful. I were so scared of dropping him...
> Michelle, son aged four months. SY

Adolescents' experiences on postnatal wards suggested that midwives were generally unable to empathise with their acute sense of disorientation. Many young women described personal behaviours which might be considered as psychologically regressive before they were considered 'fit' to discharged; all young mothers returned to the familiarity of their homes at the earliest opportunity. Once home, family members generally welcomed the new mother and baby and adjusted personal and domestic routines to accommodate them, although that is not to imply these transitions were undemanding with respect to family dynamics. In particular, the issue of 'ownership' of the baby caused considerable tensions between young mothers and other female family members:

> I hate everyone messin' with her [baby]. It's like [older sister] and [younger sister], they're always picking her up and holding her, so she's never sort of quiet, like. It's not even when she's awake or she's crying. They just come in and pick her up. They never ask me if it's all right. Clare, daughter aged nine days. SY

> His [BF's] mum, she acts like the baby's hers [...] last night she wouldn't let me feed her 'cos she said I weren't doing it right. Lou, daughter aged four days. SY

For most young women, issues of ownership and authority were generally resolved once the 'novelty factor' associated with the arrival of the new baby dissipated. Lou and Tracey, however, faced more problematic transitions as their maternal efforts were constantly undermined by older female relatives who were unwilling to affirm the teenagers' attempts to negotiate a personal style of mothering.

Midwives and health visitors also undermined young women's efforts to establish a maternal self. This was sometimes unintentional, for example when they suggested that they take it easy when their personal circumstances did not permit them to do so:

You know you shouldn't be running about as much as you are, petal. You've had a major operation. You need to be careful. Remember, that's major abdominal surgery you've had. You've got to take it easy or your scar could burst open you know. It needs time to heal properly. You've got to rest up. Let others do things for you a bit more.
Community midwife (CM7) and Tracey, two days after a c/s with her second baby. SY

Tracey's older child was just thirteen months old at the time. Her boyfriend, with whom she lived, was learning disabled and received incapacity benefit on account of longstanding mental health problems. Tracey's mother lived on the other side of town and her chaotic lifestyle meant that what help she did offer was unpredictable and unreliable. Adequate rest was therefore not an option for Tracey, because there was no one to provide the nurturing care the midwife suggested was needed. She was, nonetheless, admonished.

Discourses on the family as a social unit in need of management and reform have a long history in the health service where health visitors, in particular, are seen to embody the combined roles of 'inspector, social worker and teacher' (Symonds, 1991:256). Hence, the established role of professionals in monitoring maternal behaviours, and policing family life, on behalf of the state. Health visitors are normally the key health professionals involved in the lives of new families but research findings are equivocal as to whether unsupported young mothers perceive their input to be a helpful or not (Knott and Latter, 1999). When compared to midwives, whose professional contribution generally ceases at ten days after birth, health visitors have been described as too 'businesslike' and 'judgemental' (Hunter, 2004:25). Continued support from community midwives has been reported as preferable to that provided by health visitors, because midwives are generally already known to the family and are perceived to be the 'experts' in infant care (Hunter, 2004:25). In my study, many respondents viewed the contributions of both professional groups as generally unhelpful.

A 'classed' dimension to these discourses is evident in the orientation of many policy reforms, where the gaze of reformers set squarely on the working classes, the group traditionally perceived as having greater need for remedial intervention to improve health outcomes. In this sense, policy formulation can be said to reflect long-held professional preoccupations, rather than addressing the needs of marginalised groups. The interface between health care providers, recipients, and the state is regulated by an ever-expanding armoury of disciplinary technologies (Rabinow, 1991) which operate to scrutinise family practices[97] and coerce 'wayward' families into compliance with middle-class

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[97] Although I am referring to practices which concerned mother-child relationships, women's performance of the emotional labour which characterises all mothering activities has been shown to extend to other dimensions of female experience including the labour market and midwifery/nursing care provision. See (Hochschild, 1983; Hunter and Watts, 2003). In discussing the concept of family practices, David Morgan (1999) stresses the significance of five overarching themes: the interplay between various actors - the 'action' component; a sense of the active rather than the passive or the static - how individuals 'do' family; a focus on the routine, trivial and everyday matters – the not-worth-talking-about experiences; a stress on the repeatability and regularity of routines which tend to go unexamined; and interplay between history and biography - between the macro and micro of individual experience.

behavioural norms. The autonomy and privacy of the family are thus increasingly encroached upon, for example with respect to regulating infant feeding practices (Murphy, 2003).

Wrong(ed) maternal bodies

Many of the young women that I studied began their mothering careers under the mantle of a wrong(ed) body. For the poorest and most marginalised respondents, including Lou, Tracey, Jade and April, the 'wrongs' they endured through their exposure to maternity services simply added to their accumulated sufferings. Michelle, Alys and Lowri on the other hand, had grown up with a sense of being wanted and valued members of their respective families. They presented as sociable, articulate, and confident young women who were used to making at least some of their own decisions or when in doubt, consulting with respected others. The manner in which interactions were conducted by maternity staff came as something of a shock to these respondents, as they were unaccustomed to 'doing' deference, in accordance with the expected norms of 'marginal' persons. Nor did they identify themselves primarily as 'pregnant teenagers' - with all the negative connotations - but rather as young women who had simply encountered a patch of bad luck..

As the following quotation illustrates, midwives' opinions carried such weight that pregnant teenagers were generally framed negatively within the maternity environment:

> When she [Alys] first went to the clinic, after they'd finished with her they just left her hanging about. [...] Once I was there with her, but they didn't know who I was. They didn't know I was her mother. I overheard this one [midwife] saying it was a disgrace to see girls of Alys's age pregnant. It was just a disgrace. They were looking over at Alys and one of them said, 'There are people who shouldn't be mothers and there are people who should be mothers'. I knew she was talking about Alys when she said about the ones who shouldn't be mothers.
> Angharad (Alys's mum) W

The following excerpt summarises a midwife's commentary, following her visit to April, an extremely poor young mother living in a squalid, cockroach-infested squat, with her nine month-old baby daughter. April had recently become pregnant with her second child by a different father.

> [CM15] does not wait until we are in her car before she starts listing April's wrongdoings. As we drive away from her house she really lets her have it: Why is she is still in her pyjamas when we arrive [at 1130hrs]? Why has she not already made up a feed for her baby? Why is the dog allowed to sleep in the same room as the baby? And why is the baby also still asleep so late in the morning? The midwife also comments on the dirtiness of the house and the general state of disrepair. When she had undressed the baby [waking it first] the midwife had discovered a weeping rash on her genitals which she insisted was due to her lying too long in a wet nappy. April contested this diagnosis, arguing that the rash was caused by chlorine irritation from taking her swimming the previous day. The midwife's tone of voice suggests strong disapproval of April's style of mothering and indeed, she later confided that she would liked to have taken April's baby home with her for a bit of 'real mothering'.
> Fieldnotes, community midwife(CM15). W

I observed this midwife on a number of occasions whilst undertaking research for the Informed Choice

project (Kirkham and Stapleton, 2001), accompanying her to the homes of a wide range of women. Her responses to her most disadvantaged clients were similar to those described above, and although I found her criticism difficult, I also appreciated that she was in an impossible situation. Whilst she had a professional duty to protect, and promote, infant welfare, her poorest clients' lacked control over the material circumstances of their lives and, hence, maternal and infant well-being would inevitably be compromised.

Body matters: recovery and surveillance in the early postnatal period

All the young mothers, including Lou and Tracey, who endured long and difficult labours followed by emergency caesarean sections, made speedy recoveries from the physical effects of labour and birth. Midwives and mothers identified youthfulness as being a primary factor in the teenagers' excellent recuperative processes:

> HS   I thought Lou made a remarkably quick recovery from the caesarean. What did you think?
> Midwife Yes. Yes, she did pick up very quickly didn't she? [...] I think that might be to do with her age. The younger ones do tend to pick up quicker than the older mums.
> Labour ward midwife (LW8). SY

> I know when you're an older person that you're more likely [to have problems] but at her age well, they spit them out no problem, don't they? Angharad (Alys's mum) W

A number of respondents reported feeling uncomfortable when maternity staff did not appreciate their embodied sensitivities to the norms of clinical routines. Customary practices, including exposing the 'sexed', leaking, and/or disrupted aspects of young women's maternal bodies to strangers, especially in settings where privacy could not be guaranteed, caused considerable embarrassment and distress.

> They [midwives] came to check my [perineal] stitches all the time. Asking me to lie down and pull my clothes down so they could have a look. That were, that were just so embarrassing. Clare, daughter aged three weeks. SY

> They didn't care if you were half naked and the curtains were pulled. It was horrible. [...] I were sitting there and she came in and she just pulled my top up to look at my boobs. I nearly smacked her one. *Laughs*. Jade, two weeks following the birth of her first daughter. SY

Some young women reported being angry when their consent was not sought for students to undertake physical examinations. Two years after this experience, Alys vividly recalls her indignation:

> One day she [midwife] brought a student with her [...] She checked my stitches first and then she called the student over to look as well, which I found just so embarrassing. She didn't ask

me if I minded, she just asked the student to have a look. I think she should have asked me if I minded first. [...] It was none of the, 'Do you mind if we...?' Alys, son aged two years. W

Uninvited bodily exposure seemed less problematic during labour, perhaps because women's expectations in this regard are somewhat different:

> I didn't care when I were in labour, you could have three monkeys in there and I wouldn't have minded who had a look, but afterwards it were just so embarrassing.
> Clare, daughter aged three weeks. SY

The presence of mothers and/or significant others during labour may have worked as a protective device, whilst pain-relieving drugs may have reduced teenagers sensitivity to procedures which would normally be perceived as invasive.

Despite attempts in recent years to encourage maternity staff to be more mindful of their clients' needs for privacy, unannounced intrusions remain commonplace. Whilst it may be relatively uncomplicated to make cosmetic adjustments to the material aspects of the maternity environment, for example by fixing locks to doors and blinds to windows, changing the habits and attitudes of staff is a rather more complex, and long-term, task.

    o   The six week postnatal check

As far as I could ascertain, all respondents visited their GP for a routine postnatal check, generally around six weeks following birth. As a minimum, they anticipated that the doctor would perform a vaginal examination, 'to check everything were all right', and to assess perineal and/or abdominal wounds for signs of satisfactory healing. In the event, GPs rarely appeared to do anything which young women considered to be of value:

> HS   Did you have a check-up afterwards with your GP?
> Clare   Yeah. He didn't do much though. He just had a feel of my tummy and that were it. It were waste of time really. He didn't do nowt.
> HS   So he didn't look at your stitches or ask to do a vaginal exam or anything like that?
> Clare   No, nothing. I didn't want internal anyway, so he just says well I won't look at your stitches either, then. I didn't mind if he looked at my stitches, 'cos they were still a bit sore, like, but I didn't want internal, because they really hurt when they did them in labour. [...] He says, 'Oh well we wouldn't have even asked you to have one [an internal] if you didn't want one anyway. We wouldn't force you to have one.' [...] I may as well have not bothered going. [...] It were waste of time really.
> HS   Yeah? Was that different from what you thought was going to happen?
> Clare   Yeah. Health visitor said I would have to have an internal with me being so young 'n all, and he would look at my stitches as well, but he never did any of them things.
> Clare, daughter aged five months. SY

Many respondents voiced expectations about age-appropriate maternity care. Adolescent mothers were widely perceived as requiring greater input from midwives and other professionals and many expressed

surprise when they received much the same care as other pregnant women. Indeed, compared with middle-class women, I observed many teenagers receiving an inferior standard of care and, in this respect, the 'inverse care law' (Hart, 1971:405) remains influential in maternity care (Kirkham et al., 2002).

    o   Cervical screening in the puerperium: medical bargaining and women's resistance

The NHS Cancer Screening Programme[98] currently recommends that women aged between twenty-five and sixty-four are offered cervical screening and, in the UK, financial incentives are offered to encourage medical practitioners to achieve annual targets. Women aged between twenty-five and forty-nine[99], with no previous history of atypical smears, are offered screening every three years; between the ages of fifty and sixty-four, screening is offered at five-yearly intervals. Although clinicians may offer, and women may request, screening either side of these age limits, such investigations carry no financial incentive.

Opinions vary about the appropriateness of undertaking cervical screening in the early postnatal period. From a clinical point of view, smears taken during this time may return an equivocal result, on account of the 'hyperoestrogenic' environment effected by pregnancy and/or breastfeeding. Given that 'best estimates [of conventional screening programmes] suggest it is only moderately accurate and does not achieve concurrently high sensitivity and specificity' (Nanda et al., 2000:810), screening undertaken during clinically sub-optimal periods, including the early puerperium, may be less than helpful. To date, limited evaluative evidence is available for the use of liquid-based cytology screening[100] recently introduced throughout the UK (National Electronic Library for Health, 2006).

Some teenagers reported GPs insisting on the necessity for a cervical smear, as a prerequisite to obtaining hormone-based contraception. This stipulation, which has no scientific basis, proved problematic for respondents wishing to resume early sexual relationships because cervical screening was generally not available within three months of giving birth:

> I went to my GP to go back on the pill again, but she said I had to wait until [the baby] was about three months old. She said I had to have a smear first. [...] She was a bit funny with me. She said things like, 'Oh you can't want to have sex again yet anyway, you've only just had a baby.' Michelle, son aged six weeks. W

> My doctor wouldn't give me another prescription for pill until I had a smear test. I'd never had one [smear] before, and I didn't really want one, but he said I had to have one or he wouldn't give me pill. Clare, daughter aged three months. SY

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[98] See: http://www.dh.gov.uk/assetRoot/04/12/68/74/04126874.pdf
[99] At the time of my fieldwork, the lower age limit was 20; this was raised to 25 in April 2006.
[100] The system for preparing cervical samples in UK laboratories currently uses liquid-based cytology. See: http://www.cancerscreening.nhs.uk/cervical/lbc.html

It is difficult to know whether the practice of insisting on a cervical smear as a pre-requisite to accessing postnatal hormonal contraception is anomalous or whether, and to what degree, it is routine within the wider medical community. While the general consensus is that smears should not be undertaken in the first six weeks following delivery, there is no specific guidance on this issue. And although cervical screening for teenagers is not incentivised, the widespread stereotyping of this population identifies them as a likely target for opportunistic testing. There are obvious tensions here with respect to government targets to halve conception rates in the under 18s by the year 2010 (SEU, 1999), particularly with respect to preventing second pregnancies, reckoned to account for 20% of all births to this age group (DfES, 2004). In order to meet these targets, health professionals will need to demonstrate more, not less, flexibility in their attitudes and in developing appropriate, and user friendly, services for teenagers.

Some young women reported their first smear test as being very uncomfortable, not least because it reactivated negative memories of labour:

> It were horrible. [...] I were shakin' 'n shakin' after it. [...] If I'd known it were going to be that horrible I'd have asked my mum to come with me. [...] It felt like when I were in labour and they put my legs in those poles so they could fetch baby out.
> Michelle, son aged five months. SY

Alys was particularly upset when the results of her smear test indicated abnormal cervical cells[101] and the need for further investigation. When she returned to the clinic, she did not appreciate that a colposcopy[102] would be performed and a sample of the affected cervical tissue removed for laboratory examination:

HS   So you were by yourself – you didn't have anyone with you?
Alys   No, 'cos like I said, they told me it was just for another smear test. [...] I was terrified. [...] You were sitting on a dentist's chair and they put your legs in stirrups. It felt exactly like the labour room. [...]
HS   Do you know why your cervix has got these abnormal cells?
Alys: No. The only thing I can think of is that it's something to do with having him (baby). I never had trouble before him.
Alys, son aged two years. W

Although Alys appears to link her atypical screening result to the birth of her baby, there is no evidence that these events are causally related.

o   Health professionals and health messages: contraception, contraception, contraception...

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101 Commonly referred to as cervical intraepithelial neoplasia (CIN), which is strongly associated with specific strains of human papilloma virus (HPV).
102 A colposcopy is an examination of the cervix (the neck of the womb) using a specially designed microscope (a colposcope).

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Health professionals' concerns for young women's health in the postnatal period did not necessarily reflect teenagers' agendas. The one health message which teenagers reported that most health professionals emphasised was that of contraception. As I have previously explained, however, this was at odds with the restrictions some GPs imposed on accessing hormonal contraception in the early postnatal period.

> HS   Has your doctor been to see you then?
> Lou   Yeah. But he were horrible. He were just on 'n on about if I were using contraception. [...] Before I left hospital [twenty-four hours following c/s] midwives were banging on 'n on about it as well. *Laughs.*
> Lou, two days following an emergency c/s under general anaesthetic. SY

From my observations of midwives undertaking routine postnatal visits, the focus on contraception was often inappropriately timed and improperly presented. At different times throughout my fieldwork, both for this study and for the 'Informed Choice' study (Kirkham and Stapleton, 2001) which preceded it, I also observed a tendency for midwives to construct the most disadvantaged teenagers as appearing to be singularly focused on sexual intercourse and unregulated reproduction. In the following excerpt, a community midwife shares her suspicion that, in order to present herself in a better light, April lied about her use of contraception:

> During the consultation the midwife asks April about her previous history of using contraception. April tells her she was on the pill and that she and her boyfriend were also using condoms. The midwife purses her lips and exhales loudly; her body language suggests that she does not believe her. Later, she tries to trick April into admitting that she had forgotten to take the pill - an accusation which April quickly refutes. After we leave the house the midwife tells me that she thinks April is a 'liar' and that she doubts whether she has ever used any form of contraception: 'You can see she's that type of girl but she has to put the front on for us. You know, seventeen, pregnant with the second kid, unstable relationship, grotty housing, blah blah blah...'
> Fieldnotes, interaction between community midwife (CM17) and April, who is ten weeks pregnant with her second baby.

I rarely heard midwives challenging assumptions about the gendered nature of contraception responsibilities, an omission which is reflected in the research literature. For example, a highly successful specialist service operating in the South Tyneside region of the UK for the past twenty years, which currently provides 85% of the service needs for local teenagers, lays emphasis on 'the young *woman* [to feel] *she* has made a well-informed choice about *her* chosen method and that *she* has enough information, knowledge and understanding to take ownership of *her* choice' (Doherty and Smith, 2006:238 emphasis added). It was generally young women in this study who organised contraception: who took the pill or consented to the administration of injectables. Even when they suffered distressing side-effects, including headaches and weight gain, young women generally lacked the authority to persuade boyfriends to use condoms:

> HS   So Pete, if you're not wanting another baby right now, what's going on with contraception?
>
> Pete   I don't know, you're [to Lou] the one that goes to doctors, you're the one that gets the pill. I don't go to doctors me. Don't like 'em.
>
> HS   But you don't need to go to the doctors to get condoms?
>
> Pete   Whatever. Don't like using condoms anyway.
>
> Pete (Lou's boyfriend) SY

When I questioned other young women about the stance their boyfriends adopted on this issue, Pete's response proved typical. The terms of the current NHS contract appear at best unhelpful, and at worst discriminatory towards men as GPs are currently financially rewarded for providing contraception services to their female, but not to their male, clients. Additionally, many young men perceive family planning services to be run for, and by, women (SEU, 1999), and this may further discourage them from accessing provision and from participating in discussions. The following excerpt from my fieldnotes alerted me to the gendered comparisons midwives make between their own adolescent children, and the young people in their care:

> After Jade leaves the room CM3 waits until the door is closed before she leans back in her chair, sighs, and says, 'Oh, I feel so sorry for her. She's got such a lot to deal with anyway, and that's before the baby's born. [...] It makes me really glad I've only got boys. *Laughs.* I'm really, really grateful I don't have to worry day in day out about whether they're going to come home one day and tell me they're pregnant.
>
> Fieldnotes, community midwife (CM3) and Jade, eleven weeks pregnant. SY (emphasis added)

Theoretically, there is no method of contraception which is unsuitable for new mothers, although medical considerations and infant feeding decisions are normally taken into account. The majority of teenagers were initially prescribed Combined Oral Contraception (COC, otherwise known as 'the pill'), but some had rejected this in favour of injectable forms of contraception, including Depo Provera or Noristerat. 'Injectables' were generally preferred by young women because, following administration, they could 'forget about it', attending family planning clinics only for repeat injections. As I mentioned previously, some respondents were refused hormonal contraception until after they had seen a GP and completed their six-week postnatal check:

> Well, I remember she went down to make her postnatal appointment and she asked about contraception and he [GP] told her she can't have anything until after she's had her postnatal check-up. I said that was nearly eight weeks away but he still wouldn't give her anything before then. I told her she'd have to cross her legs and not let him [BF] come near her in case she fell pregnant again. *Laughs.* Agharad (Alys's mum) W

The postnatal check, and attendance by young mothers at mother and baby clinics, were opportunities for professionals to offer contraception advice and to enquire about their clients sex lives. In the

following excerpt, Lou describes a visit to her local clinic for the purpose of having her baby weighed and measured. Although this was a clinic which Lou was expected to attend in her role as a new mother, the midwife erroneously assumed she had attended because she was pregnant again:

HS   So you went last week to the baby clinic?

Lou   Yeah, I took 'er [baby] to get weighed, like. I were there 'n then one of 'em [midwives], she says, 'Have you come to see me then?'

HS   What, you mean she thought you were pregnant again?

Lou   Yeah, like I got nothing else to do. *Laughs.* I reckon I got me hands full with this 'un. *Laughs.*

HS   How did you feel when she said that?

Lou   At first I were, like, cheeky sod, you know? [...] Well, I do want another one but, same as I said to her, like, yeah I want another one but not just yet. [...] I wanna wait till she's a bit more grown up. I wanna feel better in m'self. Not so tired like.

Lou, daughter aged three months. SY

Jade described a similar response from a midwife she met in her local supermarket:

She [midwife] goes, 'Are you missing me yet then?' I goes, 'What? What'ya mean?' She goes, 'Oh, I thought you'd have been back to see me by now.'

Jade, daughter aged ten weeks. SY

Many respondents recalled similar incidents of friendly banter, particularly in their interactions with midwives and health visitors they encountered in social settings. This was particularly noticeable amongst the South Yorkshire cohort, most of whom who lived in a small town, in close proximity to the professionals providing their health care. Whilst friendly banter may be understood as linguistic convention which eases the difficulty of approaching sensitive topics, the boundaries between ironic commentary and stereotyping may sometimes be difficult to judge. Jade and Lou were two of the most poorly-resourced young women and hence may have been more vulnerable in this respect. Whilst Jade did conceive again shortly after her re-acquaintance with the aforementioned midwife, the desire to re-engage with maternity care providers was not a motivating factor.

    o   The side-effects of contraception and pregnancy: the 'fat' (postnatal) body

A number of respondents spoke passionately about weight gain as an unwanted side effect of hormone-based contraception and, indeed, of being pregnant. This issue was of particular concern in the early weeks and months following birth when many young women were struggling to come to terms with a body which had not yet shed the weight gained in pregnancy.

Only side effect [of Depo] were I put on weight. [...] Only time I were ever heavier than eight stone two [pounds] were when I were carrying him. Now I'm nine stone six [pounds]. It's horrible. Clare, daughter aged six months. SY

Some young women reported being distressed by boyfriends' comments about their changed body shape:

> Susan   He {BF] hates it when I'm fat but I keep telling him I can't help it. I told him he should try having a baby and then taking the pill and see what happens to him. *Laughs.* [...] I hate it when he teases me about being fat. It makes me really nervous. *Laughs.* I think, Oh he's gonna leave me if I stay looking like this.
>
> HS   How does your body feel to you? Do you feel fat?
>
> Susan   *Starts crying.* Yeah, yeah I do. I hate myself. I can't fit any of my clothes so I'm still wearing the horrible ones I were wearing at end of pregnancy. [...] like my trackkies [track suit bottoms] 'n that. [...] My stomach's totally revolting. [...] No-one told me I were gonna end up looking like this. *Still crying...*
>
> Susan, son aged two months. SY

Adolescent females constitute a group particularly vulnerable to media, fashion, and social pressures to conform to a stereotype of femininity which valorises thinness over most other attributes, including intellectual excellence (Tiggemann et al., 2000). However, concerns about looking attractive to males, and having the 'right' body shape to wear preferred styles of clothing, are important issues for most women, including those who are pregnant (Earle, 1998; Longhurst, 2001).

Mental (ill) health: social and biological factors

The over-representation of women in conventional and feminist writings on mental health issues has been noted (Ussher, 1991), notwithstanding explanations which differentiate biological from social aetiologies (Stoppard, 1997). The historical belief that women's hormones are a primary cause of depression is not supported by research (Brown and Harris 1978) but, rather, as something which affects women across the life course, beginning in adolescence (Nolen-Hoeksema and Girgus, 1994). Depression in women has been linked to low socio-economic status (Everson et al., 2002), which, in turn, is linked to women's lesser power and status, and greater vulnerability to sexual and psychological abuse (Nolen-Hoeksema and Keita, 2003). Whether, and to what degree, mental illness in women is socially constructed (by men), or 'real', perhaps resulting from material and/or physiological disadvantage, is a complex and unresolved question.

For some time, however, the 'women's bodies/women's lives' explanatory models of depression have polarised debates. Health psychologist Alan Radley has argued that theories of embodiment have tended to foreground the 'mindful body' but have rather neglected the 'incarnated mind' and hence have positioned 'the body as essentially a physical substrate to mind' (Radley, 2000:298). The separation of mind from body (the Cartesian split) has a long history in Western biomedicine (Kirmayer, 1988), although recent attempts to involve clinicians in creative writing programs may be interpreted as attempts to 'heal the divide' (Bolton et al., 2002:97). Illnesses are not equally 'weighted'; a diagnosis of mental illness, especially in women, is frequently accompanied by stigmatization and pathologisation. A considerable body of literature attests to the oppression of women

within patriarchal psychiatric systems, both from the perspective of the 'outsider' (Ussher, 1991) and from those who have been incarcerated (Millett, 1991). These texts explore gender subjugation by examining sex-roles and the ways in which they are reinforced, particularly within the context of institutions. They also illustrate how 'sane' and 'insane' female identities are constructed and measured in accordance with the narrow social norms of femaleness, for example by an insistence on modest clothing and a demure, passive and acquiescent, presentation of self.

Of the six young women in the South Yorkshire cohort, Tracey, Jade and Lou commenced mothering with pre-existing mental health problems. Jade's health temporarily improved when she was re-housed, following eviction from her family home when she became pregnant. With support from her surrogate parents, Jade ceased self-harming, started eating regularly, and substantially reduced her alcohol and cigarette consumption. Her mood also improved and she started to take more interest in her appearance. Following the birth of her second child, Jade and her two daughters were permanently housed in a squalid council bungalow in a rough neighbourhood some distance away from her surrogate parents and the friend she had made in the hostel where she had been re-housed. Isolation, loneliness, and aggravation from her older sister, who began an affair with the father of her second baby whilst he was still officially her boyfriend, stimulated a further deterioration in Jade's mental health status.

Lou's long history of poor mental health was almost certainly due to the systematic abuse she had suffered throughout her life. From an early age she endured a succession of care and foster homes which afforded her limited protection, especially from her mentally unstable, and violent, mother. The experience of being a 'looked after' child, however, appeared only marginally better than the 'care' Lou received from her biological mother, during the brief intervals she spent at home. By the time Lou became a mother herself, she was severely asthmatic and her respiratory health was further compromised by heavy smoking. She suffered from panic attacks, chronic insomnia, migraines, and a moderate degree of agoraphobia. She had no close friends and relied entirely on her boyfriend and his family for all her support needs.

Tracey's family background categorised her as vulnerable and fragile and, hence, predisposed to mental ill-health. At an early age Tracey witnessed the violent death of her younger sister and she herself had been subjected to periods of physical and sexual abuse. She had been hospitalised on a number of occasions and had undergone investigations for a range of conditions without a cause having been identified. A psychiatric report referred to her as a 'Munchausen-prone personality'. Although she had not previously attempted to harm herself, she voiced intentions to 'top' herself during my study (see Chapter five). Aged fourteen at the time of her first conception, Tracey was also one of the youngest respondents. Despite all the hardships and traumas she had endured, however, Tracey appeared to be more resilient than either Lou or Jade.

Although the socio-economic, cultural, and familial circumstances of children's lives have long been implicated in adult ill-health (Power and Matthews, 1997; Smith et al., 1998; Wilkinson, 2003), the

data contributing to research of this kind is largely derived from retrospective accounts in adulthood. These 'straightforward causal explanations' (Backett-Milburn et al., 2003:621) have been modified by the findings from child-focused research, in which young respondents locate inequalities 'as much in relationships and social life as in material concerns' (ibid:621). In this respect, poverty in childhood may be understood to act 'in the same way as other adversities. By itself, it is only a statistical risk factor for psychological sequelae, with most people being resilient to its effects. As with other adversities, cumulative risks are more pathogenic, with the combination of poverty with severe family dysfunction being a potent toxin for children' (Paris, 2000:25).

The structuring of power within their social environments was an important and ever-present aspect of respondents' lives. Previous experiences of powerlessness, including debt and disadvantage, exposure to family violence, early parental separation and/or divorce, and difficult relationships with parents or substitutes, are associated with maternal depression (Reading and Reynolds, 2001), especially amongst young mothers (Quinlivan et al., 2004; Walters, 2005). Arguments have also been made for the 'classed' aspects of power relationships to be recognised in mental illness: 'it [class] is seen to taint everything we do, how we speak, who we know, where, what and how we eat, where and what we learn, the kind of job we do, the size, type and location of our home [...] It is more than economic deprivation, it's about constantly looking up or down at each other to see who is superior or inferior to us. [...] The most devastating blows fall on working-class people' (Hagan and Smail, 1997a:260).

A classic study of the social origins of depression in women (Brown and Harris, 1978) revealed that depressed patients had twice the rate of pregnancy and birth events than those who were not depressed. And although this association had previously been recognised, the authors covered new ground by questioning the tendency to identify cause and effect by implication. They found no evidence that the events of childbearing *per se* are causally linked with postnatal depression, except for those women who became severely ill with psychotic-like symptoms within the first few weeks of birth. The authors could find no *physical* trigger for depression, and suggested it was often the *social* circumstances in women's lives which provoked their illnesses: grossly inadequate housing, poor marriages that failed to support the newborn child/ren, and pregnancy losses (including those sustained through forced abortion). Brown and Harris concluded that 'it is the meaning of events that is usually crucial: pregnancy and birth, like other crises, can bring home to a woman the disappointment and hopelessness of her position – her aspirations are made more distant or she becomes even more dependent on an uncertain relationship' (Brown and Harris, 1978:141). This reiterates an important point made by these same authors, that 'by and large, clinical depression arises because of the *meaningfulness* of experience' (ibid p141 emphasis added). The links between economic hardship and women's health are clearly articulated in a later study:

[...] hardship frames and constrains what mothers can do for their children [...] low income affects not only the quality of the home but living standards within it. For mothers struggling to make ends meet, the drive to economise means cutting back on items that they know are important for health [...] food [...] fuel and transport, clothes and toys. Poverty does more than restrict access to material resources. It also restricts access to the events and experiences which make up the everyday lives of most children in Britain. School trips and family outings, bus journeys and meals out are sacrificed as mothers struggle both to protect basic necessities and service household debts [...] caring on less than you need drains the energy of mothers. It leaves them searching for ways of keeping themselves as well as their families going, ways which - ironically - are often health damaging. (Graham, 1993b:185)

Psychological factors, including depression, continue to be leading causes of maternal death in the UK (CEMACH, 2004). What is more, recent research (Hall and Wittkowski, 2006) suggests that 'negative cognitions' are also experienced by mothers who are not clinically depressed.

The results of a recent survey (British Medical Association, 2006) demonstrated that the mental health status of children and young people in the UK is also problematic, with one in every ten children under the age of fifteen diagnosed with a mental health disorder. Mental health statistics in this population are worsening and variation in service provision (the 'post code lottery' affect) means that vulnerable young people are often not diagnosed or referred for appropriate treatment. Mental health problems are also more prevalent amongst 'cared for' children and young people, those from poorer backgrounds, and those who have witnessed domestic violence (ibid, 2006).

Whilst the majority of the young women I studied described feeling 'low' and/or tearful, often for some months following childbirth, Lou was alone in being prescribed antidepressants. Her repeated requests for sleeping pills, however, were consistently refused by her GP:

HS   Are you still taking the anti-depressants?
Lou   I'm on anti-depressants, yeah, 'n I'm taking 'em. I've asked her [GP] for some
        sleeping pills as well, but she won't give me any. She says I'll get addicted to them.
Lou, daughter aged fifteen months. SY

Immediately after her baby was born, Lou's domestic situation deteriorated and she faced greater difficulties than perhaps any other respondent at this time. The council housing which had been promised had not materialised, and Lou and her baby had no option but to return to her unstable and unsafe family household. Within two days she was forced to flee to her boyfriend's home, following an attempted rape by one of her mother's boyfriends.

There is some evidence to suggest that social support in the perinatal period, including that provided by professionals, may be preventative against maternal depression (Ray and Hodnett, 2000), but even when young women in this study were well supported, many nonetheless reported feeling depressed and often found themselves unable to initiate routine activities and/or control their emotional lability:

When I'm here on my own I just get really really depressed [...] I have to keep doing something because if I just sit around doing nothing, I end up in tears all the time. My phone bill's sky high. [...] Before I was pregnant I could control my emotions but now I can't. I just end up bursting into tears at the slightest thing. Nia, son aged six weeks. W

| Alys | [BF] used to say to me, 'Come on, come to the shops with me and get something to drink or let's go down to get the papers or something?' But I was like, no, no, you go. I was just crying and crying. It was horrible. |
| Mum | Yes, she was very very low for a long time afterwards. |

Alys and her mum, two years following birth. W

In addition to feeling generally miserable, many young mothers complained about feeling chronically tired, often from interrupted sleep. Young women who lived at home were generally helped by their mothers during the 'night shift', especially in the immediate period following birth, when babies were often very restless. On the occasions young women returned to education or secured employment, the help mothers provided was considered invaluable and ensured that daughters were sufficiently well-rested to cope with the demands of employment and/or study. Young women who lived with their boyfriends generally assumed greater responsibility for attending to their baby's needs, especially during the night. This was true regardless of whether or not young men were employed, or had other daytime commitments.

For the seven young women whose relationships were known by me to have survived the disorienting, and disruptive, effects of pregnancy and birth, becoming a parent presented a new set of challenges. Working arrangements and financial pressures meant that young couples often had no option but to live apart, usually in parental homes and sometimes at quite a distance from each other. Separation from a partner increased the stresses on young women:

We don't see much of each other. Not as much as we like to. It really stresses me out. *Starts crying.* It's too far to go [to see BF] every day and he's too tired after work to come here. [...] He's saving so we can get a place for ourselves to live. [...] Because he works so much and then he comes here to see me and him [baby], the only time we have to go out is if my mam looks after him or his mam looks after him. So we don't see each other alone very much. Alys, son aged two years. W

Like other young parents who remained in the parental home following the baby's birth, Alys and her boyfriend enjoyed little time in each other's sole company. Furthermore, privacy was rarely available because domestic spaces were generally overcrowded and communal areas busy and noisy.

Despite difficult conditions, most young women assumed their maternal roles with a minimum of fuss; they also managed to retain good relations with their extended families during this challenging transition. Indeed, for many respondents, becoming a mother strengthened their 'relational sense of self' (Bailey, 1999:344). It also nurtured mother-daughter communication, deepened kinship networks and

increased a sense of belonging to an adult female community, in similar ways to descriptions of first-time, middle-class mothers (Bailey, 1999).

Naming and registering the baby

The act of naming communicates the 'confluence of historical, cultural, biographical, political, and symbolic themes that express membership in a particular group' (Tanno, 1994:33). The rituals of choosing a name for the baby, and registering its birth, were significant preoccupations for all respondents. Visiting the registry office was one of the first social events to be undertaken by young women and this was generally achieved within the first week following birth[103]. Indeed, some teenagers visited the registry office for this purpose immediately following discharge from hospital. The majority of young women registered the baby in the father's surname, even when the young couple had already ended their relationship.

When parents are not married, only the mother has parental responsibility for her child. The term 'parental responsibility' denotes the 'powers, rights and responsibilities of parents with respect to decisions concerning the welfare of their child(ren)' (Stevens, 2004:314). Traditionally the two routes by which unmarried fathers acquired such responsibilities were by formal legal agreement with the mother or by a court order. As of December 2003, however, the mother may consent to her unmarried partner acquiring parental responsibility by being registered as the child's father in the register of births (Stevens, 2004). In this study, Jade and April were the only young mothers who were estranged from the fathers of their children at the time I completed data collection and, in Jade's case, it was only the father of her first child with whom she had lost contact. Even when young women, such as Clare, were no longer interested in pursuing a relationship with their former partners, and they assumed full parental responsibilities on behalf of an absent partner, they did not deny the young father access to his child.

In many cases, the decision to register the baby in the father's name was a commonsensical response that anticipated future marriage - at which point young women intended to relinquish their own surnames and assume that of their spouse:

> Susan   He's going to be registered under [BF's] name because we're going to get married anyway, so it doesn't matter if the baby has his name in the meantime.
> HS   You wouldn't have a double-barrelled name - say have your name and his name?
> Susan   No. I don't see the point of it really. My name's going to change to his anyway when we get married so what's the point?
> Susan, son aged three days. SY

Only a few respondents were unsure about including their boyfriend's name on the birth register. Clare, for example, initially refused to accommodate her partner's request to include his details but finally

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[103] In England and Wales, a birth must be registered within 42 days of the event. See: http://www.gro.gov.uk/

conceded when her baby was about a year old[104], only to avoid further harassment.

> I've only done it to keep him happy. I were fed up with him going on 'n on about it. *Laughs.* I've not changed her surname to his. No way I'd do that. He can walk away anytime he wants, surname or no surname. I can't walk away. I don't want him walking off and her staying here with me with his surname... Clare, daughter aged fourteen months. SY

Whilst acknowledging the limits to her boyfriend's parental claim, Clare simultaneously voices her resentment that his freedoms are at the expense of her responsibilities. Relieved of the monotony and responsibility of childcare, young men were viewed as having 'the best of both worlds'. Outside of work commitments, they were free to 'come and go as they pleased', confident in the knowledge that girlfriends and/or mothers would continue to service their domestic needs and look after the baby.

Infant feeding practices

In many Western societies, breastfeeding generally denotes 'good' mothering[105] whilst formula feeding tends to be constructed as an inferior practice – at least by the middle classes and maternity experts. Indeed, infant feeding has been described as a 'highly accountable matter' (Murphy, 1999:205), because decisions are weighted with significant 'moral baggage' (ibid: 205) and set against broader ideologies and conceptualisations of 'appropriate' parenting. Teenagers in this study, however, gave no indication that they saw the matter in this way. They approached infant feeding decisions in a pragmatic manner and after an initial 'flirtation' with breastfeeding most followed locally normal formula feeding practices.

Following on from critical discourses advanced by feminist scholars on maternity (Murphy-Lawless, 1998; Oakley, 1980), and motherhood (Bassin et al., 1994), infant feeding has become something of a contested practice in recent years. Increasing social, medical, and more recently political, pressures on childbearing women to breastfeed their infants (and women's strategies of avoidance) have tended to polarise debates about the material circumstances of women's lives and the impact on infant feeding decisions. In particular, lack of attention to socio-cultural conditions has encouraged a misperception that breastfeeding, as it is practised by women living in 'traditional societies', may be regarded as a homogenous event to be exported as an example of good practice for Western women (another supposed homogenous category) to emulate (Maher, 1995).

Recent guidelines from the World Health Organisation and the United Nations Children's Fund recommend exclusive breastfeeding for a minimum of six months, followed by partial breastfeeding for two years or more (World Health Organisation and UNICEF, 2003). Prevalence rates in the UK,

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[104] This process is termed a 're-registration' and enables the natural father to be included in the birth register. Following this procedure, new registration details of the birth are issued.
[105] Paediatrician and psychoanalyst Donald Winnicott, the originator of the term 'good enough' mother, suggested, however, that 'it is not impossible for a mother to be a good-enough mother (in my way of putting it) with a bottle for the actual feeding' (Winnicott, 1971:11).

however, currently fall well below these targets, with only 21% of women still breastfeeding at six months and only 13% continuing at nine months (Department of Health, 2005a; Hamlyn et al., 2002). Although an increase in breastfeeding initiation rates for women in lower social classes has been reported (D'Souza and Garcia, 2003), working-class women are still much less likely than their better-educated peers to breastfeed. Little is known about how to target young women effectively with respect to breastfeeding promotional strategies (D'Souza and Garcia, 2003).

Within the UK, there is considerable local variation in initiation and continuation rates of breastfeeding, which reflects differences in class, ethnicity, education, and maternal age. Negative associations with breastfeeding have been consistently identified for mothers who are young, of low social class, and/or who leave full time education at an early age (Foster et al., 1997; Wylie and Verber, 1994). More recent research suggests that 'embodied', rather than 'cognitive' knowledge, for example as might be accessed through an apprenticeship style of learning experience, may be more influential on breastfeeding decisions for lower social class women (Hoddinott and Pill, 1999). Although breastfeeding is widely promulgated as the morally superior choice, and a sustained improvement in breastfeeding initiation has been reported in the UK (Hamlyn et al., 2002), statistics confirm that most new mothers experience difficulty overcoming deeply entrenched socio-cultural, economic, and practical barriers.

All six young women from the South Yorkshire cohort signalled an initial interest in breastfeeding and Clare, Michelle, Jade and Louise subsequently suckled their babies shortly after giving birth. Susan remained undecided. Having fed her baby formula milk in hospital, she changed her mind when she returned home and expressed a desire to begin breastfeeding. A community midwife dissuaded her from taking this initiative, however, suggesting that the baby would become 'confused', as it had already become accustomed to feeding from a bottle. Tracey expressed an intention to breast-feed, but was unable to follow this through when her son was born prematurely and was admitted to special care baby unit. Both Jade and Tracey formula-fed their second babies from birth.

Of the young women in the Welsh cohort whose infant feeding practices were known to me, Alys opted to formula feed her baby, whilst Nia was fully breastfeeding when I interviewed her six weeks following birth. See Table A for a synopsis of feeding decisions for both study cohorts of teenagers. Regarding young women's mothers, Dilys (Lowri's mum), and Polly (Michelle's mum), both breastfed at least some of their children for substantial periods while Marg (Susan's mum), and Chris (Clare's mum), both initiated, but did not sustain, breastfeeding with some of their children.

In agreement with earlier research in this area (Earle, 2000), most respondents were knowledgeable about the benefits of breastfeeding and they voiced a keen interest in transmitting these benefits to their babies. Those who opted to bottle-feed, however, did not downplay their knowledge or otherwise 'play dumb' (Murphy, 1999:195) and feign ignorance about the benefits of breastfeeding. Rather, their narratives suggested 'that they are at pains to assert that they do know that breastfeeding

is reputed to be healthier for their babies' (ibid:195) but that they proceeded with bottle feeding mostly because this was the cultural norm within their families and local communities.

In the following excerpt, I am interested to know whether Rhian, who expressed an intention to breast-feed, considers it beneficial or burdensome for midwives to discuss controversial information about this issue. Her response confirms her considerable knowledge and also reiterates earlier research findings (Dykes and Moran, 2003) which emphasise the need for good support if adolescents are to successfully realise their breastfeeding intentions:

HS   Do you think it's useful for midwives to give you information [about breastfeeding] which is, like, a bit open to question. Like here in this [Informed Choice] leaflet it says there might be a link between breastfeeding and the baby's IQ.

Rhian   Yeah, I read that, but things like that don't really bother me. You're either intelligent or you're not. I don't believe breastfeeding makes that much difference. It's like I wasn't breastfed and I just passed ten GCSEs. *Laughs.* It's other things that make the difference, like if you have someone to help you, to cook your dinner so you can sit and just breastfeed. [...] No, I'm breastfeeding 'cos it's better for the baby, there's things like antibodies and for me there's less chance I'll get breast cancer and my womb contracts quicker as well so I'll lose weight. *Laughs.*

Rhian, thirty-seven weeks pregnant. W

The positive effects of breastfeeding on children's intelligence have, in fact, been challenged by recent research which reported that purported benefits are accounted for by maternal characteristics, including higher maternal IQ (Der et el., 2006). Younger mothers' experiences of breastfeeding are comparable with older first-time mothers (Nelson and Sethi, 2005), although teenagers may require additional support to initiate and sustain breastfeeding, especially in environments lacking a socio-cultural precedent. Contemporary midwives are in a difficult position with respect to advising pregnant women about infant feeding. On the one hand, they must strive to be 'with' women (and the choices they make which go against government policy) but, on the other hand, they 'are caught up in the disciplinary technologies to which they contribute' (Murphy, 2003:458) and, as such, are expected to vigorously promote breastfeeding (Royal College of Midwives, 2004). Within this contested territory the preferences of individual childbearing women may be easily overlooked as midwives struggle to be facilitators, rather than coercers, of choice.

Infant feeding decisions tend to be made early in pregnancy, sometimes in anticipation of a prompt return to (low-paid) work, and/or a desire to enlist help from partners and significant others (Lee and Furedi, 2005). Study respondents echoed this pattern:

To be honest I never even thought about breastfeeding anyway, 'cos I'm planning to go back to work, only for four hours a week but that's an extra fifteen quid isn't it?

Elenor, twenty-three weeks pregnant. W

Susan   I'm going to bottle feed him. I was going to breastfeed him, but I won't have time now, 'cos I need to go back to work

HS   Would you have liked to give breastfeeding a go?

Susan   Yeah, but I can't now we've moved here. We worked out how much money we need just to pay rent 'n bills 'n all. I'll have to go back to work for us to afford it.

HS   What about just breastfeeding at night?

Susan   Yeah, but they can get attached, can't they? I thought then he might not take to the bottle from Joe [BF] 'n then I'm going to be in a right state when I need to go to work.

Susan, twenty-six weeks pregnant. SY

Concerns about (over) attachment were voiced by respondents with respect to different aspects of child rearing practices. For example, allowing the child to sleep in the parental bed was understood to encourage 'bad' habits, which would lead to unwanted dependency, and was widely discouraged for this reason.

Young women who initiated breastfeeding against prevailing norms struggled to assert their needs for adequate, and appropriate, midwifery support:

When [daughter] were born, I weren't actually sure she were going to breast feed even though I wanted her to. [...] There were no-one to help me except for one [midwife] but she only stayed for coupla minutes after she were born. She made sure she were on me [breast] right, and then she left. [...] I mean, I know it's good 'n all to leave you do it yourself, but when you don't know what you're doing, and you're only fifteen... Clare, daughter aged ten days. SY

Clare breastfed her baby for a total of ten days. She persisted with it despite being in considerable pain, initially from engorged breasts, and subsequently from raw and bleeding nipples. When I asked her why she persevered, she stated her desire to give her daughter the best start possible before other demands, including returning to education, claimed her time:

HS   But you kept on with it even though it really hurt?

Clare   Yeah.

HS   Why? How come you managed to do that?

Clare   'Cos it's best for her. That's what all books said. That's what everyone said. My mum said it would be really good for her if I start her off on breastfeeding. And I thought, well, I'm not really gonna be giving her much while I'm at school and college 'n all, so if I can give her best start now, then at least I'm doing something for her when she's young.

Clare, daughter aged five months. SY

This study reiterates the findings of previous research (Hoddinott and Pill, 1999), which documented women's reluctance to breast-feed in front of others, including family members. Young women singled out fathers and brothers as being particularly problematic in this regard. The private/public distinction between domestic and non-domestic environments, for example, was also influential in respondents' decisions:

HS: Do you think Megan would breast feed in front of her dad?
Mum   Oh no, she'd never do that.
HS   And what about outside home, say in places like cafes?
Mum   No I don't think so. [...] She'd probably do it in front of me, but anyone else, I think no.
Anwen (Megan's mum) W

I'd really like to [breast feed] but I wouldn't feel... I'd feel so self-conscious I couldn't do it. Not here at home with all my brothers and their mates around. I just couldn't.
Alys, thirty weeks pregnant. W

I like walking round the street and sitting in the cafe and things like that. If I'm going to do that it'll be easier to have a bottle. I'd never breastfeed outside home.
Catrin, sixteen weeks pregnant. W

Interestingly, Clare's mother identified the community midwife as being someone in whose company her daughter did not feel comfortable breastfeeding:

Midwife, she just come in and of course the baby were a bit grizzly then, and it were about time for her to be fed, but Clare, she doesn't like doing it in front of people. She's all right in front of me, but not anybody else. So [midwife] she's just stood there, waiting for her to feed baby. 'Well, come on then', she says, ' I haven't got all day. Feed her!' I were thinking, 'She will do, she's just waiting for you to get out...!' *Laughs.* I mean, I thought it were really comical. Of all the people she don't want to feed in front of, I can understand, but she were the midwife... But it's their attitude isn't it? If they put you off, then you don't want to feed in front of 'em *Laughs.*
Chris (Clare's mum) SY

The mothers of childbearing women are also known to influence infant feeding, including weaning, decisions (Kirkham and Stapleton, 2001) and to uphold cultural norms regarding the timing of solids and the choice of food the infant is offered (Bentley et al., 1999). In this study, young babies from poorer households were frequently offered food and drink that would generally be considered unhealthy and inappropriate, particularly for this age group. The following excerpt is both typical and illustrative:

Jasmine   I'll get you some little Milky Bars, for when he's [three month old baby] a
        bit better, aye? (To Tracey)
HS   Has he been having much of that kind of thing - Milky Bars, 'n stuff like
        that?
Jasmine   Yeah. But not now... Not while he's mardy. Not till he's eating proper
        meals again, like.
Tracey   He had one [Milky Bar] this morning, but he just sicked it all back up.
Jasmine   Yeah, well he would wouldn't he? I told you not to give 'em to 'im
        when he's mardy. [To me]: Every now and again we give him one. Just for a treat like.
Jasmine (Tracey's mum), baby aged three months. SY

In this study, other family members were also influential in decisions regarding the foods offered to infants:

I am invited to eat lunch with the family. As a 'good' researcher I feel that I should accept the invitation but I decline, because I am very fussy about food and the meal which I can see about to be served, consisting of baked beans, sausages, fried eggs, and some small chunks of something brownish sprinkled over the top, does not appeal to me. A vast pile of white bread and a large tub of margarine have been set in the middle of the battered pink formica table. [...] Pete's dad mashes up a portion of his meal, which he has covered in ketchup, and offers it to the baby - who is not quite six weeks old. [...] Later, Pete takes the baby on his knee and spoons warm, heavily sugared tea from his mug into the baby's mouth. On a previous occasion, when the baby was barely three weeks old, I observed Pete's dad making a similar offering to the baby with his coffee. Fieldnotes. Lou and Pete, daughter aged five weeks. SY

A number of young women reported that they struggled to assert their authority when they disagreed about food items offered to their child by other adult members of the household. This was particularly in relation to food which young mothers thought had a negative effect on the child's behaviour, or was detrimental to their health:

Jade   Soon as we walked in door he [surrogate father] turns round and says, 'Do you want some chocolate?' Well of course she does, doesn't she, so then that's it, chocolate was in her hands, in her hair, it was everywhere, and I thought, 'Oh no, oh my God...'

HS   Was it the mess you were worried about?

Jade   No, it weren't mess. I'm not bothered about that. Laughs. It were chocolate. She's very, very hyper after she's had chocolate. She goes haywire. Completely mad she is after she's had it. I keep telling 'em all not to give it her, but they think it's a joke when she flips out. It's all right for them, they don't have it all night.

Jade, daughter aged six months. SY

At three months most babies were reported to be enjoying a variety of food and drink. At this stage the food which was offered was generally determined by the child's preferences and by the extent to which the young parents, and their extended families, wished to experiment with commercially prepared food, and/or to encourage the baby to sample 'adult' food, mashed to an appropriate consistency:

He's had some mashed potatoes but that's all so far. He's not that bothered on proper foods [i.e. the same as that eaten by Susan and her boyfriend]. I started him on some baby yogurts, but then I read on the label you shouldn't give them before four months old. I told health visitor, but she just said, 'Oh, don't matter, he's nearly four months now anyway and if he's hungry, he's hungry. You have to give him more.' Susan, son aged three months. SY

Young women who had moved out of the family home, and who lacked consistent, and trustworthy, support from their mothers, were most likely to seek nutrition-related advice from health professionals:

HS   How about things like rusks - are you giving those to him?

Tracey   No. I were, but then health visitor said I shouldn't be givin' 'im stuff like that, 'cos it's got too much sugar in. She said he'll get too fat, so I ain't givin' im them any more.

Tracey, son aged three months. SY

Tracey's response is interesting in light of the earlier reference to her mother's habit of feeding the baby milky bars with their higher sugar content. Tracey rarely directly challenged her mother, however, even when she disagreed with her opinions.

o Feeding older children

In this study, food purchasing, preparation, and family feeding routines were designated locally as 'women's work' (DeVault, 1991:95). Compared to adult family members, who have 'bodily licence' (Bell and Valentine, 1997:34) to eat food of their own choosing, children must generally accept the food which is offered to them. Hence, food and feeding practices are potentially important media through which mothers may exercise power over their children, at least until such time as they develop strategies of resistance. The feeding-related activities of older children were widely reported as stress-provoking occasions for most young mothers; fussy or picky children especially taxed their mothers' patience:

HS   How's he doing with his eating at the moment? Is he eating what you give him?
Susan No. *Laughs.* He's a right pain with that. He's so fussy. He won't eat anything. I try and make him eat it but he just screams and spits it everywhere. *Laughs.* He does eat a lot of fruit though. He loves his fruit, so I s'pose that's one good thing.
Michelle, son aged sixteen months. SY

Toddlers in this study who refused to eat their food, especially when this was freshly prepared from raw ingredients, rather than extracted from a tin or jar, were viewed as particularly vexing. Young mothers who had grown up in environments where eating 'proper' meals was a regular feature of family life, expressed a wish to reproduce this pattern in their newly constituted family. Most of these young women cooked 'proper dinners' for their children and were upset when their children expressed refused food they had prepared, and/or expressed preferences for junk food. Children's fathers and grandmothers often acted as mediators between children and their agitated mothers:

HS   What causes you the most stress with him [toddler] right now?
Michelle It's him not wanting to eat the food I cook him! *Laughs.* I cook him a proper dinner every day - like yesterday I made him vegetable lasagne - but he just wants junk food all the time. He just loves it. *Laughs.* I know it's only a phase but some days I get really upset when that's all he'll eat. Ryan [BF] tells me off. He says I should stop fussing so much, that he'll eat when he's hungry. [...] When we're down at my mum's on a Sunday, he eats all his dinner for her no trouble. He makes out I'm a right liar, he does...! *Laughs.*
Michelle, son aged sixteen months. SY

More than two decades ago Anne Murcott (Murcott, 1982) described the social significance of the 'cooked dinner' produced by women for their families. In this research, cooked dinners were often unaffordable, and thus unavailable, to children in poorer households. Lou and Pete, for example,

frequently had insufficient money to buy enough food for themselves, even before their daughter was born. Had it not been for the regular mealtime invitations extended to the young family by Pete's parents, the hunger they occasionally experienced might have been a more regular feature of their lives:

> I mean, over the past week, she [toddler] loves her cooked dinners, and we haven't had a cooked dinner for ages, and that's what she's missing. She went round to [mother-in-law] other day 'n she gave her a cooked dinner, 'n she ate the whole lot she did. [...] I give her Frosties in morning, like, 'cos that's all we've got left. That 'n potatoes, but she were having them all week, so she were a bit fed up with 'em. That's why she ate all her cooked dinner.
> Lou, daughter aged fifteen months. SY

The impact of poverty on the outcome of pregnancy, and as a significant constraint on childhood development, is well documented (D'Souza and Garcia, 2003; Nelson, 2000). Despite reportage from the tabloid press to the contrary, there is evidence to suggest that the problems which arise in households with inadequate food supplies occur because there is insufficient money available to spend on food, not because money is being spent unwisely (Nelson, 2000).

Infant feeding decisions are undoubtedly value-laden consumption practices. Unlike many older mothers, who strive to project a morally sound representation of 'good' mothering, the teenagers in this study did not appear to 'do' guilt in relation to breastfeeding. They also appeared disinclined to endure prolonged discomfort in order to demonstrate allegiance to a politically correct (breastfeeding) 'cause'; when their circumstances changed and they were unable, or unwilling, to continue breastfeeding, they switched to formula feeding with little evidence of regret or disappointment. In many ways, this attitude reflected their pragmatic mothering style: young mothers tended to simply 'get on with the job' of looking after their infants with little heed to the moral messages emphasising the 'oughts' and 'shoulds' of mothering practices.

CHAPTER ELEVEN: MOTHERING IN EARLY CHILDHOOD; IDENTITIES AND PRACTICES

In this chapter I explore young women's different experiences of an assortment of adult roles, including mother, daughter(in-law) and lover. I discuss the framing of young mothers along the autonomy-dependency continuum, and the impact of stereotyping on their lives. Finally, I look at relationships between mothers and daughters and the ways in which these influence teenagers' maternal trajectories and everyday mothering practices.

Everyday life: harsh realities and rewarding pleasures

Once the 'novelty effect' of the new baby had diminished, young women faced the monotony and hard work of motherhood. Teenagers with supportive kinship networks, and whose living arrangements provided stability and security, fared best in their new roles and enjoyed time with their infants. A few respondents planned their future engagement and/or marriage, and many were saving to buy their own homes. For these young women, motherhood as a rite of passage was a strengthening and empowering experience.

Other, less fortunate, young mothers had the odds stacked against them in the shape of poor quality housing on 'sink' estates, an absence of friendship and kinship networks, and few relationship or employment opportunities. Parenting responsibilities weighed heavily on these respondents and most were immobilised rather than enabled by the challenges they faced[106]. For these, less resilient respondents, the 'turning point' of young motherhood tended to accentuate maladaptive behaviours (Rönkä et al., 2002). The following excerpt from my field notes summarises Jade's situation:

> I ask Jade how things have been. There is a heavy silence before she announces that she is, 'Bored...bored...bored... I get up every day. I get these ones dressed. I come over here 'n I feed them 'n then I go back over road [to her small bedroom in the hostel accommodation where she has lived for the past fifteen months]. I watch telly till its time to put them to bed. I'm so fuckin' bored. I did the same thing yesterday and I'll do the same tomorrow and the next day and day after...' Josie, Jade's sister, interrupts to suggest they could go away for a day in the summer. Jade stares at her, curls her lip in a gesture of contempt and responds, 'Yeah, yeah great idea. Where d'ya think I'm gonna get money for bus fares? It'll cost at least ten quid for me and then there's kids...'
> Fieldnotes. Jade, daughters aged sixteen and two months respectively. SY

Although Jade's circumstances were difficult when she became a mother for the first time, they worsened considerably by the time her second daughter, Gemma, was born. Shortly after this event, Jade was re-housed on a crime-ridden council estate, some distance from the centrally located accommodation where she had previously lived, and where she was well liked and well supported. Her new neighbourhood lacked basic amenities and was poorly served by public transport. At the time, Jade was still 'mad in love' with Tom, father of Gemma, although her affections changed when he and her

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[106] See Appendices Five and Six for summaries of all respondents.

sister Josie started 'having it off' with each other. Tom subsequently moved in with Josie and her five-year-old daughter. Shortly afterwards, Jade agreed to relinquish Gemma into Josie and Tom's care.

Michelle was at the opposite end of the mothering spectrum from Jade – at least on the surface. When her son was three months old, Michelle moved from her family home into rented accommodation with her boyfriend, Ryan. Michelle's mother, Polly, put aside her concerns about Ryan, which had emerged following his assault on Michelle, and helped the young couple set up home. She offered practical and financial assistance, organised cleaning and decorating parties, and brought them essential household items. At the end of the first year, Michelle appeared happy and well adjusted. She had resumed her education and had achieved the 'A' levels she required to undertake a nursing degree. She put her university place on hold, however, after she was talent spotted by a modelling agency and started earning 'fantastic' money on fashion shoots in UK and European locations. Ryan secured more hours with his industrial warehouse employer and, on the basis of Michelle's income, the young couple purchased their first home. Most Sundays, Michelle and her newly-constituted family returned home for a traditional roast lunch. For Michelle, balancing her professional life with the demands of motherhood, and her ongoing relationships with her partner Ryan, and her mother, was a demanding, but satisfying, set of challenges. Educational and social differences between herself and Ryan, although substantial, did not initially hinder their capacity for mutual respect and nor did these differences prevent them from sharing parenting responsibilities:

If I'm at home [from a fashion shoot] I get up with Ryan around four thirty (am) and get his breakfast ready and do his packed lunch, then I go back to bed with [son]. He usually wakes up round half seven/eight. We play a bit in bed and sometimes I read him a story. [...] He can't say sentences yet but he loves his words. *Laughs.* I've always loved books. I think that's rubbing off on him. *Laughs.* We read to him every night. Ryan can't read very well - he can just about keep up with [son]. *Laughs.* But he makes it up if he can't understand it. *Laughs.* We always had books around and our parents always read to us. Ryan's didn't. [...] Ryan finishes work at lunchtime so then he looks after him in the afternoons. He's much better at playing with him than I am. And [son] adores his dad. [...] Being a mother is so exhausting. *Laughs.* I feel sorry for girls who haven't got their mums.
Fieldnotes, final interview with Michelle when her son was sixteen months old. SY

When I was in the final stages of writing up this thesis, however, I received a phone call from Polly, requesting my help. Michelle and Ryan had separated some months previously and Ryan was currently awaiting trial for charges relating to his repeated assaults on Michelle, whose modelling career was in tatters because her face had borne the brunt of his violence. Ryan was subsequently convicted and received a custodial sentence. Michelle was forced to sell the house and split the proceeds of the sale with Ryan: although she had advanced the deposit and paid the mortgage, only his name was entered on the mortgage contract because her earnings, although substantial, were deemed insufficiently reliable to access a mortgage in her own right. In a final conversation with Michelle she reported that things had improved slightly: she had a new boyfriend and she was no longer taking sleeping pills and

antidepressants. The scarring from her facial surgery had healed better than she expected and she was hopeful her modelling contract would be renewed. She still intended to study nursing but was delaying this until her modelling career ended.

I positioned Clare and Alys towards the middle of the mothering continuum. Following childbirth, both young women continued to live in the family home, where they were well supported. Both enjoyed time with their boyfriends, although Clare's relationship, by her own admission, was more 'off' than 'on':

> We're still together and my mum still hates him. *Laughs.* [...] They say mothers can get depressed after they've had a baby but I think it's him [BF] that's depressed. [...] I think he's jealous of me. He's drinking and smoking loads. He's still living with his gran but they don't get on. [...] I passed my driving licence and mum's letting me borrow her car, 'n it's, like, now I've got this really great job 'n my mum's always helping me with stuff 'n he hasn't got anything. Not really. Clare, final interview when her daughter was two years old. SY

When her daughter was six months old Clare had returned to college to study child psychology. She abandoned her course after her boyfriend complained that her coursework was 'coming between us'. Around this time she briefly moved into rented accommodation with her boyfriend and her daughter but these arrangements did not work out and Clare and her daughter returned home. Following a frustrating period of employment interviews and rejections - ostensibly due to lack of work experience although Clare suspected that 'the real reason's 'cos I'm a teenage mum' - she finally secured a full-time job with a local marketing firm. Her employers invited new staff to consent to psychometric testing and when Clare was assessed as very bright, she was offered, and accepted, a fully-funded day-release scheme studying business skills.

Alys decided to delay job seeking a return to education until her son was eligible for state nursery provision. Her boyfriend remained in the same low-paid job and continued to live with his parents, some distance away. The young couple visited one another's homes and stayed overnight on alternate weekends. Alys expressed considerably more ambivalence about her maternal role than did other respondents:

> Before I had him I had my life cut out. *Laughs.* I'm not much of a stay-at-home. I mean, I like staying in, but if I had the option, I'd rather go out down the pub or go out socialising. But I don't do that as often as I'd like. Not like I woulda done if I'd not had him. I'd probably be a lot richer now if I didn't have him as well. *Laughs.* Don't get me wrong. I love him to pieces but he has changed my life. [...] I'd probably be in my own job. I probably wouldn't even be living here [at home]. I'd probably have moved in with [boyfriend and father of baby] by now. [...] As soon as he's old enough for nursery I'm going to college.
> Alys, final interview when her son was two years old. W

Alys was constrained by her maternal role and especially by the demands of childcare. She missed

socialising with friends and having regular contact with her boyfriend and looked forward to a time in the future when she could return to activities which were not so child-focused.

Formulating adolescent maternal identities: class, age and agency

Differences were noted in the way that adolescents and power-holders conceptualised teenage parenthood, which often presented as dichotomous, insider/outsider discourses (Phoenix, 1991b). Outsider views, usually from 'authoritative' elders, focused on issues of dependency, whilst insider views, from teen mothers and their kinship groups, were more concerned with identifying markers of independence. Age was a defining factor which categorised and set young mothers apart. Whilst it was normally health professionals who enacted the most divisive and stereotyping behaviours, respondents were also observed making negative judgements about their peers on the basis of (younger) maternal age. Some respondents were concerned that association with younger mothers might spoil their own reputations:

> A lot of girls round here, they've got young babies and some of them they're girls a lot younger than me. I mean, I look at them and to be honest they don't always look after the babies all that well. I mean sometimes their babies look a bit uncared for and the way they treat them and whatever is not always good. That's my opinion anyway. [...] I think they [midwives] just assumed that was me, that would be me as well, that I'd be exactly the same because I was fifteen, not married or anything. Rhian, thirty-seven weeks pregnant. W

Mothers suggested that the combination of adolescence and impending parenthood was problematic because these categories tended to be conflated:

> Mum   The midwives in the clinic, now, they're like, 'Oh you're too young to be pregnant', but then they say, 'You're old enough to know better.' Now what are you? Are you old enough to know better or are you too young to get pregnant? You can't be both, can you? I think they must be old enough, because, well, they are pregnant aren't they, so they should be treating them as old enough.
>
> Alys   Yeah... It's, like, you can't win and they don't want you to win. [...] You're stuck in the middle. You don't know where you are with 'em.
>
> Alys and Angharad (her mum). W

Mothers expressed ambivalence about whether adolescent motherhood conferred more, or less, adult status on their daughters. This reflects the tensions expressed in tabloid and academic discourses, where teenage mothers are depicted either as immature dependants unable to survive without the benefits of a welfare state, or as young adults struggling to assert mature and self-sufficient identifies. At different times and in different circumstances individuals are considered more, or less, proficient in the presentation of an independent and autonomous self. Faced with rapidly changing environments in which the 'rules of the game' are not always clear, but where moral judgements are nonetheless operating, regression to a more psychologically dependent state is not unusual. Daughters switching in and out of a mature, and an evolving, identity was a frequently articulated theme in mothers' narratives:

> She's not one for asking for herself. Before we go [to the clinic] she says, 'Mum, don't forget to ask about so 'n so will ya?' She's like that with everything though. She won't phone hairdressers to make an appointment. She won't phone doctors or nowt for herself, she just goes through me. I think it's an age thing, isn't it? Polly (Michelle's mum). SY

Most young women were not in the habit of maintaining personal diaries and neither did many arrange their own appointments, relying instead on their mothers' organisational skills. At this stage in their development then, many teenagers accessed adult status through the agency of their mothers.

In contrast to the mother-daughter relationship, which was generally very sensitive to nuances in the dependency-autonomy continuum, maternity staff were more rigid in their interactions with their young clients. The fieldwork for the Informed Choice study (Kirkham and Stapleton, 2001) provided an exceptional opportunity to observe a wide range of maternity-related professionals interacting with a cross-section of childbearing women. A recurring feature of these hundreds of observation episodes [n=853] was the high value attributed to traditional female characteristics such as passivity and compliance. This was particularly evident when a significant hierarchical gap, largely accounted for by age and social class differences, but intensified by gender differences, existed between client and professional. Few mothers anticipated the degree to which their daughter's teenage status would be perceived as problematic by maternity staff, particularly midwives. Although mothers did not necessarily remember their own childbearing experiences as enjoyable events, many nonetheless offered more positive comparisons of their relationships with midwives. Dilys was pregnant at the same time as her daughter and when she compared their parallel experiences of maternity care, she suggested her older age commanded greater respect:

> I've been with her [daughter] to the clinic and I've seen the way she's been treated and it's made me so angry. They treat her like she's stupid, like she's irresponsible. She was brushed away from the start. [...] When I go to the clinic I'm treated like a proper person, like an adult. I'm sure the only difference is our age. And if that's how they treat her at sixteen, God knows how they treat the younger ones. Dilys (Lowri's mum), twenty weeks pregnant. W

Legitimate access to the title 'Mrs' increased a respondent's status and appeared to improve the likelihood of her being treated more humanely by antenatal staff. It was unclear, however, whether women who were addressed in this way were actually married or whether some simply claimed marital status in order to protect themselves from negative attitudes. It is also possible that staff automatically used this form of address for pregnant women they identified as 'older' and, therefore, 'respectable'.

> They'd call them ones out properly. They call out, 'Mrs X please', and then they'd call out, 'Alys'. They wouldn't call her, 'Miss X'. She could have been married as well for all they knew, but they'd still have called out, 'Alys', just so they could rub it in, isn't it?
> Angharad (Alys's mum). W

Attending for maternity care may be a unique opportunity for young childbearing women to have a sense of agency reflected back to them. If pregnant teenagers were to be legitimated as 'mothers in the making', with all the potential for personal growth and development inherent in that role, their subsequent transition to, and status as, young mothers might be improved. Such recognition would, however, require health professionals able to keep pace with their clients' alternating needs for dependency and autonomy.

Motherhood and mothering practices

Mothering has been defined as:

> 'the maternal behaviour learned in interaction with a particular child, beginning in the process of achieving a maternal role identity and continuing to evolve throughout the child's development. [...] the blend of nurturing, caring, teaching, guiding, protecting, and loving that enhances the infant's physical, emotional, social, and cognitive development to adulthood. [...] derived from the mother's resources and extensive knowledge of each individual child that enables her to meet the child's needs in unlimited situations and conditions from a very expert and creative base' (Mercer, 1995:1).

To situate this perfectly reasonable, but arguably unachievable, list of desirable maternal attributes in a less idealised context, maternal practice can only ever respond 'to the historical reality of a biological child in a particular social world' (Ruddick, 1980:348). As is evident from the snapshots of respondents' lives provided throughout this thesis, the social worlds of the poorest young mothers were very grim. They were badly resourced, both materially and psychologically, and hence their attention to their child's developmental needs was often secondary to the satisfaction of more basic needs, including hunger, warmth, and physical safety. The effects of poverty severely limited their options and made 'interested maternal practice and therefore maternal thinking nearly impossible' (Ruddick, 1980:349).

In common with other first-time mothers, the narratives of the young mothers in this study reflect a diversity of experiences. The absence of a universal maternal script for the way in which mothering was individually performed, from a 'matrix of images, meanings, sentiments, and practices that are everywhere socially and culturally produced' (Scheper-Hughes, 1992:341), allows for a 'pragmatic' rather than a 'poetic' approach to the everyday aspects of 'doing' mothering. This echoes what David Morgan has referred to as an increased 'fluidity' in family life and family practices (Morgan, 1999). In examining the conditions in which their experiences are based, I hope to highlight the features of respondents' parenting experiences including those which are unique to adolescence, and to illuminate the challenges these adolescents faced, as well as their accomplishments.

o   Performing mothering: the gendering of domestic responsibilities

Despite the popular image of men in contemporary Western societies having greater involvement in their children's lives, women continue to undertake the bulk of domestic responsibilities, including child caring and rearing activities. Hence, 'society's expectations of men as fathers are still incredibly low [...]

with the partial exception of financial support for children, fatherhood is a matter of personal choice, not an obligation' (Smart and Neale, 1999:135). In other words, 'to know that a man is a father is generally less informative about how he spends his time and energies than to know that a woman is a mother' (Phoenix and Woollett, 1991:4).

Following birth, three young couples in the South Yorkshire cohort set up home together. All three couples adopted conventional roles in terms of apportioning domestic responsibilities; there were no 'Mr Mom's' (Aitken, 1999:118) 'playing' at being mothers. In general, the expectation was that the female partner would manage childcare and household affairs, because male partners were seen as needing to be sufficiently well-rested to engage in the 'real' work of being men - regardless of their employment status. The domestic division of labour, which designates housework as 'women's work' - as what women 'do' - has been comphrensively described (Oakley, 1974b; Oakley, [1974a]1985). The prominence of women's contributions to all aspects of child-rearing activities, accelerated by the increase in lone-mother households, has been termed 'the feminization of childhood' (Jensen, 1994:59). Young women whose male partners were not in paid employment were disadvantaged by traditional arrangements because, although these same partners had a similar amount of time available to contribute to childcare and household tasks, they rarely participated:

Lou	It's the night that's getting me, because you don't like getting up with her do you? [To Pete] And he doesn't like the early mornings, neither, so I have to do both ends.
Pete	That's because I stay up longer than you though, you go to bed about eight/nine o'clock and I stay up while eleven.
Lou	But I'm up every morning from seven and then I'm with her [daughter - Amy] all day. It's fuckin' exhausting it is. *Starts crying.*
Pete	Well I'm awake at seven every morning as well, because you say every morning, 'I'll leave you in bed' but I never do stay in bed, do I?
Lou	No, you don't. But you don't get up to help me. You have a shower or you go out and have a fag or summat.

Lou and Pete, daughter aged sixteen months. SY

A few moments later Pete leaves the room to fetch a toy for Amy. Immediately the door closes Lou starts sobbing and says she wishes she was by herself again; that although she loves Amy, she can't cope with her demands as well as having to cajole Pete, on a daily basis, to undertake basic household chores. When Pete returns I challenge his gendered stance. In the following excerpt, he resists my suggestion that he could make a greater contribution to household tasks and he eventually forces closure on the discussion by suggesting that his uncontrollable 'temper' is a primary contributor to creating (literal and symbolic) 'mess'. He also describes enacting his daughter's behaviour ('throwing things all over the place') which creates the mess he complains about:

HS	So when there's a mess everywhere Pete, do you see it as Lou's job to clean up?
Lou	Yeah! He does 'n all.
Pete	Yeah, I s'pose I do a little bit. *Laughs.*

HS   Why do you see it as Lou's job?

Pete   'Cos I don't normally do it. I don't make mess so why should I clean it up?

Lou   I don't neither, it's her [daughter - Amy] that throws everything all over. It ain't me makes mess either.

Pete   I don't mean that mess, you idiot! I mean cleaning up. That's your job. I normally do fire 'n stuff like that, other things, but I have started to help more now haven't I?

Lou   Mmm. When we first moved in, after about a week, I were doing all cleaning and washing and everything, everyday. It were just killing me, and then, by what, eight at night, he's saying, 'What're you going to sleep for now, what're you going to bed for?' And I said 'cos I'm knackered, that's why.'

Pete   She's saying she's knackered and I've done all cleaning up 'n all, and I'm looking round here and I'm thinking, this place is a right mess. What's she mean, she's been cleaning...? *Laughs.*

Lou   Look, shuddup will ya? I'm at it from seven in morning til ten at night. It's a long time and it still looks a mess, but that ain't my fault. *Crying*

Pete   Well, we both chip in, anyway. She sometimes does fire in morning, like she's done fire this morning, so we do stuff like that together, but, Oh I don't know, it doesn't

seem   to work. I just seem to get stressed, me, and then I start 'n throw things all over place. I get in right tempers, me. I do...

Lou and Pete, daughter aged fifteen months. SY

Young fathers from poorer backgrounds consistently expressed resentment at the demands imposed by family life. Expectations that they would comply with partners' requests to explain their absences were a source of particular frustration and irritation:

Luke   It's like, if I go out for five minutes or two minutes, and then I'm like seven minutes well, then it's a problem.

Tracey Oh, shut up, seven minutes!

Luke   Well, you know what I mean. If I say I'm going to be two minutes and I'm back in fifteen minutes, then it's a problem 'cos I'm that bit later than I said I'd be.

Tracey He says, every time he goes out, he says, 'Oh I'll be two minutes', but then he'll be half an hour. Always he's gone much longer than he says. [...] He'll go and he'll come back half an hour later. 'Oh, it wasn't my fault', he says. Well whose is it then?

Luke   It's not something you can help. [...] It's not something you can say, 'Oh I'll be five minutes and I'll go and do this 'n that'. It takes longer than you think to do things.

Tracey Like yesterday, you only went round to take five pence back round to [neighbour]. He only went round to take 5p back and pick a bottle of milk up and he comes back half-hour later.

Tracey and Luke, sons aged thirteen months and six days respectively. SY

Carl   I hate that I can't just go out when I please. I don't want to have to say where I'm going and how long for and who with 'n all, like as if I'm still a kid. I can't be inside four walls all day. I gotta be out. Carl (Clare's boyfriend) SY

The two young fathers (Joe and Dave, partners of Susan and Alys) who had grown up in more secure and supportive environments, however, expressed less frustration and, indeed, appeared to embrace the responsibilities of fatherhood with alacrity. They also seemed to enjoy the company of their children and were more consistent in their responses to them. All young mothers, including those who enjoyed

easier relationships with their male partners, expressed envy at their male partners' continued access to a life outside that of home and parental responsibilities:

> Susan   Even though he's working, he's still out isn't he? To me he's still out. He's got another life. When he comes home, I want him to give me a break for me to go out. Just to go into town for an hour.
> HS   And will he do that?
> Susan   Sometimes. Depends what mood he's in. *Laughs.* [...] He thinks he's doing me favour, like.
> HS   So he doesn't see that you need a life outside home as well?
> Susan   No *Laughs.* He thinks being here with him [son] all day, I'm doing nowt anyway. That's what he thinks.
> Susan, son aged nine months. SY

The allocation of nappy changing duties, together with the disposal of the baby's excrement and other waste products, symbolise the extent to which mothers assumed responsibility for the most 'abjected' aspects of childcare. Managing the child's bodily functions is an important aspect of socialisation, because such training helps the child to recognise, and control, the boundaries of its own body. Understanding behavioural limitations are central to disciplinary regimes, not least because 'Boundary experiences affect the quality of interpersonal relationships and the quality of the relationship between the child and the material environment' (Sibley, 1995b:123). In the following excerpt Pete graphically describes his visceral response when faced with changing his daughter's dirty nappy:

> Pete   There's one thing that's given me one answer.
> HS   What's that then?
> Pete   That's one of her nappies. I'm never going to change another one.
> HS   Why's that?
> Pete   *Bleerr* [makes a retching sound] They're, they're totally disgusting they are.
> Lou   His mum nearly made him change Ross [Pete's nephew] round there and he nearly spewed up. *Laughs.*
> Pete   It's true. *Laughs.* I swear to God I did. I were nearly throwing my guts up. Urrgh.. I can't stand smell of it and I can't stand sight of it. Dog shit's same, can't stand smell of that, neither.
> Pete and Lou, daughter aged three months. SY

Pete's refusal to engage in the 'women's work' of changing his (female) child's nappy is in keeping with the ethos of his working-class background; it also fits with his macho character and his 'bad boy' identity. The (macho) identities available to working-class men may be understood as facilitating a sense of inclusivnesss, which in turn, signifies a sense of belonging. This contrasts with the experiences of working-class women for whom a classed identity is often a source of 'othering' and exclusion (Skeggs, 1997).

    o   Doing mothering differently: young women's mothers as role models?

Mothering practices are embedded within a social context in which relationships with others are a fundamental aspect. Young women's experiences of relationships influenced, and cumulatively affected, their capacity as mothers. Hence the importance of identifying relevant classed, and other, socialisation processes because, 'Behaviours we associate with a specific life stage may more truly reflect the conditions through which a group has lived collectively, such as its access to education, than biological age' (Monk and Katz, 1993:30). When I asked young mothers if they intended raising their children similarly or differently from how they themselves had been raised, their replies tended to reflect their individual experiences of being mothered. In effect, this reiterates a point made some twenty-five years ago: 'what happens to women when they become mothers reflects what has already happened to them as they became women' (Oakley, 1979[1986]:11). An historical perspective insists that 'women are seen not only as mothers, wives and workers, but also in relation to other generations – as daughters, grandmothers, aunts and so on – and in domains outside the family and workplace and their wider community of friends, as well as in relation to various social and political institutions' (Monk and Katz, 1993:20). Over the life-course, then, women's circumstances may undergo profound changes which, in turn, will influence their maternally-derived relationships.

Young women's mothers often disagreed with how their daughters managed socialisation processes with their grandchildren. Although many of the teenagers articulated a desire to 'do' mothering differently from the patterns they 'inherited', the majority conformed to the intergenerational patterns described over forty years ago by Josephine Klein (Klein, 1965) in her study of 'Ashton', a fictional community in the heart of the Yorkshire coalfields. The most emotionally deprived respondents in my research mirrored the behaviours of parents in Klein's study, for example by stressing their children's material, rather than psychological, well-being, which accentuated 'the taboo on tenderness and [...] concentration on the outward signs – new clothes, new toys...' (Klein, 1965:115). External appearances were especially important to poor respondents and most strove to maintain a façade of plenty which they hoped would protect them from being negatively appraised by others. Living with debt was a common experience and some young families went without food and other essential items in order to afford status symbols such as expensive toys and designer clothes for their children.

Mothers played a central role in the formation of daughters' characters and, hence, in shaping their potential as mothers. Four of the six mothers in the longitudinal cohort participated in my study and another woman (a non-mother) participated in a surrogate capacity (see Appendix six). Regarding the Wales cohort, six of the ten available mothers participated in initial interviews, and two joined their daughters for follow-up interviews two years later. As my contact with the Wales-based mothers was very limited, however, I am unable to provide much detail on the lives of these young mothers.

The quality of mother-daughter relationships varied greatly and although some daughters complained about their mothers, they nonetheless made frequent reference to them. If they were estranged they agonised over whether, and on what terms, they might re-establish contact and, hence, the volatile nature of mother-daughter bonds often appeared ambiguous, 'with bitterness masquerading

as love, and bondage masquerading as attachment' (Apter, 1990:7). Young women who had enjoyed a stable and nurturing upbringing mostly expressed a desire to emulate at least some of the parenting practices to which they themselves had been exposed. In this way the 'inherited' self is woven into a pattern of cyclical transmission, with the potential for the child to make of its past what it will (Lawler, 2000). Hence, both continuity and change are reflected in the parenting styles of each generation.

Michelle expressed a more ambivalent attitude. As I have mentioned previously, Michelle's modelling career necessitated her travelling to European locations for fashion shoots, where she was exposed to the glamour and allure of lifestyles she had only previously encountered in glossy magazines. She was earning a wage far in excess of that earned by anyone she knew and she was beginning to get a feel for, and to enjoy, the independence and status associated with her emerging identity as a 'high flyer'. Her mother, Polly, provided a point of comparative reference and the emotional support which enabled Michelle to do mothering differently: to have a career *and* be a good mother:

HS   Do you think the way you're a mother to Daniel is very different from how your mother was with you?
Michelle Yes, I think so. I'm very different from my mother.
HS   Tell me more - in what way would you say you're different?
Michelle Well, for a start, I'm not putting my life on hold the way she did for us. I don't want to be mad with Daniel when he's older for taking chances away from me. I don't mean I don't get upset when I'm away from him - I do. I was really upset when I went to Greece [on a modelling contract] but my mum told me that lots of mums go out to work now and that it's something he'll get used to. She said it doesn't mean I don't love him just because I want a life of my own...
Michelle, son aged sixteen months. SY

Polly encouraged her daughter to maximise the opportunities offered by her new career and usually looked after her grandson when Michelle worked abroad. Although she was disappointed that both her eldest and youngest daughters had become teenage mothers, Polly viewed these events as temporary setbacks which would resolve when grandchildren commenced schooling and her daughters became more independent.

Teenagers', whose childhoods had been disrupted by violence and/or multiple changes in family structure, expressed no inclination to replicate their parents' childrearing patterns and, indeed, some were very concerned least they inadvertently reproduce these practices. Hence, with respect to mothering potential, systems of 'inheritance' may be both benign and threatening, with the latter having specific, and potentially troublesome, repercussions for daughters (Lawler, 2000). The expression 'matrophobia' - the fear of becoming (too) like one's own mother - has been employed to describe the unwelcome intrusion of socially (classed) and genetically acquired maternal characteristics into the minds and bodies of daughters (ibid). The reproduction of 'inherited' characteristics, or the fear of this occurring, may be detrimental to creating mothering potential:

> I don't want to turn out like my [alcoholic] mum and end up being a bad mum like her. That's what I'm worried about the most. [...] I'm scared I'll turn out just like her no matter how hard I try not to be like her. *Starts crying.* I just couldn't bear it. I'd rather have a termination. I can't bear the thought of doing that to my child. [...] She was the worst mother you can imagine. Vile, she was, vile. Catrin, sixteen weeks pregnant. W

A personal experience of negative mothering provided Catrin with embodied knowledge about how she did *not* want to be as a mother. Exposed to chaos and uncertainty from an early age, Catrin talked at length, and at an early stage in pregnancy, about her fear of reproducing her mother's 'vile' parenting style. Her experiences of being mothered were largely conflictual and adversarial, and in the absence of alternative examples of mothering, Catrin's parenting skills will have to be learned. In this respect she will become a 'self-developed' mother (SmithBattle, 2000:87).

Clare, who endured her mother's early separation and subsequent divorce from her alcoholic father, followed soon afterwards by the sudden deaths of her only two uncles, was aware of the impact of tragedy on family cohesiveness. She expressed an intention to protect her daughter from the emotional distress of such events:

> I think my mum has been, like, a really good mum, but I wouldn't go round saying, 'Oh I want to be a mum like my mum', 'cos my mum's had a really rough time, wi' me dad and her brothers 'n everything, and I think that's, like, affected me as well. [...] I don't want my kids having to grow up wi' all that going off. It's too hard. I think that's what's made [younger sister] go off the rails is all that stuff that happened when we was younger. Clare, daughter aged two years. SY

Jade frequently articulated a desire to be more emotionally consistent with her daughters than she experienced in her family of origin. On a number of occasions throughout the study, Jade, the younger of two girls, alternated between despair and anger when she described differences in the relationship between herself and her mother, and between her mother and Josie, her older sister. Although Jade's mother did not participate in the research, and hence I am unable to offer an independent analysis of this particular mother-daughter relationship, anecdotal evidence suggested that Josie was the favoured daughter. Jade's intention to demonstrate a more equal relationship with her own daughters may thus be interpreted as a desire to 'disinherit' her mother's parenting legacy. This was perhaps best illustrated by her mother's acceptance of her older sister Josie's pregnancy at age fifteen, and her rejection of Jade in similar circumstances two years later.

> HS   Do you think the way you're a mother to Janey and Gemma is different from how your mother was with you?
> Jade Yeah, 'cos, like, my mum, she favoured Josie. She were always down on me for everything. I'm trying to treat both of these equal, like, so I'm definitely different from her in that way.
> Jade, daughters aged eighteen months and four months respectively. SY

At the time Jade made the above claim, however, she had already arranged for her younger daughter, Gemma, to live with Josie and Tom (Gemma's father and Jade's ex-boyfriend with whom Josie was now living). Despite Jade's intentions to do do mothering differently, her relationships with her daughters replicated the very pattern she was trying to avoid: that of distancing herself from her younger daughter, just as her mother had done with her.

In the following excerpt, Lou is reminded by her partner that even seemingly small gains in parenting status nonetheless deserve to be recognised and celebrated:

> HS   What about you Lou, are you being a mum in a different way to what your mum was like with you?
>
> Lou: I dunno, 'cos when I were Amy's age, I were in care weren't I? Yeah, I were 'n all.
>
> Pete: Well then, that proves you <u>are</u> doing better job then, 'cos like, if she's [daughter] still here then you must be. You were in care and she's still here so that proves it, doesn't it? Pete and Lou, daughter aged fifteen months. SY

Apart from occasional 'glitches', Michelle, Clare and Susan maintained close and caring relationships with their mothers throughout the research period. Towards the end of my study Jade and her mother had re-established contact and were beginning a reconciliation process, although her mother had not yet met her youngest granddaughter. Lou remained estranged from her mother and, following her daughter's birth, successfully sought legal aid to obtain a court order banning her mother from further contact.

Childcare provision: formal and informal contributions

Childcare was a gendered activity which most young women who could, shared with their mothers, at least during the time they continued to live at home. When daughters moved into rented accommodation, usually with male partners, most mothers continued to support them, albeit sometimes on different terms. Family support is crucial to young mothers, especially at the point of exiting the family home (Allen et al., 1998) and, indeed, during the first year of living away a sizeable number spend considerable amounts of time in the parental home accessing support, returning to their newly acquired residences only to sleep (Speak et al., 1995). When young women in this study commenced independent living, mothers-in-law often assumed, or indeed were offered, a greater role in childminding activities. Offers of help were sometimes resisted, because the 'natural' order of established domestic hierarchies tended to make it all to easy for older female relatives to usurp younger women's attempts to establish their own maternal identities. Not all female relatives were willing to assist the young couple with childcare; lack of support added significantly to respondents' feelings of helplessness and distress.

Young women who lacked support from their own mothers, and/or who were re-housed at some distance from established social support networks, usually had little choice but to accept whatever help was available to them, regardless of the quality or the conditions attached. For example, Lou was economically and socially dependent on her boyfriend's parents and hence had limited bargaining

power to challenge her mother-in-law's demands for greater involvement in her granddaughter's life. She repeatedly thwarted Lou's attempts to assert mothering control, for example by dictating the timing of her availability, refusing to provide childcare if she disagreed with the purpose for which it was requested, and occasionally failing to return her granddaughter at agreed times. As her granddaughter transformed from a passive baby to a demanding toddler, she withdrew her support altogether.

Many mothers looked after their grandchildren to help their daughters progress their education and/or careers, or simply to take occasional 'time out' to enjoy themselves. Bureaucratic procedures, which currently require prospective childminders to complete recognised training programmes, and to return satisfactory clearances from the police and local authorities before being eligible for registration[107], frustrated some mothers attempts to claim for the childminding services they provided. Mothers who knew what registration entailed dismissed suggestions that training and registration was in everyone's best interests:

> HS   Do you think you'll go to the bother then of training and registering [as a childminder]?
>
> Chris   No, it's too much faffing about. I only want to look after my granddaughter, it's not like I want to look after the whole neighbourhood. *Laughs.* And when she goes to school I'll stop doing it anyway, so what's point of stressin m'self, just to look after <u>one</u> baby. It's not worth it. [...] I think it's a total con.
>
> Chris (Clare's mum) SY

The requirement to be registered, and to undergo continuing 'professional' development in order to receive the payment to which many mothers felt they were anyway entitled, provoked heated discussions. Some mothers claimed that an altruistic desire to ensure their grandchildren enjoyed the best possible childcare made them vulnerable to being emotionally and materially manipulated, by what they perceived as irrelevant state requirements:

> HS   So, because you're related to [granddaughter], because she is family, then you can only be paid if you register with the local authority?
>
> Polly   That's right, that's what they told me. It's ridiculous. If she [Michelle] were paying for childcare, say in nursery or something, it'd cost her a fortune. [...] Well, she'd not be able to afford it would she? But 'cos I'm related to [granddaughter] then I'm only allowed to look after her if it's for free. *Laughs.* They really make use of you don't they? *Laughs.* We're stupid for doing it 'n all, we are. *Laughs.*
>
> Polly (Michelle's mum) SY

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[107] OFSTED, a government agency, is the inspectorate for children and students in England. All registered childcare providers, schools and colleges must be registered and available for inspection by Ofsted. Inspections take place at approximately three-yearly intervals with little or no advance notice given. Although no formal qualifications are required for childminders, attendance at a 'short' sixteen hour preregistration course is required and a commitment to attend regular and ongoing training is a condition of continuing registration. Registration is subject to a satisfactory home and clearance from the Criminal Records Bureau (CRB) is required for the prospective childminder, partners, and anyone over the age of sixteen who is living in the home. See: http://www.ofsted.gov.uk/

Mothers in receipt of benefits found it necessary to undertake a comprehensive financial analysis in order to confirm that, if they decided to proceed with registration, their earnings would not effect a reduction in benefit payments. This was particularly important for women who had not been in paid employment for many years, some of whom were in considerable debt:

HS   So are you saying you wouldn't be able to receive any money for childminding anyway, because it would upset your benefits?

Chris Yes, that's right. Because I'm on benefits I can only earn fifteen pound a week [...] When she starts school I'll have to go back on benefits if I can't get a job, but then they might tell me, 'Oh no, you've been working, you can't have benefits.'

Chris (Clare's mum) SY

The restricted availability of affordable commercial childcare negatively affected some young women's decisions to continue their education. For example, Susan's and Michelle's intentions to take up college places proved impossible, because the subsidised college crèche only admitted children over the age of two years and neither could afford the fees charged by independent childcare providers. Poor public transport links created additional obstacles for these young mothers, both of whom successfully sought employment opportunities rather than returning to education as they had originally intended. Similar barriers to young mothers continuing their education were identified in critiques (Dawson and Hosie, 2005; YWCA, 2004) of earlier Government guidelines (DfES, 2001) which emphasised that teenage pregnancy and/or motherhood should not be used as reason for exclusion from education. Indeed, the Care to Learn initiative (DfES, 2003), was intended to remedy these very deficits by providing financial assistance with childcare to teenage parents wishing to continue their education. A subsequent evaluation of the scheme, however, highlighted a number of shortcomings, including inflexible provision and a lack of proactive targeting (Dench and Casebourne, 2005). Further research reported a 'childcare gap' (National Audit Office, 2004) of affordable, high quality, care in the most disadvantaged neighbourhoods (Wiggins et al., 2005a), which rather undermines the ideology espoused by social inclusion agendas

Young mothers differed from their older counterparts in that the majority were able to access informal childcare arrangements. In the first instance, most daughters negotiated with their mothers about the childcare they wanted, and what mothers were prepared to provide. Localised family networks often provided additional help, which was flexible and usually available at short notice.

HS   So, do you like have an agreement with your mum where you both can say, right, I'm off duty now and you're on duty now? Or how does it work out between you?

Alys   Laughs. Well It's not, like, I just like tell mum to go away and I'm doing whatever with [son] now. Like, obviously, sometimes I go out and I just leave my mam to carry on. [...] My mam doesn't go out much anyway, so she doesn't mind staying in with him.

Alys, son aged two years. W

In addition to maintaining their regular domestic responsibilities towards other family members, most mothers absorbed the additional tasks associated with looking after grandchildren:

> HS   And who does things like getting Chloe's [Clare's daughter] tea for her?
> Clare   Sometimes she eats before I get in, if I'm going out like, but if mum knows I'm staying in she probably gives Chloe hers first.
> HS   And then you and your mum and [younger sister] all eat together later on?
> Clare   Yeah. We usually eat our tea and watch telly.
> HS   And who does the cooking and cleaning and, you know, the household stuff?
> Clare   Oh, mum *Laughs.* I can't cook nowt. And I'm totally crap at cleaning. *Laughs.*
> Clare, daughter aged two years. SY

Although mothers did not expect their daughters to pay for the childcare they provided, payment in kind was sometimes negotiated. For example, soon after Tracey returned home with her new baby, she resumed the task of collecting her two younger siblings from school each day. Similalry, when Clare passed her driving licence, she took on her mother's role ferrying her younger sister to her social engagements. As soon as they started earning a regular wage, both Clare and Michelle paid their mothers for some of the childcare they provided (which, to some extent, demonstrates the ineffectiveness of government attempts to legislate against informal childcare arrangements). Payment for tasks previously undertaken (usually by women) for love, or from a sense of duty or social obligation, reflects the increasing 'marketisation' of everyday life (Hardill et al., 2001:89).

> o   Delegating childcare responsibilities: envied boyfriends

When young mothers moved out of the family home to live with their boyfriends, childcare was opened up to wider kinship networks. Respondents appreciated the support afforded by a wider circle of largely female kin and particularly treasured acts of generosity shown towards the baby. An increased support network did not, however, diminish young women's envy of their boyfriends' continued freedoms:

> It's like he comes home [from work] and then he'll just go out again. I can't do that. If I want to go out I have to ask my mother to look after [her son]. I have to arrange it all first, I can't just go out the door when I feel like it. Not like he [BF] can. Alys, son aged two years. W

Occasionally, tensions between young mothers and their boyfriends spilled over into hostilities:

> He [BF] thinks 'cos he's at work all day it's up to me more now. But he forgets I'm with him all day and I get fed up with him by the time he comes in at night. Then I want to have some time off but then he's tired from working all day. So we have fights about that.
> Susan, son aged nine months. SY

Paid employment signified power within the household, and this gave (higher) wage-earning males licence to take 'time out' for themselves. The exception was Michelle, whose earnings far outstripped

those of her partner, although the disparity in their incomes did not reduce Michelle's domestic, or maternal, responsibilities.

Disciplining the child: constructing good, future, 'classed' citizens

Children were seen by their parents and grandparents as requiring regulation in various aspects of daily living. In the previous chapter I discussed this issue in relation to infant feeding. Here I address concerns about children's everyday behaviours, including sleeping practices and arrangements.

The project of motherhood is central to the way in which mothers influence their child's development 'in such a way that her child becomes the sort of adult that she can appreciate and others can accept' (Ruddick, 1980:349). The setting of boundaries, and 'the prevention of naughtiness and the promotion of goodness' (Ribbens, 1994:174) in children were seen as central to children's successful socialisation and, indeed, have long been considered as central to the mothering project. Badly behaved, unruly children suggested a dereliction of parental duty and parents and grandparents in this study were generally of the opinion that a child's bad behaviour should be corrected. The power to exert appropriate control was considered intrinsic to the maternal, but not necessarily to the paternal, role. Respondents described the exercise of power in various ways: restricting the child's physical movement by putting it in its room or cot, or by making it sit in a designated place for a set period of time; inflicting physical punishment directly on the child's body ('slaps', 'taps', 'smacks'); depriving the child of favourite routines (bedtime stories); and/or shouting or swearing at it. Most respondents were very concerned about their child's behaviour and interactions with others; 'proper manners' and 'good behaviour' were highly regarded and, if not spontaneously volunteered by the child, were induced through systems of reward and punishment. The tendency to blame and discipline the child, as a first response to behaviours considered inappropriate, was more noticeable amongst poorer parents:

> When [daughter] is with other kids she'll slap them so then I slap her back again to teach her a lesson. She's right wild she is. [...] The dog got her yesterday. It bit her leg. Served her right. She's learned her lesson now. She needed stitches.
> April, ten weeks pregnant with second baby. W

> You throw that at me again (to toddler) and I'll throw you! [Daughter repeats earlier action of throwing a cushion at Lou] No! You bad girl, I'm going to smack your bum for that [smacks daughter across buttocks]. Lou, daughter aged fifteen months. SY

Psychological theorising suggests that adolescent mothers are more likely to adopt authoritarian attitudes towards their children and tend to be less tolerant of irksome behaviour (Mercer, 1995). However, research findings and subsequent theories on this topic often fail to differentiate such behaviour on the basis of participants' social class, and hence middle-class standards are assumed as the ideal standards (Lawler, 2000). Working-class parenting methods may thus be considered deviant because they are judged against norms which discount individuals' 'classed' preferences and

experiences. Respondents whose personal experiences of parenting were mostly negative, tended to see disobedience in their children as deliberate attempts to undermine their authority. Such respondents tended to interpret childlike behaviours in children as personal attacks on their maternal authority and even when alternative explanations were suggested, they appeared reluctant to change their viewpoint:

Lou	Every time I pick her up, she's [daughter] slamming her lip back or something stupid. [...] It feels like she's against me for some reason. She's got a right temper on her. She's always trying to get at me. She does it deliberately to wind me up. [...] Yesterday I put her down and she wouldn't settle. She were waving her arms around and one of 'em smacked me across face. She does it to get at me. I know she does. *Starts sobbing.*
HS	Mmm. Yeah I can understand it might feel like a wind up to you but it might be that she's only doing what little kids do normally. She's only expressing herself in the ways she knows.
Pete	Yeah, that's what I think. That's what I've been telling her, but she won't listen.
Lou	She won't do nowt to you. It's only me she does it to. She knows what she's doing. She's just trying to get at me.

Lou and Pete, daughter aged fifteen months. SY

This excerpt also illuminates the degree of agency which Lou confers upon her child, which is in marked contrast to that which she claims for herself. In the following excerpt, Jade demonstrates a similar parenting style:

Jade	[to Janey, her eldest daughter] Your mamma don't have a life, it's just you 'n your sister. That's my life. That's about it.
HS	Do you get angry with them for that, for putting you in that situation?
Jade	No, it's not their fault. Sayin' that, sometimes I've been scared of what I might do to her [Janey] 'cos I get so angry at her sometimes. She winds me up 'n sometimes I just get so mad.
HS	Have you ever wanted to take it out on her, like you know, hit her or something like that?
Jade	No. Sometimes I've thought about it but I ain't ever done it though. No! Not with Gemma [younger daughter] either. I've left her in her room when she's roarin' her eyes out and givin' me a headache. I've left 'em both in the room for that. Their cryin' does my head in, so sometimes I just put 'em in there 'n shut the bedroom door 'n leave 'em in there to cry.
HS	Right.
Jade	I've never, ever wanted to hit her. Or Gemma.
HS	Right, OK.
Jade	I've smacked her [Janey's] bum when she's like gone off or whatever, not hard though. Enough to teach her a lesson. It's just been like a tap, you know, I just tap her on bum or whatever.

Jade, daughters eighteen and eight months respectively. SY

Lou and Jade both entered motherhood scarred by troubled relationships with their mothers and both young women appeared to be replicating, at least in part, the mothering styles to which they themselves had been exposed. The teenagers who entered motherhood without such troubled legacies appeared to be more patient in their interactions with their children, offered more sophisticated rationales for their

child's (mis)conduct, and were less likely to resort to physical violence when disciplining children for unacceptable behaviour:

> Clare   Well, if she's naughty I make her sit on the chair and she's not allowed to move until I tell her, so she has to sit there and do nothing till I tell her she can get up.
> HS   And how does she respond to you telling her to do that?
> Clare   Oh it depends. *Laughs.* Sometimes she just Laughs. or she'll kick and scream, and then sometimes she'll just get up after about five minutes and walk away so I say 'Get back on that chair', but then she'll just laugh at you and go, 'Funny, funny, mummy's funny.'
> HS   And what do you then?
> Clare   I put her back on chair. But then she'll get off as soon as I'm not looking. So if I want her to stay in chair I have to sit with her and then she just thinks I'm playing a game.
> Clare, daughter aged eighteen months. SY

When mothers were respected, daughters tended to express positive sentiments about the contributions they made to their grandchild's care; such grandmothers were seen as emotionally capable and more able to tolerate a wider range of mischievous behaviours:

> I think my mum's more patient than me. She's really good with him. Even when he winds her up I don't think I've ever really seen mum shout at him. Susan, son aged sixteen months. SY

And these mothers praised their daughters' mothering efforts:

> HS   How's Michelle coping with Daniel's temper tantrums?
> Polly   Oh, she copes marvellous. She does. [...] Michelle doesn't, like, expect him to always be on best behaviour, you know, to know how to behave, 'cos after all he is just a baby. She's not like some young mothers in that way, 'cos some of them do expect their kids to behave like little adults almost, don't they?
> Polly (Michelle's mum) SY

The age at which young women started disciplining their children, and the methods they used, varied considerably. That said, all children were subjected to some form of discipline by the age of six months. In older children, temper tantrums, biting and kicking, and refusal to obey adult commands, were viewed as serious violations of behavioural norms, requiring immediate correction. When particularly stressed, some young mothers sought additional support from male partners, and/or had recourse to tears:

> Michelle   He has lots of tantrums now when he doesn't get his own way. He just screams and lays himself on floor 'n kicks 'n all, if you don't let him do something he wants. Last week he did it in shop and that were really embarrassing. *Laughs.*
> HS   How do you cope with him when he's like that?
> Michelle   Oh I just ignore him. *Laughs.* If I'm at home I just go into other room and leave him till he quiets down.
> HS   Mmm, that sounds like a sensible thing to do. Do you get angry with him as well? You know, do you yell at him or hit him, or anything like that?
> Michelle, No, not really.
> HS   No?

> Michelle No, 'cos usually I've always got Ryan [BF] here, so he can sort it out. He's a right
>   daddy's boy he is. *Laughs.* He'll do anything for Ryan, so that makes it easier.
>   *Laughs.* [...] No, I don't get angry with him. I do cry a lot though. *Laughs.*
> Michelle, son aged ten months. SY

Young mothers did not always describe their children in terms of problematic behaviours:

> HS   Is there anything that [daughter] does that really winds you up?
> Clare   No, not really. No, there's nothing really. She's good as gold. She's no problem
>   really. She's just pleasure on legs. *Laughs.*
> Clare, daughter aged two years. SY

Mothers and daughters frequently disagreed about the need for, and the type of, punishment for children. When relationships between mothers and daughters were affable and accommodating, responses to behavioural infringements were broadly similar and did not need additional discussion. On the rare occasions one party was perceived by the other to have overstepped the mark and applied a punishment thought to be inappropriate, reconciliation was quickly effected.

Observing daughters' mothering efforts provided opportunities for mothers to reflect on their own experiences of childrearing. Many sought to protect their daughters from repeating the 'mistakes' they had made, especially with first-borns. Children's behaviours which infringed on the personal 'space' of others were particularly disapproved of: making 'too much' noise, refusing to sleep alone, and throwing objects at other. Daughters who disregarded their mother's advice on disciplinary matters were seen as lacking judgement, as spoiling their children and hence as reducing opportunities for the future enactment of socially acceptable behaviour. Daughters, however, tended to live 'in the moment' and looked for immediate resolutions to problems:

> When he [toddler] can't move about, 'n get what he wants, he just goes mad. He starts
> screamin', shoutin'. [...] He goes on 'n on, till you give it 'im. Me mum says I shouldn't give in to
> 'im all time. She says I'm spoiling 'im, but I can't stand the noise he makes! *Laughs.* It's well,
> give in to 'im or leave 'im making noise. Susan, son aged three months. SY

When mothers and daughters were less kindly disposed towards one another, differences of opinion about discipline were not easily resolved, and were more likely to escalate and to endure longer. Disagreements which initially focused on discrete aspects of the child's behaviour tended to become 'global', involving not only the parent-child relationship but the mother-daughter relationship and, occasionally, also the extended family, some of whom exercised considerable influence over disciplinary decisions:

> Jasmine You can't tell Tracey [daughter] owt. That's thing that really annoys me with her, is
>   she's got it all mapped out.
> HS   How do you mean?
> Jasmine Well it's like she thinks you can just tell kids what to do and they'll do it automatic, like.

I told her look, Tracey, you can't just tell 'em what to do, like little Hitlers. [...] She brings in his [BF's] mother to sort things out, 'n then he [BF] brings his sisters in on it as well, 'n they don't know nowt about bringin up kids [...] But he rules her, do you know what I mean? So then I said to Tracey, 'Well good luck to you both then. If it works out that's fine, but I think you're making a big mistake.'
Jasmine (Tracey's mum). SY

There is now a sizeable body of literature elaborating Donald Winnicott's original concept of 'good enough' mothering – the style of mothering provided by the 'ordinary' and 'devoted' mother who makes 'active adaptation to the infant's needs' (Winnicott, 1971:10). Whilst the mothering provided by 'good enough' mothers (not necessarily the infant's biological mother, as Winnicott points out) may be flawed and imperfect, it nonetheless is usually sufficient to provide the child with the security needed for the development of an autonomous ego. In Eriksonian terms, 'good enough' mothering enables the child to develop a basic sense of trust in the world (Erikson, [1950]1963). The concept has since been critiqued, developed and popularized by object relations theorists (Flax, 1990) and feminists interested in historical patterns of mothering and competing ideologies about 'doing' family (Silva, 1996). Although the 'good enough' maternal status was an attempt to repudiate the good-bad dichotomy, it was not intended to gloss over the fact that some mothering is actually quite bad, at least some of the time (Brown et al., 1997).

Whilst the good-bad dichotomy may be a rational response to unknown and unpredictable circumstances, it reduces options for mothers to be good *and* bad, sometimes simultaneously. Furthermore, the concept did not evolve from research with a cross-section of families and ethnicities, but from studies of middle-class families, where mothers, largely supported by wage-earning husbands, attended to the needs of infants. How then, to compare mothering within the context of a more cooperative endeavour which includes not a wage-earning, but an absent father, and parenting contributions provided by extended family and kinship networks? Within a 'classed' context, the meaning of 'good enough' mothering must be re-examined in the light of the 'terrible burden on women who, having been "let go of" and "let down" so often themselves, as well as left "holding the baby" are sometimes unable to summon up the extraordinary courage needed to "hold on" or "hold fast"' (Scheper-Hughes, 1992:361) when relationships between themselves and their child/ren falter.

Sleeping practices and arrangements

Mothers and daughters often argued about babies' sleeping routines, including bed sharing, the 'right' time to settle a baby for the night, and the appropriate age when a daytime nap might be abandoned. A mother's advice to her daughter often reflected her own experiential learning, including her perceived 'mistakes'. Practical arrangements influenced young women's bed-sharing decisions, particularly in the early months of the baby's life. For example, when young women remained in the family home, rather than leave the baby to cry at night and disturb other family members, they brought them into their own

beds. As some young women were already sharing their (single) beds with their partners, however, accommodating an additional body, even that of a baby, was difficult, and frequently meant one or other partner slept on the floor or on a sofa:

HS   Is it OK having [son] in the bed with you?

Susan   Mmm. It's all right when it's only me but when [BF's] here as well it's not very good, 'cos he's [baby] very wriggly, so one of us usually ends up sleeping on floor, or coming down here and sleeping on settee.

HS   Are you in a single bed?

Susan   Yeah, so it's not what you'd call comfortable. *Laughs.*

Susan, daughter aged two months. SY

Narratives of bed-sharing with infants provoked 'horror stories' about parents rolling onto the baby and accidentally suffocating it. Although no respondent personally knew anyone who had suffered this calamity, the fear of it happening deterred some respondents from adopting this practice. Mothers were generally critical when daughters succumbed to the demands of their infants and initiated shared sleeping arrangements. Most saw in their daughter's actions a repeat of earlier mistakes they themselves had made in their own mothering practices, especially with first-born children:

Jasmine But like with Tracey [daughter] she's done similar things to what I've done, putting [younger child] in bed with her. I used to do the same thing, because it were easier. Mistakes you make. *Laughs.*

HS   Things you regret afterwards?

Jasmine Yeah, exactly. Things you think, oh no, why didn't someone tell me. But you   can't be told. Not with your first. You have to learn the hard way. [...] I've said to her, 'Oh you shouldn't have him in bed', but then, like I've said to Tracey, that's what people used to say to me and I never listened, but now I've learned. [...] They shouldn't be in bed with you. Start that and you never stop. Rod for your own back. I learned hard way. I had no mum to tell me owt. She's got me to tell her but she won't listen.

Jasmine (Tracey's mum). SY

First-time mothers were considered particularly prone to making errors of judgement, because expertise in childrearing was understood to accumulate through previous mothering experiences.

Decisions about infant sleeping arrangements often reflected the degree of intimacy available in the original mother-daughter relationship. Daughters whose relationships with their mothers were problematic tended to show greater determination to control sleeping spaces and, unless a child was ill or a special occasion was being marked, discouraged their child/ren from sharing 'adult' bed space:

HS   So she's [daughter] sleeping in her own room now?

Lou   Yeah yeah, she has been for ages.

HS   Did she ever sleep in bed with you?

Lou   No. No, she never sleeps in our bed. Never has done. [...] She stayed in our room when she were really little, 'cos health visitor said she shouldn't sleep by herself. But she were always in cot. We moved her into her own room pretty quick.

HS   Would you ever let her come into your bed?

Lou   No. Oh, on occasion in morning, yeah we do. Yeah, well like we brought her in other morning. It were just for like a treat like. It were my birthday.

Lou, daughter aged nine months. SY

Even when children were restless and kept their young mothers awake, most continued to sleep separately. Mothers valued independence in the child as a positive attribute; they were of the opinion that parental bed sharing encouraged 'mardiness' and/or 'clingyiness'.

Jade   She's [oldest daughter] a right pain at the minute. She just will not sleep. So then I don't sleep either. Last night I were up and down to her all night.

HS   Would you ever think about having her in bed with you?

Jade   No. No way. Not to sleep. I don't want her getting too clingy, so then she won't sleep on her own.

Jade, daughter aged five months. SY

He were in our bed for first few weeks but now he sleeps on the top bit of his pram. [...] He's going in the cot soon, so he gets used to it from the start. They get right mardy if you leave it too long to get 'em in their own bed. Susan, son aged three months old. SY

Exceptionally, Michelle's son continued to sleep with his parents from birth until the close of the study, when he was sixteen months old. Michelle considered herself 'too soft' to exert the necessary discipline needed to change what had become an established pattern. The following excerpt also suggests that Michelle's decision rested as much on pragmatic concerns about protecting the quality of her own, and her employed partner's, sleep, as on concerns about fostering bad habits in her son.

I wanted him [son] in his own room by three months, but that didn't happen. It's 'cos I'm too soft. *Laughs*. [...] It started after he were born, when he were only a few weeks old. I'd just put him on the settee or on our bed till he went to sleep, and then I'd put him in his crib, but now it's just got that he'll like fall asleep down here on the settee and I'll take him up to bed and he'll sleep in his crib for about an hour, but then he knows, he must know somehow he's not in bed with anyone, so then he wakes up, and then I'll just put him in our bed and he'll sleep then till half eight, nine in morning. *Laughs*. [...] Only way we get any sleep is to let him come in bed with us. My mum thinks we're mad but Ryan [partner] has to get up at half four, so we can't spend half the night trying to settle him down. He gets upset if you put him in his own room and then me and Ryan get upset and we can't sleep 'cos he's upset. *Laughs*. So what's point? He's only little. He's got his own bedroom, but he's never been in it yet! *Laughs*.

Michelle, son aged sixteen months. SY

Acceding to babies' demands for attention and gratification was generally negatively regarded by young women's mothers. Most were of the opinion that parents had a duty to set firm boundaries and that children had to learn that they could not manipulate their parents, by paddies and tantrums, beyond these defined limits:

> I think the one thing that both girls have got wrong is the bedtime routines because none of the children will go to bed at night. All three [grandchildren] rule 'em at bedtime. None of 'em go to bed till they [parents] go up. [...] He [Michelle's son] will not go in that lovely cot he's got in his own room, he just sits in it to play in, but he will not go in it to sleep in it. He paddies and tantrums and I say, 'Look, all you've got to do is have a couple of nights of paddies and tantrums and when he learns he's not coming back down, then he won't do it, but they won't let him cry.' [...] They're both working and they say they never have any time on their own but I say, well, look, this is your own doing, this is your own fault. You've made the rod for your own back. Polly (Michelle's mum). SY

The more confident young mothers such as Michelle and Clare shared easy and relaxed relationships with their mothers and relied on them for advice although that is not to imply that they necessarily felt obliged to act on it. They were also more able to tolerate their mother's criticisms of their childrearing practices. These young women exhibited more flexible and responsive attitudes to their child's needs, for example for comfort and reassurance when they were frightened at night:

> HS   So [daughter] has her own room and normally she'd sleep by herself?
> Clare Yeah, but sleeping, at the moment she not so good on that. She's sleeping wi' me 'cos she says she's scared of dark. [...] I think she must be going through a phase or summat. [...] Sometimes she'll go to sleep in her own bed wi' the light on, but if she wakes up and she sees light is off she'll come running into my room. [...] I've been trying to move her, when she gets to sleep, but she wakes up so it's not worth it, you end up getting up and down all night.
> Clare, daughter aged two years. SY

Young mothers were overjoyed when their infants finally started sleeping through the night because this meant that they too, were assured of sleep. Most respondents knew about contemporary risk discourses regarding 'approved' infant sleeping practices, including positioning the baby on its back and well down towards the bottom of the bed, and not sleeping with the baby following the consumption of drugs or alcohol. Some respondents circumvented these official discourses, however, by creating 'exceptional' circumstances whereby the child's refusal to sleep alone could be excused, for example, because of children's expressed fears or anxieties.

Reflections on young motherhood

At the final interview, I asked young women to describe their new lives to an unknown person. Although most admitted that the transition to motherhood had been a difficult process, even the poorest and most marginalized young mother responded affirmatively and positively with reference to her child/ren. This echoes the findings of a recent systematic review of qualitative studies in this area which reported that, despite the constraining affects of poverty and stigma, many young mothers demonstrate resilience and pragmatism in using available resources to best advantage (McDermott and Graham, 2005).

Some young women voiced regrets about having become pregnant, although not about having had sex. All respondents spoke about the significance of having a baby and behaving 'appropriately' as a mother. Young women's narratives changed over time and, with increasing distance from the events

of pregnancy and childbirth, the 'big deal' which had previously foregrounded (becoming pregnant at a young age, was superseded by the pragmatic demands of motherhood:

> It's [motherhood] not as bad as I expected. [...] If I could have not got pregnant, I wouldn't have got pregnant. Definitely not. Having sex were OK but not getting pregnant. *Laughs*. No, that were a mistake. But that's behind me now. I've got a baby and I'm responsible for her. I'm her mum. Clare, daughter aged twelve months. SY

> It's not like it's a big deal any more that I got pregnant when I was only fifteen. It's more like, well now I'm seventeen and I'm his mum, so what's the big deal, you know? You just have to get on with it. Alys, son aged two. W

Although most young mothers looked to the future with a sense of hope and ambition for themselves and their child/ren, isolated and penniless young women such as Jade, who had been abandoned by her mother, the fathers of both her babies, and her sister, anticipated a bleak and miserable existence:

> HS   How do you see your future Jade?
> Jade   Future? *Laughs*. What future? I ain't got no future far as I can see it. Not with two kids 'n no money 'n no boyfriend 'n no mum. I ain't got nowt have I? I ain't even got a sister any more. *Laughs*.
> Jade, daughters aged eighteen and eight months respectively. SY

And whilst leaving the parental home to live with a boyfriend was eagerly anticipated by most young women, some mothers anticipated this event with trepidation:

> I don't know what I'll do when these two [daughter and baby] move out. I'll be feeling lonely then all right, I will. But as long as they don't move too far, it'll be all right. As long as it's in the area. Angharad (Alys's mum) W

While living independently from her mother may be interpreted as an expression of autonomy for Alys, it constituted a breach in maternal identity for her mother.

A number of respondents became engaged doing the study period and some set dates for the wedding ceremony. Others delayed announcing these events until children were of an age when they could act as bridesmaids and pageboys. For working-class women, although partnership and marriage tend to be a primary objective, with young women's lives directed towards these ends, this is despite 'the wealth of evidence that it is within their intimate relationships with men that they are most likely to be molested and raped, beaten up and driven mad, de-skilled and required to work long hours, after hours' (Cain, 1989:12). At the close of the study, respondents had developed a diverse range of parental identities and displayed considerable variation in parenting styles. While many demonstrated evidence that they were replicating intergenerational patterns of 'doing' motherhood, at least in some

aspects of family life, a small number described practices that were at variance with their personal experiences of being mothered.

TWELVE: LOOKING BACK, AND LOOKING FORWARDS

This study of teenage pregnancy, and young motherhood, was complicated by a number of tensions which manifested in different ways. On a personal level, I often found myself caught between conflicting loyalties and hence I sometimes experienced difficulty maintaining a neutral stance. For instance, I was sometimes overly critical of midwives' interactions with respondents, forgetting that I had once been in their shoes and had similarly experienced the frustration of being confronted with, and horrified by, the circumstances of clients' lives. I too had been on the receiving end of violent and abusive behaviour from clients and had observed similar behaviours in their interpersonal and familial relationships. As a practitioner, I had witnessed the appalling neglect some mothers visited upon their children and I had passed judgements on some mothers I had deemed unfit, requesting intervention by social services and/or the police. I had justified my actions by invoking the mantra of professional accountability, aware that failing to act could be interpreted as a dereliction of duty.

In my role as a researcher and an observer of midwives' practices, however, I sometimes reacted as if my former identity had been obliterated. I blamed midwives for what I judged to be their inappropriate responses, although I also knew that many of the situations they faced were complex and unresolveable, at least in the short term. On the occasions that midwives voiced their frustrations with clients, I was often too quick to interpret this as evidence of prejudice, rather than a need to simply 'let off steam'. I had forgotten what it was like to be on call 24/7, to feel crazed with sleep deprivation, and/or to be consumed with grief and guilt about a birth gone wrong. I was also out of touch with how it felt to be responsible for delivering a service which was inadequately resourced, especially for the most marginalised women. I often found the experience of being confronted by the deprivation and adversity which characterised the lives of my poorest respondents extremely difficult to tolerate, but I expected midwives to be endowed with the capacity to rise above their personal feelings on these issues. I held double standards: blithely uncritical when the teenagers behaved badly, but hypercritical when midwives voiced their disapproval of behaviours which I also experienced as offensive. Perhaps in an effort to conceal my feelings of inadequacy, I projected unrealistic expectations onto midwives but, in passing judgement, I emulated the very behaviours I was criticising.

How had I become so far removed from the everyday worlds of midwives? How had I become so duplicitous, encouraging midwives to regard me as a confidante, only to betray them by over-interpreting their comments about their clients as other than what they usually were: spontaneous and benign outbursts of helplessness and frustration? It was as if the research environment had dulled my awareness to the harsher side of childbearing and rearing; to the raw emotions and crude responses which are so powerfully present and which cannot always be contained or explained by clinicians (or researchers). In some ways, I now think my attitudes were closer to my midwifery respondents than I had wanted to believe and, in distancing myself from my professional roots, I reduced my empathic capacity.

An additional tension that I experienced was the need to establish equitable and trusting relationships with the young women, and also with their mothers. Initially this was complicated by the fact that I was entering respondents' lives at an acutely sensitive time, when family relationships had often been temporarily fractured by disclosures of pregnancy. Perhaps because I was closer in age to the teenagers' mothers, and indeed to many of the midwives, some young women initially regarded me as a maternal/midwifery ally rather than as someone who might want to form an independent relationship with them. Although I am a daughter, I have never experienced being a mother, and although I had previously worked with teenagers in a professional capacity, I have had little recent contact with them in my personal life. My lack of embodied understanding in both these dimensions thus reinforced my sense of distance and separateness and this sometimes created difficulties in positioning myself appropriately, and to resist over-interpreting my data.

These constraints undoubtedly influenced the manner in which I conducted my research, including the relationships I formed with my respondents. The processes of analysing my data and writing up this thesis, however, have provided me with opportunities to reflect on these issues, and to see my background and previous experiences as integral to my research journey.

Limitations of the research

My personal limitations are bound up with another constraint which restricted the scope of this study. Embarrassment prevented me from inviting respondents to engage in 'sex talk' and hence to elaborate on their experiences of sex in any detail. The one respondent who spontaneously volunteered information on this issue reported that her first experience of sex was not only 'crap', it was also painful.

Personal shortcomings aside, this study, like all research, has its limitations. Although I did not investigate health as a primary focus of young women's maternal transitions, many respondents reported concerns about their general health which were dismissed by maternity staff, whose explanations for 'unwellness' were generally confined to the effects of pregnancy. Although some aspects of early childbearing are associated with negative medical outcomes, research to date, which I have referred to elsewhere in this thesis, suggests that these are largely the result of disadvantage and/or physiological immaturity.

This study did not seek to include the experiences of young women of black and minority ethnic (BME) origin, and nor did it include non-English speaking teenagers. Hence my findings are population-specific and can only be interpreted in relation to the socio-cultural characteristics of the sample, rather than being seen as generalisable to all young mothers. Research which has examined the experiences of BME young parents has, however, been recently undertaken (Higginbottom et al., 2005) which supports the findings from my research: that adolescent parenting experiences are diverse, and that early motherhood is a normal, rather than problematic, event for some social groups.

Time constraints also created limitations, preventing me from undertaking a comprehensive investigation into the specific roles young men and their families occupied throughout individual

parenting transitions, although most male partners were varyingly involved in young women's maternity trajectories.

Daughters' maternity experiences often prompted mothers to reflect on, and discuss, their own experiences of childbirth with me, and some confided that this was the first time they had disclosed their feelings about these events. Mothers who had experienced a traumatic childbirth worried that their daughters might suffer similarly. Some suggested that they might protect themselves from further distress by refusing to be present when their daughters were in labour. Such decisions were generally misinterpreted by staff and they invariably upset daughters. As the focus of my research was the maternity experiences of teenagers, however, I was unable to do justice to mothers' historical accounts and the possible consequences of their negative experiences on daughters' transitions to motherhood.

Finally, spatial arrangements and organisational procedures within maternity units restricted the number, and timing, of visitors. Whilst these arrangements may have helped maximise clinical efficiency, they appeared to increase respondents' sense of isolation and disorientation, especially at critical points such as the onset of labour. As my fieldwork did not include observations of labour, however, I cannot comment on the possible impact of these arrangements.

An overview of this study

The categories of teenage pregnancy and young motherhood are not homogenous and uniform but, as demonstrated by this study, contain a wide variation of individuals and experiences and this diversity makes it difficult to consider universal solutions to the problems confronting young parents. It also confirms that whilst those identified as socially excluded have received considerable policy and research attention in recent years, the 'black box' (Jones, 2003:197) of family life, in its most varied forms, remains largely unexamined. Alternative understandings of 'lone' motherhood and 'lone-parent' families are urgently needed, however, not least because, in the public imagination at least, they tend to be viewed as 'less-than' families lacking a father figure, rather than as social groups constructed in response to particular circumstances (May, 2004).

The fact that all of the young women in this study embarked on their mothering careers with bodies and psyches marked by experiences of being mothered themselves should not be overlooked. The teenagers who embraced motherhood with the least difficulty could lay claim to a style of parenting which fostered warm and loving relationships and this provided them with a robust capacity to embrace, sometimes even to enjoy, the challenges. The teenagers who fared badly were those scarred by early, and repeated, experiences of rejection, violence and family disruption; these young women (and some of their male partners) brought with them to parenthood a sense of 'unwantedness' which inhibited their ability to adapt to their new roles. Thus, for Alys, Clare, Nia and Susan, becoming a mother during adolescence was largely an affirming and empowering experience, whilst for Lou, April and Jade, it was mainly undermining and disempowering. Michelle's maternity career was marked by extremes of good and bad fortune and without the unwavering support of her mother, it is unlikely that she would have

weathered her difficulties as well as she did. Hence, this research restates the claim that poverty, class, and/or disadvantage are not necessarily, in themselves, instrumental in the production of unhappy childhoods, but, rather, it is the cumulative effect of these experiences impacting on 'a predisposed and vulnerable minority' (Paris, 2000:xv) which is problematic .

The context in which young women become mothers, then, cannot be overlooked. In line with very recent research (Arai, 2007) in geographically discrete areas of the UK with high teenage pregnancy/fertility rates, early childbearing was relatively 'normal', rather than a deviant, event for the majority of teenagers in this study. Many had siblings and/or mothers who were, or had been, teenage mothers. Furthermore, all respondents lived within areas of the UK marked by disadvantage and the risks associated with early childbearing (SEU, 1999). Hence, respondents became young mothers within a particular socio-cultural context which supported childbearing at an earlier age and the transmission of powerful maternity norms made termination of pregnancy an unlikely proposition within this subculture. Whilst some teenagers moved out of their localities when they became mothers and, subsequently, became more dependent on fewer people, the majority continued to live within their communities of origin, where they could access extensive family networks for advice and support. This enabled young women such as Michelle and Clare to pursue employment and educational opportunities. Respondents' experiences in this respect reiterate the findings of a recent systematic review of qualitative research in this area: 'for a significant number of young, working-class women, identity and belonging are secured through informal rather than formal modes of participation' (Graham and McDermott, 2005:33).

Most of the teenagers were accustomed to their mothers attending to their everyday needs, especially regarding food provision, laundry and transport services, and arranging their personal appointments. Moving to rented accommodation with male partners disrupted these established routines and forced young mothers to become more self-reliant and better organized. It also pressured them to acquire sophisticated negotiation skills in order to manage sometimes complex relationships with family and friends, and with health (and other) professionals. Some respondents handled these multiple demands with ease and good humour, whilst others adopted a 'poverty of expectations' (Jones, 2003:201), which reflected their low self-esteem and socially excluded status. The latter group, which included Jade, Lou and April, did not cope well with the demands of motherhood and it was difficult to see how they might avoid becoming increasingly marginalised. As I have previously mentioned, however, the lives of these young women were already spoiled before the events of early childbearing. Having been chronically deprived of affection, and lacking the most basic of support structures, it is probable that even in the absence of pregnancy, a catastrophe of a similar magnitude might have occurred, changing their life courses with equally damaging results.

Ongoing media, policy, and public health attention to teenage pregnancy may be understood to represent largely unexpressed concerns about the supposed dissolution of moral values and the disintegration of family life. The focus on young women is significant in this context because

adolescents are not viewed as fully adult, as 'full' subjects, but rather as subjects-in-the-making, constrained by parental and societal jurisdictions. Their bodies are not (yet) expected to reflect a mature adult subject position, but rather occupy a developmental phase in the life cycle, somewhere between autonomy and dependence. The rhetoric framing teenage pregnancy and young motherhood as 'deviant', then, obscures the fact that some young women actually plan their pregnancy and view early motherhood as a chance to create a new identity which will change their life course for the better (Cater and Coleman, 2006). Indeed, once the initial hurdles are behind them, many young mothers actually do rather well (Ermisch and Pevalin, 2003a). Where this is not the case, it is usually against a backdrop of considerable material and psychological deprivation. Hence, punitive attitudes to young motherhood are unjustifiable and may even be counter-productive. They almost certainly distract attention from the more pressing need for society to reconcile itself to the implications associated with long-term changes in family and kinship formation, relations, and obligations. In this context, teenage pregnancy may be a manifestation, rather than a root cause, of social malaise and, as such, will require a concerted focus to address the factors which create, and reinforce, the bleak and empty lives denoted by early, and repeated, childbearing (Selman, 2003).

The transition from childhood to adulthood has been cited as 'the most dangerous period of a woman's life' (Reekie, 1998:207). This is not least because contemporary Western societies are generally devoid of the institutional arrangements and supports which might adequately protect the sexual reputations of the most vulnerable through this increasingly protracted transition. The identification of 'vulnerability' is not straightforward, however, and current policy does not distinguish between that which requires strategic intervention, and that which does not. Nor does current policy discriminate between risks which are acceptable, and indeed necessary for the process of identity construction and maturation, and risks from which young people need to be protected. Perhaps because teenage pregnancy 'interrupts the lines between adult/child, [...] asexual/sexual' (Pillow, 2003:153), policy makers tend to focus on strategies which attempt to control and mould young women's maternal bodies in ways which reflect political ideals. The emphasis on these particular bodies, however, 'implodes and interrupts the supposed neutrality of policy studies, forefronts policy's role in regulating bodies and exposes the lived experiences of subjects of policy' (ibid, 2003:156). Although not directly concerned with policy issues *per se*, this study nonetheless illustrates the multiple ways in which a selected sample of young women subverted, deliberately or otherwise, the infiltrating power of policy directives.

Adult status may be attained or conferred, and may be self-defined or 'other' defined, but 'the resultant boundaries to the category are, in the main, simply boundaries of *exclusion, rather than inclusion'* (James, 1986:156, emphasis added). From the mid twentieth century onwards, the period of transition from childhood to adulthood has lengthened, resulting in longer periods of dependence and the emergence of discrete stages marking the separation of child and adult categories. Understandings of dependence have also been reconfigured in recent years, shifting from pre-industrial interpretations

denoting hierarchical relations of inequality, to contemporary notions of personal pathology, including behavioural syndromes (Fraser and Gordon, 1994).

The transition to parenthood is widely construed as a marker of adult status, although in many Western societies, as evidenced by this thesis, the status of young parents tends to be disregarded by policy makers and health professionals. With few exceptions, respondents in this study were not regarded by maternity staff and authoritative others either as adults-in-the-making, or as mothers-in-the-making, with the potential for personal growth and role development. This is perhaps unsurprising as such recognition would require a significant cultural shift, a respect for the shifting identities and transitional status of young parents, and an acknowledgment of their complex, and alternating, needs for dependence and autonomy.

Many respondents had already internalised a degree of adult status through events connected with death, prolonged family disruption, and/or the responsibilities involved with becoming a surrogate parent to younger siblings. Hence, most young women understood the transition to adulthood as a process of *becoming*; one of gradual maturation evidenced by a constellation of ongoing events. While they may have been 'just messing around' at the point when pregnancy became an inescapable reality, by the time the study was complete the consensus of opinion was that 'as soon as you have a child, you've got to grow up. You've got to be a bit more mature'. Young women perceived themselves, and were generally perceived by others, as further along the child-adult continuum than their male partners, regardless of the older age of the latter. The arrival of a baby forced a reappraisal of social relations, including those with male partners, whose habitual behaviours and attitudes were often negatively reinterpreted by their female partners as 'selfish and babyish'.

Young men's attempts to participate in maternity care arrangements were generally negative. A combination of pragmatic and attitudinal factors contributed to their invisibilisation and left most feeling unwanted and overlooked. Young men who managed to secure waged work were generally engaged in low-paid, low-status, jobs and, hence, lacked the necessary bargaining power to negotiate time off work to attend antenatal consultations. Even when they were present, however, midwives generally failed to include them in proceedings and this contrasted with the somewhat prurient interest some showed in other aspects of their lives, including whether they were being 'faithful' to their female partners and if they intended to 'stick around' after the baby was born. Midwives' attitudes to their younger male clients contrasted with their approach to the male partners of older, middle class, women, whom they treated with a deferential respect similar to that accorded to male obstetricians and others of authoritative rank (Kirkham and Stapleton 2001).

As well as attitudinal barriers, the dearth of facilities within local communities prevented some young fathers from actively engaging with their children in social settings, because activities for children typically focused on the needs of young mothers. Hence *inclusionary* practices for one category of young parents (mothers) were perceived as *exclusionary* for another group (fathers). At a societal level, the exclusion of (young) men from maternity events may be seen as reinforcing the low expectations of

fathers in general, and of working class fathers in particular. It also, of course, emphasises the gendered division of childrearing, which sees mothers as primarily responsible for the behaviour and welfare of children (Lee, 2000), and for ensuring their socialization into law-abiding, and productive, future citizens. Indeed, it has been suggested that there exists an 'inequitable gender division of labour at the scale of the day-to-day, the local and the body that should (but rarely does) guide local and political imaginaries' (Aitken, 1999:123).

Finally, this study also draws attention to the generic aspects of childbearing and rearing and the constraints which are not specific to the experiences of teenagers but, rather, may be applied to women across the childbearing age range. For example, my research findings reiterate the gendered nature of adolescent childbearing and rearing and it was this element which many young mothers experienced as most burdensome. Most envied their boyfriends' continued freedom, and their ability to absent themselves from household, including childcare, routines. Although this general sense of unfairness was perhaps most keenly felt by young women who had left the family home, and the plethora of domestic services provided by their mothers, to live with their boyfriends, previous research suggests that similar feelings are, in fact, common to many first-time mothers (Barclay et al., 1997).

Another example concerned respondents' access to hospital-based clinics, and restrictions on hospital visiting hours. These issues may be problematic for many pregnant women and their relatives, especially those lacking access to private transport and without childcare facilities for older children. Adolescents, however, are perhaps rather more vulnerable to suffering psychological distress in these situations because they are less experienced in dealing with institutions and health professionals and, hence, may be expected to have fewer coping strategies.

Furthermore, some of the younger women in this study had never spent a night alone away from home and many had never been separated from loved ones for extended periods, especially against their volition. Feelings of abandonment were exaggerated when young women did not know when they might be reunited with their loved ones. This occurred, for example, when they were admitted to the maternity unit thinking they were in labour but remained on the antenatal ward (where adherence to visiting hours was strictly imposed) until staff confirmed that labour was 'properly' established. Observance of scheduled visiting times was especially difficult for partners and parents working inflexible or unsocial hours, those without access to private transport, or those living in areas which were poorly served by public transport. Young women's relatives were often sent home from hospital but, not infrequently, labour progressed more rapidly than predicted and maternity staff recalled family members, sometimes very soon after they had returned home. Those without private transport usually had no option but to pay a return taxi fare, which they could often ill afford. Enforced separation at critical times was particularly difficult for those adolescents who were already damaged by a lifetime of abandonments and difficult interpersonal relations.

Finally, growing up in poverty and disadvantage affects childbearing women across the age range, as does the experience of being of BME origin, and/or having no language in common with

service providers. Like teenage pregnancy, these categories of potential exclusion may also be expected to impact negatively on individual women's experiences of maternity care. A key finding from this research is that working-class teenage mothers are a particularly vulnerable group, who require support rather than policing, especially from maternity service providers.

Suggestions for further research

It is evident from the limitations I have outlined at the beginning of this chapter, that further research into teenage pregnancy and young motherhood is needed. This is particularly true in the following areas:

1. Closer scrutiny of the attitudes of maternity staff towards pregnant teenagers and young parents might identify whether, and to what extent, they are contributory factors in negative reproductive outcomes.

2. The role of young fathers, and their kinship and family networks, in the formation, and endurance, of families constituted during adolescence, has not been explored in any depth. Teenage fatherhood is a subject overdue for more comprehensive research.

3. The potential impact of mothers' negative birthing experiences on their adolescent daughters' preparations for birth, and subsequent transitions to motherhood, is an under-researched area.

4. Finally, the impact of the maternity care environment on the integrity and longevity of relationships between young couples, and between young couples and their significant others, including their children, is worthy of in-depth exploration.

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Helen Stapleton, researcher

PROJECT TITLE: TEENAGE PREGNANCY, WHAT ARE THE IMPORTANT ISSUES?

You are invited to take part in a research study. Before you decide, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information and discuss it with a friend or a family member, or anyone else. If there is anything which you do not understand, please ask me (see bottom of page 2 for my details).

What is the research about?
The research aims to find out how teenagers feel about being pregnant and becoming a mother, and the things which matter to them during this time. I am also interested in finding out about the kind of support available to young women during this time.

Who can take part?
I would like to talk with teenagers who become pregnant when they are aged 16 or younger. If you are older than this but would like to take part, this may be possible so please ring me to talk about it. I would also like to talk to teenagers' mothers and to midwives who are involved at key points during pregnancy and birth. Boyfriends and other friends and family members are also very welcome to join in the research.

In addition, I would like to observe some of the antenatal consultations between teenagers and midwives or doctors. During the observation sessions I will make notes but will not take part in any discussions.

What taking part in this research require of me?
• Taking part in interviews at different points during pregnancy and up to two years after your baby's birth
• Allowing me to sit in on some of the antenatal consultations between you, the midwife and/or doctor

Each interview will generally last for about an hour but the exact timing will depend on how much you have to say and how much time we both have. The time and place for the interview can be arranged to suit you; what is important is that you feel relaxed and comfortable and that you are able to talk freely.

Tape recording
With your permission, I would like to tape record the interviews to make sure that I have an accurate record of what is said. You will be free to turn the tape recorder off at any point if you wish to speak "off the record". I will keep the transcripts (the typewritten pages of the interview

recording) in a safe place and I will destroy the tape once I have finished listening to it. With your permission I will use some of what you say in my final report. I make sure, however, that nothing you say can be traced back to you and no-one will have access to any details about you or your family.

Consent
If you do decide to take part in the study, at our first meeting I will ask you to sign a consent form but this does not oblige you to continue with the research (see section below: What happens if I change my mind?). If you are under the age of 16 (i.e.15 and below) I am legally required to ask your parent(s) or guardian(s) for their consent for you to take part.

What happens if I agree to take part and then change my mind?
Although I hope you will take part in this study, you are under no obligation to do so. If you do decide to take part, and then change your mind, you can withdraw at any time without needing to give a reason. Leaving the study will not affect your legal rights or the care you, or your baby, receive.

Is this research likely to cause me any harm?
Whilst it is very unlikely that taking part in the research will harm you in any way, there may be times when you become upset by talking about things which have hurt or offended you. If you do become upset during an interview, I will do my best to make sure that I do not leave you until you are feeling all right again. If you wish to discuss anything further, I can provide you with the details of a qualified counsellor employed by the School of Nursing and Midwifery, University of Sheffield.

Why am I doing the research?
I became interested in teenage pregnancy when I was working on another research project in maternity care. During this time I talked to a number of teenagers about their experiences of being pregnant and becoming a mother. I also talked to teenagers' mothers about what it was like for them. There wasn't enough time to go into much detail during this project so I decided to study teenage pregnancy for my doctorate degree. I am doing it in my own time and I will not receive any extra payment.

The study has been approved by the local Health Authority ethics committee. Although I am a registered midwife, I do not work in clinical practice and I am not employed by this Health Authority.

Who do I contact if I want to take part?
If you would like to take part in the study, or you want more information, please contact me: Helen Stapleton, University of Sheffield, Department of Nursing and Midwifery, Bartolomé House, Winter St. Sheffield S3 7ND. Ph: 0114 222 8285(w); 07990 590 661(m)

- You can also contact my supervisor, Professor Mavis Kirkham at the same address. Her ph no: 222 9707/3
- You can also tell the midwife who is looking after you and ask her to contact me.

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Helen Stapleton, researcher

TITLE OF STUDY: TEENAGE PREGNANCY: WHAT ARE THE IMPORTANT ISSUES?

Name of Researcher: Helen Stapleton

Please initial box

1. I confirm that I have read and understand the information sheet for the above study   ☐
    and I have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any   ☐
    time, without giving any reason, and without my care or my legal rights being affected.

3. I understand that Helen Stapleton might require access to my medical records.   ☐
    I give permission for her access to my records.

4. I agree to take part in the above study.   ☐

_____   _____   _____
Name of Participant   Date   Signature

_____   _____   _____
Researcher   Date   Signature

SAMPLE CONTACT SCHEDULE for Tracey and Jasmine, her mother

Date	Gestation/age of baby/ies	Type of contact & who initiated	With whom	Brief notes
4.5.00	7+/40[1]	c/midwife (community midwife)	HS	C/midwife phones say that she has arranged to 'book' 14-year-old Tracey the following week. Apparently Tracey has consented to my presence at the consultation and will decide afterwards whether she wants to participate in the research. The c/midwife is adamant that Tracey does not want me to contact her or her mother in the interim. I express my concern that Tracey is a 'minor' and requires parental consent but I accept that there is little I can do.
12.5.00	9/40	HS - *Observation of booking visit*	Tracey + c/midwife	Booking visit with c/midwife, followed by interview (i/v).
12.5.00		HS	Tracey	Following the booking visit I explain my study to Tracey. She agrees to participate and thinks her mother, Jasmine, 'will be OK about it as well'. She gives me her phone number and agrees to take an information sheet home for her mother. I subsequently phone and arrange to visit .
23.5.00	11/40	HS – visit Home: *taped i/v*	Tracey	First i/v with Tracey
31.5.00		HS – visit Home: *taped i/v*	Jasmine	First i/v with Jasmine
14.7.00	16+/40	c/midwife	HS	Tracey's c/midwife phones me to inform me that Tracey has been admitted to hospital with abdominal pain. She also informs me that another c/midwife will be taking over as Tracey's 'named' midwife following internal re-organisation...
24.7.00	18/40	HS – visit Home: *taped separate i/vs*	Tracey + Jasmine	Tracey tells me she was in hospital 2 weeks ago with abdominal pain. All investigations negative.
29.7.00	18+/40	HS - phone	Tracey + Jasmine	No contact possible - all phones incl. mobiles off. I'm mildly worried in case this turns out to be another 'lost to the study' scenario.
31.7.00		HS - phone	Tracey + Jasmine	Still no contact. Now I'm worried in case I'm seen as 'pestering' – although I suspect this is in response to received scripting from my days as a community midwife: call twice and leave a card. If clients Want you they'll contact; don't make a nuisance of yourself and definitely don't look as if you're 'checking up'. I later appreciated that respondents were generally fine about being 'pestered' – there was simply little they could do when mobiles ran out of credit and/or land lines were disconnected. When we did make contact (and we always did) there was usually a warm greeting and an occasional apology.
4.8.00	22+/40	HS - phone	Jasmine	I phone Jasmine to ask how Tracey's hospital visit went yesterday for her routine anomaly scan. Jasmine thinks it was 'OK'. She did not accompany her daughter but thought that her boyfriend was with her.
7.8.00		HS – visit	Tracey	Tracey alone at home.

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[1] 9 weeks etc. pregnant (40 weeks being the length of an average pregnancy)

		Home: *taped i/v*		
10.9.00	26+/40	HS - phone	Tracey + Jasmine	No contact – both mobiles off and Jasmine not at work. I send separate notes to both parties
24.9.00	28+/40	HS - phone	Tracey and Jasmine	Still no contact. I am doing interviews in the area so I call at home - no-one there. I try Jasmine's workplace but she has not been in all week. I leave a note in the letterbox. I later find out that Tracey has been in hospital with suspected SROM[2].
5.10.00	30+/40	Jasmine - phone	HS	CONTACT! Jasmine phones me from work: tells me that she is very worried about Tracey. She was recently admitted with suspected SROM and, at a routine antenatal appointment this am, she was apparently told that the 'baby had stopped growing' and that a c/s was 'on the cards'. Jasmine asks me to 'find out what in hell's goin' off.' I take down her (new) mobile phone no and tell her I'll do my best.
6.10.00		HS – visit Home: *taped i/v at home* + hospital observation	Tracey	Whilst interviewing Tracey, her narrative leads me to think that she has SROM'd. She agrees to my taking her to hospital where she is admitted and later transferred by ambulance to the tertiary unit in my hometown some 25 miles away. Jasmine arrives just in time to go with Tracey in the ambulance - not in the back with her daughter and the midwife, but sitting in the cab with the driver.
7.10.00		HS – hospital visit: tertiary unit	Tracey	The tertiary unit is in my home town. I visit Tracey and take her fizzy pop and magazines. Tracey is alone though she's quick to tell me her b/friend has just left. I later discover this is fiction; no-one had visited.
8.10.00		HS - visit hospital: antenatal ward	Tracey	Tracey has been transferred from the tertiary unit back to her local hospital. Everything appears to have settled down.
12.10.00		HS - phone	Tracey	I phone Tracey to confirm she is now back at home. I enquire about the outcome of her follow-up hospital appointment the previous day. She tells me it was rescheduled at last minute for the following day.
13.10.00		HS - phone	Tracey	I phone Tracey to check how her hospital appointment went. All seemingly OK. For ultrasound scan next week and decision re: future management.
22.10.00		HS - phone	Jasmine	Jasmine appears very stressed. She tells me Tracey is lying in order to get herself hospitalized; that she's 'just trying to get some attention'. Jasmine also says she's 'fed up with trekking up and down to hospital'.
22.10.00		HS - phone	Tracey	Tracey tells me she was in hospital overnight during the previous w/e with a possible urinary tract infection for which she was prescribed antibiotics. She is informed by medical staff she might need a c/s.
23.10.00		c/midwife - phone	HS	Tracey's c/midwife phones to report that she'd seen Tracey in the antenatal clinic that day and had sent her up to hospital where she was once again admitted with ?SROM
25.10.00	33+/40	HS - visit hospital: antenatal	Tracey	Tracey expresses an intention to 'top' herself.

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[2] SROM = spontaneous rupture of membranes – which often precedes the start of labour. At only 28 weeks of pregnancy, this is a serious event with potentially damaging consequences for the baby's health and future well being.

		ward		
26.10.00		HS – phone hospital: antenatal ward	midwife	I phone and introduce myself to the midwife who answers the phone. I enquire after Tracey. The midwife appears very uninterested and asks me to ring back later.
27.10.00		HS - phone	Jasmine	Unable to make contact. Mobile off and Jasmine not at work.
27.10.00	34/40	HS - visit hospital: antenatal ward	Tracey	I visit Tracey in hospital. Jasmine has still not visited.
27.10.00		HS – phone	Jasmine	Jasmine answers the phone! I tell her I've been trying to contact her for some days. She tells me that she's quitting her job (again). She has not yet visited Tracey in hospital.
29.10.00		HS – visit hospital: antenatal ward	Tracey	Tracey tells me that she had a urinary catheter passed because she was apparently unable to pass urine. 350 ml of urine released.
30.10.00		HS – phone: antenatal ward	Tracey	I phone to have a chat with Tracey. She sounds OK. Says she has not experienced any more urine problems.
31.10.00	34+/40	C/midwife - phone	HS	This community midwife had initially booked Tracey – and been extremely critical of her. The midwife has heard that Tracey is currently an in-patient and has phoned me to try to extract information about her to present at a case conference scheduled for the following day. No chance! My allegiance is with Tracey. I fob off the midwife…
1.11.00		HS – visit hospital: antenatal ward *taped i/v*	Tracey -	Tracey has been admitted in ?premature labour.
1.11.00	34+/40	HS – *taped i/v*	Jasmine	I i/v Jasmine at her work place, as previously arranged.
3.11.00	35+/40	HS – visit hospital: antenatal ward	Tracey	I encounter a midwife whom I don't know. She takes me aside and whispers that Tracey has Chlamydia and Gonorrhoea but that *she doesn't know yet*. I'm instructed not to disclose as Tracey and her boyfriend will be informed by the genitourinary specialist with whom they have an appointment in three days time. The midwife tells me that Tracey's blood results revealed a raised white cell count (indicative of an infectious process).
5.11.00	35+/40	HS - phone hospital: antenatal ward	Tracey	I phone the ward and manage to speak to Tracey. She tells me there is 'nothing happening'. I ask about the vaginal discharge and infection - which appear to be decreasing.
6.11.00	35+/40	Hospital midwife - phone	HS	Midwife on postnatal ward phones to say that **Tracey delivered a baby boy earlier via emergency c/s.** Baby is well but has been admitted to SCBU[3] for observation.
7.11.00	1/7 p/n[4]	HS – visit hospital: postnatal ward	Tracey	Tracey is in a 4 bedded room with two other mothers.
12.11.00		HS – phone: postnatal ward	HS	Still on the case of trying to track down a (any!) midwife to i/v who looked after Tracey in labour! So far no-one wants to know…
14.11.00	8/7 p/n	HS - visit: hospital: SCBU	Tracey	Tracey's baby has 'capitus pediculous' (head lice) but is otherwise doing OK. Still feeding via a tube.

[3] Special Care Baby Unit
[4] postnatal

21.11.00	2/52 p/n	HS - phone	Jasmine	M tells me that Tracey and baby are still in hospital. Baby is now feeding on demand from a bottle. Discharge date to be set in near future.
24.11.00	2+/52 p/n	HS – visit hospital: SCBU	Tracey –	Tracey with baby in SCBU – bottle feeding at the time of my arrival. Baby for discharge later this week.
27.11.00	3+/52 p/n	HS – visit *taped separate i/vs*	Jasmine + Tracey	Tracey and her son are now both at home. Both Tracey and her mum are full of praise for SCBU staff.
6.12.00		HS - phone	Tracey	Tracey tells me that she has fallen out with Jasmine's boyfriend and does not want to see him again. She has accused him of stealing from her to feed his heroin habit.
7.12.00		HS – phone	Jasmine	Jasmine tells me she's resigned from work. Tracey has the keys to her new council flat & will be moving out shortly.
13.12.00	5+/52 p/n	HS – visit. *taped separate i/vs*	Tracey + Jasmine	Tracey and her boyfriend are if about to move into council housing.
19.12.00	6+/52 p/n	HS - visit *taped i/v*	SCBU staff	I interviewed this member of staff because she self-identified as someone who *'knew the family Best'*.
28.12.00		HS: post		It's Tracey's birthday - I send her a card.
17.2.01	3+/12 p/n	HS - phone	Jasmine	Jasmine's mobile phone is out of credit again. Ditto Tracey's. I hear through the grapevine that Tracey is currently a hospital in-patient as her baby is unwell.
19.3.01	4+/12 p/n	HS - visit *taped separate i/vs*	Tracey + Jasmine	I had not unable to pre-arrange these i/v's as I had lost phone contact with both Tracey and Jasmine. When I turn up 'on spec', Jasmine is at home and has a spare half hour to talk. She tells me that Tracey is also at home and phones to arrange my visit. Jasmine comes with me to Tracey's house and remains for most of the i/v. Tensions between them are palpable. Jasmine is critical of Tracey's allegiance with her boyfriend's mother and accuses her daughter of 'ganging up on me and checking me out'. She makes a number of threats to 'get the law in' if Tracey does not relent. Tracey's baby is poorly; he is subsequently admitted to hospital for overnight if observation.
22.3.01		HS - phone	Jasmine's boyfriend	I phone Jasmine but get her boyfriend who tells me that 'she's just gone out'. I leave a message although I know from previous experience that this is unlikely to generate a response from Jasmine.
10.4.01	5+ /12 p/n 2nd baby due ? Nov. 01	HS - phone	Tracey	Tracey is her usual polite self. She tells me her mum has 'packed job in' and they are currently not speaking to each other. Tracey disavows knowledge of her mum's current mobile phone number.
2.5.01		HS: phone	Tracey	I had heard through the grapevine that Tracey was pregnant again. I phone her to (dis)confirm the rumour. She seems fine about my having heard the rumour – which she confirms. Tracey tells me that she 'hasn't a clue' about the date of her last LMP[5]. She had been to her GP for a contraceptive implant six weeks previously but a routine pre-implant pregnancy test was positive.
28.7.01	8+/12 p/n	HS - phone	c/midwife	I phone one of the c/midwives who has been very supportive of my study, and who also knows Tracey and

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[5] last menstrual period

Date		Method	Who	Notes
				her family, to see if she has had any contact with Tracey. She tells me she is no longer working in that locality and advises me to contact midwife K who has recently assumed responsibility for all pregnant teenagers in Tracey's area.
31.7.01		HS - phone	c/midwife	The newly appointed consultant midwife - K -confirms she has responsibility for all teenagers attending one of the GP clinics. I ask if she has seen Tracey. She tells me that although she is on her caseload, she's not yet contacted her as she's been busy with the older sister of another teenager in my study who is currently pregnant. I refrain from pointing out that this young woman is considerably older than Tracey and has a very supportive family. I do not disclose my anxieties about Tracey.
4.8.01	10/12 p/n	HS: post	Jasmine	I've not heard from Jasmine – I send a note asking her to make contact.
9.10.01	11/12 p/n	HS: house call	Jasmine + Tracey	I have lost contact with both Tracey and Jasmine. I have sent them both cards, with an SAE, explaining that I have been unable to make contact but that I would like to see them both again for a final i/v. I was aware that Tracey's 2nd baby was due mid-late November and I was concerned that something untoward had happened.
3.11.01		HS: post		I send a card for Tracey's oldest baby's first birthday
21.11.01		HS: house call		I am out interviewing in the area and call around at both Tracey and Jasmine's homes. Neither is in. I leave my calling card.
29.11.01		HS: house call	Jasmine + Tracey	I am out interviewing in the area and call around at Tracey and Jasmine's homes but neither is in. I leave my calling card.
01.12.01		HS: visit *taped i/v*	Jasmine	I am out interviewing and make a spontaneous home visit to Jasmine - who is in! She tells me that Tracey is currently in hospital and that she **gave birth to her second baby (boy) 2 days ago. [27.11.01].** I tell Jasmine that I will visit Tracey on my way home.
01.12.01		HS: visit Tertiary hospital	Tracey	I call at the local hospital only to be told that Tracey and her son were transferred to a tertiary hospital in my hometown the previous evening. It appears that the baby's testicle may have strangulated. It is Tracey's 17th birthday today. I visit her en route home. She asks me not to phone her mother as she does not want her to know her whereabouts.
5.12.01	Josh: 3 days Ricky: 13mths	HS: final visit *taped i/v*	Tracey	Tracey is at home with both her children. Her boyfriend is upstairs playing with the older child. Final i/v undertaken during which time the c/midwife makes a routine postnatal visit.
5.12.01		HS final visit *taped i/v*	Jasmine	Final i/v undertaken.

THE SUPPORT NETWORK DESCRIBED BY TRACEY (JASMINE'S DAUGHTER)

1. Who would you trust with information which could get you into trouble?

4.5.2000 First interview. Tracey is aged 14 and is 11 weeks pregnant.	5.12.2001 Final interview. Tracey's babies are 13mths & 5 days old respectively.
• At first Tracey says *'nobody'*. • After a while Tracey says she would previously have trusted her sister Lori and her friend Leonie but that *'I wouldn't any more... Not any more. They're heroin addicted now.'* • Luke (her boyfriend): *'But not with everything... he goes straight to my mum...'*	• Grace (Luke's mum) • Luke (her boyfriend): *'...not with everything but with more than before...'* • Tracey says she has not had contact with either Leonie or Lori for some time.

2. Who do you go to for support when you're feeling low; who can you rely on to be there for you?

4.5.2000 First interview.	5.12.2001 Final interview.
• *'My Dad.'* I am subsequently informed by Jasmine that, to her knowledge, Tracey's father *'lives at the other end of the country'* and that Tracey has had little/no contact with him for many years. • Patsy (a friend of Tracey's mother) • *'Definitely not my mum.'*	• *'Definitely not my mother. No way...'* • *'Sometimes Grace'* (Luke's mum) • *'Sometimes Luke'* (her boyfriend) • Tracey says she no longer has much contact with her dad but reports that *'he's really poorly with cancer. He's lost all his hair now...'* Jasmine continues to deny this story. • *'Patsy'* is no longer around

3. Who accepts you totally i.e. who takes you just as you are, with all your good and bad points?

4.5.2000 First interview.	5.12.2001 Final interview.
• Luke (her boyfriend)	• Luke (her boyfriend)

At the final interview I asked all respondents an additional question: **Have you made any new friendships and / or different people to support you?'** Tracey lists Grace (Luke's mother), his grandmother, and some of his mother's (female) friends. All these women live very locally and regularly help out with childcare, shopping and cooking.

SUPPORT NETWORK DESCRIBED BY JASMINE (TRACEY'S MOTHER)

1. Who would you trust with information which could get you into trouble?

4.5.2000. First interview. Jasmine's 14 year old daughter Tracey, is 11weeks pregnant.	5.12.2001 Final interview. Jasmine's 2 grandchildren are 13 months and 5 days old respectively.
• Sasha (a neighbour) • Susan (a neighbour) • Christine (a friend)	• Susan • Jasmine explained that she had 'got rid of Sasha this summer - we had a row..' • She also mentioned having 'got rid of Christine - I got fed up with feeling used by her...'

2. Who do you go to for support when you're feeling low; who can you rely on to be there for you?

4.5.2000. First interview.	5.12.2001 Final interview.
• Sasha • Susan	• Susan • Jane – a new neighbour • BF2 (her current boyfriend) '...only to a certain extent though.'

3. Who accepts you totally i.e. who takes you as you are, with all your good and bad points?

4.5.2000. First interview. Jasmine's 14 year old daughter is 11weeks pregnant.	5.12.2001 Final interview. Jasmine's 2 grandchildren are 13 months and 5 days old respectively.
'I've only just found acceptance in myself... I can't expect anyone else to....'	• Susan • Jane • BF2 '...but really I don't give a shit nowadays what people think of me. They can take me as I am. If they can't handle me, that's their problem...'

At the final interview I asked all respondents an additional question: **Have you developed any new friendships or sources of support?** *'No. Except for Linda. ... She's the deputy head teacher at the kids' school.'* Jasmine spoke highly of the support she had received from Linda during the case conferences and meetings which had been called on account of concerns raised about the welfare of her two youngest children. Jasmine described Linda as more like a *professional friend than a real friend [...] she's been ever so good to me, like...*

WALES

Alys, 15 yrs
Son: Aled
Boyfriend: Dave, 19 yrs
Mother: Angharad, 38 yrs

Aged 15 at conception, Alys was attending school & preparing for GCSE's (which she did not sit). She lived at home in council rented accommodation with her widowed mother, 2 older brothers & the family's elderly dog; her eldest brother lives locally with his girlfriend. They were a close-knit family all of whom were bilingual (Welsh-English). Alys's father died suddenly 18 months prior to her becoming pregnant. Alys, who was doing well at school & expected to go on to higher education, subsequently lost interest in her studies & began truanting. Alys smokes & occasionally drank alcohol but had never experimented with 'recreational' drugs. The household income was benefit derived.

At the close of the study, Alys continued to live at home. She looked after her son & intended to resume her studies as soon as he started nursery. She wants to become a physiotherapist. Dave lived in rented accommodation 20 miles away; he worked full-time in a local factory. The young couple spent weekends together & were saving to buy their own home. Angharad assisted her daughter with childcare, especially on weekends.

Alys & Angharad contributed 2 joint interviews to the study: one prior to birth & another when the baby was 2 years old. I first met Angharad when undertaking fieldwork for the Informed Choice study (see Chapter Five).

WALES

April, 17 yrs

Aged 17 at conception with her 2nd child, April has one daughter aged 9 months.

April was adopted at birth by grandparents. Her grandfather, to whom she was very attached, died a few weeks before the research interview. She had intermittent contact with her mother, who lived locally.

April lived alone in council rented accommodation. Her small terraced home was in poor condition: windows were boarded & damp penetrated through the living room walls. Her income was benefit derived.

April smoked heavily &, prior to the birth of her 1st child, also consumed large volumes of alcohol. She had never taken 'recreational' drugs.

When I interviewed her, April was estranged from her boyfriend (who fathered both babies) on account of a violent incident during which he broke April's nose.

April contributed a one-off interview when she was 10 weeks pregnant. This followed my observation of her home-based 'booking' visit with a community midwife.

WALES

Beca, 17 yrs
Boyfriend: Andrew, 26 yrs
Mother: Glenys, 38 yrs

Aged 17 at conception Beca had terminated a previous pregnancy. Beca is the youngest of 3 children; she lived at home in owner-occupied accommodation with both parents & an older brother. They were a close-knit family and were all bilingual (Welsh-English).

A serious car crash in her early teens, which killed a younger sister, left Beca in constant pain following spinal surgery. Doctors had advised that a caesarean section might be required to deliver her baby.

Andrew, 9 years Beca's senior, was her former boss. He was present for most of the interview & he dominated proceedings. Both Beca & Andrew smoked heavily.

Beca contributed a one-off interview when she was 14 weeks pregnant. This followed my observation of her hospital-based booking consultation with a midwife.

WALES

Bronwyn
Boyfriend: Michael

Aged 17 at conception, Bronwyn's was the only planned pregnancy in the study. She and her boyfriend initiated a 'pre-booking' consultation with the c/midwife at 7 weeks of pregnancy in order to discuss the lifestyle changes they might make to optimise pregnancy outcomes.

Both young people left school at age 16 after passing their GCSE's; both were in full-time employment. They lived together in privately rented accommodation owned by Bronwyn's father.

The contribution the young couple made to my study was allowing me to conduct a joint interview with them following my observation of their 'pre-booking' consultation with a community midwife when Bronwyn was 7 weeks pregnant.

[1]See Table A for further details about labour and birth, and infant feeding decisions.

WALES

Catrin, 18 yrs

Aged 17 at conception, Catrin had recently been discharged from the 'care' system. At the time of interview she was living in a single person, supported housing, complex.

Catrin was a political refugee & had been living in the UK for 10 years. She had no contact with her family of origin apart from her younger sister, also a refugee, who lived locally with foster parents. Catrin's parents separated following her birth; she last saw her alcoholic mother when she was 8 years old. English was Catrin's second language. She had not revisited her country of origin since leaving, although she hoped to return when her baby was old enough to travel.

Catrin has few close friends but was well supported by her long-term social worker.

Catrin made contact with me after reading an information sheet about the study; she contributed a one-off interview when she was 16 weeks pregnant.

WALES

Elenor, 18 yrs

Aged 16 at conception, Elenor had previously miscarried a baby from a different partner. She had no contact with the father of this baby as he *took off* when she disclosed her pregnancy & refused to have the abortion he had apparently demanded.

Elenor is the youngest of seven girls. She lived at home in owner-occupied accommodation with her parents & 2 older sisters. She left school at 15 with no qualifications. She worked full-time in a local fast food outlet.

Elenor was referred to the study by another participant. She contributed a one-off interview when she was 23 weeks pregnant.

[1] See Table A for further details about all respondents

[2] See Appendix 3 for example of a contact schedule

SOUTH YORKSHIRE

Clare, 14 yrs
Daughter: Chloe
Boyfriend: Carl, 16 yrs
Mother: Chris, 36 yrs

Clare was living at home & preparing for her mock GCSE's when she became pregnant. She was the middle daughter & shared the all-female family home with her mother + 2 sisters. Her older sister also became a teenage mother during the course of my research. Clare did not smoke nor 'do' drugs. She rarely consumed alcohol and had never been drunk.

Clare had no contact with Carl, the father of her baby, during pregnancy but resumed contact after birth. Carl was the same age as Clare & attended the same school. His parents evicted him from home & he moved in with his grandmother. Carl did not contribute financially to Chloe's upkeep. Chris disliked him.

Chris was aged 39. She had not been in a relationship since she divorced her alcoholic husband 8 years previously. He lived locally & was in regular contact with his daughters, but made no financial contribution to household. Chris periodically banned him from the family home because of his alcohol induced violence.

Chris had her first child at age 20. Her only 2 brothers died 6 months after her divorce & within 6 months of each other: 1 suicide, 1 brain tumor. She has not been in paid employment since a brief period of work experience following school. The household income was benefit derived. She had debts of £5K & was in arrears with her mortgage repayments.

Both maternal & paternal g'parents lived locally & maintained regular contact.

At the close of the study Clare had gained 7 GCSE's & was in F/T secretarial work in a local firm with 1 day/week release for college study. She continued to live at home. Her total income = £215.50/wk. Her outgoings included £40/wk rent to her mum + £30/week childcare (to her mum). She had £160 in savings.

Clare & Carl were saving to buy a home although Carl's life was in disarray. He had failed his plasterer's apprenticeship exams; he owed £700 & he had been drinking excessively & smoking more heavily. He was pressuring Clare to give up work which he considered *demeaning*. Clare thought he was *depressed*. Chris continued to dislike him.

Clare was recruited to the study when she was 38 weeks pregnant. Her daughter was almost 2 years old when the study concluded. A total of 34 contacts[2] were made during the study period.

SOUTH YORKSHIRE

Jade, 16 yrs
2 daughters: Janey & Gemma
Surrogate mother: Bev 46 yrs

Jade was the youngest of 2 girls; her sister 2 years older became a teenage mum at age 15. At the end of the study Jade 'introduced' an older step-sister who had apparently lost contact with the family after becoming pregnant as a teenager. She was married with 2 daughters, one of whom was Jade's age.

Jade was made homeless by mother early in her first pregnancy – just before her GCSE exams. She was re-housed in 'temporary' hostel accommodation & remained there until after the birth of her 2nd child. Bev & Phil, the co-owners of the hostel, assumed a surrogate parental role in relation to Jade. Both Jade's children were fathered by different older men: Janey by 25yr old Jack whom she had known for 6 months & Gemma by Tom, a 32 year old co-resident in the hostel who had previously fathered 7 children in 3 different relationships.

Jade's parents lived together; her father was 20 years older than her mother (who was aged 55). Jade had no contact with her mother throughout both pregnancies; she had intermittent contact with her father. The close relationship she had previously enjoyed with her older sister, Josie, was terminated when Josie started an affair with her (then) boyfriend Tom.

Jade suffered physical & sexual abuse from the father of her first baby & began self-harming (cutting & burning) when this relationship ended. She was a heavy smoker but did not 'do' recreational drugs. Prior to motherhood she engaged in regular binge-drinking episodes.

Bev was one of 5 daughters but had no children of her own. She supported Jade through the labours and births of both her daughters; these were Bev's her first experiences of childbirth.

At the close of the study Jade was living with her oldest daughter in squalid (council) rented accommodation. Her youngest daughter was living with her sister & Tom.

Jade's income was benefit derived. At my final visit, the electricity & phone had been disconnected because of payment arrears. The previous day she had been visited by an officer from the Child Support Agency who had threatened to deduct 40% from her benefits if she continued to withhold details about the father of her first child. She was in rent arrears & had outstanding debts of £600.

Jade 16 weeks pregnant at recruitment to the study. Her eldest daughter Janey, was 18 months old, & her younger daughter Gemma, was 4 months old, when the study concluded. A total of 48 contacts were made during the study period.

SOUTH YORKSHIRE

Lou, 16 yrs
Daughter: Amy
Boyfriend: Pete, 22 yrs

Lou was aged 16 and living at home with Pete, her mother, one of her mother's (violent) partners & 2 younger siblings when she became pregnant. She had miscarried an earlier pregnancy at the age of 14. Lou one of a large family including 4 siblings & 5 step-siblings; she also mentioned the existence of other siblings whom she had never met. Lou's mother was registered mentally disabled. She had been hospitalised for extended periods & had also served time in a secure unit for the attempted murder of Lou's youngest sister. Lou had suffered physical & sexual abuse from a number of male perpetrators, including her mum's numerous boyfriends. She had lived with foster-parents and in care homes for extended periods of her life. Lou had regular contact with her biological father who lived locally.

Pete had 3 younger brothers. He had also spent time in foster care because of parental violence. His parents lived locally and the young couple had lived with them when they had no alternative accommodation. Lou experienced Pete's mum as domineering & petty but she was also reliant on her for companionship & childcare.

Lou & Pete had been in a relationship for 5 years prior to this pregnancy. Both were heavy smokers [30/day each] & although Lou reduced her intake during pregnancy, she continued to smoke throughout. Lou was on medication for depression, asthma, back pain & recurrent chest infections. She had a history of self-harming (overdoses + cutting) and she had suffered sexual and physical abuse from Pete on a number of occasions.

At the conclusion of the study period, Lou and Pete were living in poor quality, council rented, accommodation next door to Pete's parents. Although Pete had signed up for a number of government funded, back-to-work schemes, he had yet to complete a training course. The family income was mostly benefit derived, supplemented by occasional cash-in-hand work for Pete. They were £200 in debt. Neither young person had any formal qualifications and both had missed considerable amounts of schooling, mainly through truanting.

Lou was 12 weeks pregnant when she was recruited to the study; her daughter was 16 months old when the study concluded. A total of 52 contacts were made during the study period.

WALES

Lowri, 16 yrs
Daughter - stillborn
Mother: Dilys, 38 yrs

Aged 15 at conception, Lowri was the youngest of 4 children all of whom were of mixed race parentage. Her parents divorced shortly after Lowri's birth & she had no further contact with her biological father.

Lowri had a 'steady' boyfriend with whom she lived in privately rented accommodation. Both were in full-time employment, Lowri as a trainee chef in a local hotel.

The interview took place a few weeks following the sudden & unexpected intrauterine death of Lowri's baby daughter at 33 weeks gestation.

Dilys was pregnant at same time as her daughter; she was 20 weeks pregnant at the time of the research interview.

Lowri & Dilys self-referred themselves to the study after hearing about it through a community midwife; they contributed a joint, one-off interview.

WALES

Megan, 14 yrs
Boyfriend: John, 16 yrs
Mother: Anwen, 32 yrs

Aged 14 at conception, Megan was the oldest of 3 children. She was attending school when pregnancy was confirmed & she continued with her schooling until the baby was due. She lived in owner-occupied accommodation with her parents & siblings.

Her relationship with her John (father her baby) preceded pregnancy by 18 months. They both attended the same school.

Megan & Anwen were referred to the study by a community midwife. They contributed a one-off, joint interview when Megan was 36 weeks pregnant.

WALES

Luci, 16 yrs
Boyfriend: Gavin, 19 yrs
Mother: Elain, 36 yrs
Twin pregnancy; 1 IUD[3] of 1 twin @ 14 weeks

Aged 16 at conception, Luci was the youngest of 2 children. An early ultrasound scan revealed a twin pregnancy; a subsequent scan at 14 weeks of pregnancy revealed that one baby had died.

Luci's parents heard divorced many years previously; she had no contact with her biological father. She lived in owner-occupied accommodation with her mother, her boyfriend & her mother's fiancée (who was Gavin's father).

Luci attained 4 GCSE's before she left school. Her plans to start a hairdressing apprenticeship at her local college were put on hold when she realised she was pregnant. Gavin was in full-time employment as an apprentice engine fitter. Elain, a nurse, worked full time.

Luci, Elain & Gavin contributed a one-off interview to the study when Luci was 15 weeks pregnant. This followed my observation of her home-based 'booking' interview with a community midwife.

[3] IUD = intrauterine death

SOUTH YORKSHIRE

Michelle, 15 yrs
Son: Daniel
Boyfriend: Ryan, 19 yrs
Mother: Polly, 42 yrs

Michelle lived at home & was preparing for GCSE's when she became pregnant. She was the youngest of 4 children: 2 sisters + 1 brother. Family members enjoyed close ties & were very supportive of each other; paternal and maternal grandparents lived nearby. An older sister, who has 2 children, was also a teenage mum.

Polly lived with her husband in the family home in which all the children had grown up. Although her physical health was good, she was on medication for depression and insomnia. Her husband had recently been made redundant and the associated stress had impacted negatively on her health.

Immediately prior to recruitment, Michelle's beloved horse had been put down after being savaged by another horse. Michelle, who was riding the horse at the time, narrowly escaped serious injury. She had stopped riding and was still recovering from the shock when she discovered she was pregnant. Six months after Daniel's birth her maternal grandmother, to whom she was very close, died suddenly.

Although Michelle had been taking the pill for some months prior to conception, she periodically suffered recurrent cystitis & kidney infections, accompanied by severe vomiting. A midwife suggested that these events may have reduced the effectiveness of the pill. Michelle continued to suffer repeated urinary tract infections during pregnancy which, on 2 occasions, necessitated in-patient treatment.

Michelle continued her education during pregnancy, obtaining 9 GCSE's + certificates and business studies & IT. She had intended to undertake a nursing degree but put this aside after she was 'talent spotted' by a modelling agency and subsequently signed up. She began working as a fashion model doing European tours earning £200/day + expenses.

At the close of the study Michelle & Ryan were living in owner occupied accommodation close to her mother's house.

Ryan was aged 19 and worked locally in a warehouse. Ryan, one of 8 children (fathered by 3 different men), was prone to violent outbursts and on a number of occasions attacked Michelle causing injuries which warranted hospital admission and/or surgery. Michelle initially refused to press charges against him but eventually changed her mind after she had been badly beaten whilst on honeymoon. Ryan was subsequently convicted of grievous bodily harm and received a custodial sentence.

Michelle was 17 weeks pregnant when she was recruited to the study; her son Daniel was 16 months old when the study concluded. A total of 35 contacts were made during the study period.

WALES

Nia, 18 yrs
Boyfriend: Tim, 20 yrs

Aged 17 at conception, Nia was living in privately-rented accommodation with her student boyfriend in a town some distance from her home town & her parents. Nia was in her first term at university when she realised she was pregnant.

She underwent an elective caesarean section for a breech presentation. Nia self referred to the study after receiving information from a health visitor. She contributed a one-off interview 6 weeks following the birth of her son.

WALES

Rhian, 15 yrs
Boyfriend: Lewis, 18 yrs
Mother: Gwyneth, 36 yrs

Aged 15 at conception & attending school when conceived, Rhian subsequently passed 10 GCSE's in late pregnancy. Rhian continued to live in the council-rented family home with her parents & 4 younger siblings. Lewis, who lived with his family 20 miles away, visited frequently.

Rhian & Lewis were "going steady" for 2 years prior to pregnancy.

Rhian contributed a one-off interview to the study when she was 37 weeks pregnant. This followed on from my observation of a 'birth plan' visit with her community midwife.

SOUTH YORKSHIRE

Susan, 15 yrs
Son: Jed
Boyfriend: Joe, 18 yrs
Mother: Marg, 34 yrs

Susan was attending school & preparing for GCSE's when she conceived. She lived at home in owner-occupied accommodation with mother & stepfather (whom she disliked). The youngest of 2 girls, she also has a stepsister the same age whom she described as her *best friend.* Her older sister (by 9 years), who was also a teen mum, was married with 2 daughters. She lived locally & visited daily; Susan has been involved with caring for both nieces since their births. Susan's maternal and paternal grandparents, & her biological father, lived locally. She had regular contact with her grandparents & occasional contact with her father.

Joe was in fulltime employment in a local garage. The 2nd oldest of 4 boys, he lived at home with his parents & brothers. He & Susan had been dating for 8 months prior to pregnancy.

Susan gained 9 GCSEs. She delayed her place at College to study hairdressing until Jed was older as she had no childcare & the College crèche did not admit children under 2yrs old.

Susan's finances were part benefit derived and partly derived from p/t work as a cleaner in the nursing home which her mother managed.

Marg: aged 44, she left school aged 16 and worked briefly before becoming pregnant aged 18. Events during her first labour left her psychologically traumatised and fearful of leaving the house. She worked full-time managing a local nursing home. The required her to work long, and unsocial, hours and this generated tensions with her partner.

At the close of the study Susan & Joe had purchased their own house, on the same street as Susan's parents. The mortgage (just under £300/mth) was considerably less than the rent (just over £400/mth) they had been paying.

Susan was 16 weeks pregnant when she was recruited to the study; her son Jed was 11 months old when the study concluded. A total of 33 contacts were made during the study period.

[4] OD = Overdose

SOUTH YORKSHIRE

Tracey, 14 yrs
2 sons: Josh & Ricky
Boyfriend: Luke, 17 yrs
Mother: Jasmine, 32 yrs

Tracey was in her GCSE year at school, & living in the council-rented family home with her mother and 2 younger stepsiblings, when she became pregnant. The family lived in overcrowded conditions primarily because the children of Jasmine's (many) boyfriends also shared the home and competed for the available space. Theoretically, Tracey shared a bedroom with her younger stepsister but mostly she slept on the kitchen floor, in the bathtub, or on a cushionless sofa. Following the violent death of a younger sibling in suspicious circumstances, Tracey was placed in a number in care/foster homes where she was exposed to significant emotional and physical abuse

Tracey initially described her biological father as a *close friend* who lived locally but was dying from lung cancer. This story was disputed by Jasmine who declared he had in fact *shoved off* shortly after her birth & had retained only very occasional contact. Tracey's older sister (aged 15) was a registered heroin addict and was currently serving a custodial sentence for her part in a robbery with associated GBH. Tracey stated that had never taken drugs and did not drink nor smoke; she frequently stated that she *hated* her sister. Tracey acts as the main carer for 2 younger stepsiblings.

Tracey's current pregnancy was initially thought to have resulted from rape by one of her mother's boyfriend is although DNA testing subsequently confirmed Luke's paternity. Tracey had been hospitalised on a number of occasions for vague symptoms including 'abdominal pain' & 'headaches'. With the exception of positive results for sexually transmitted infections, all other investigations proved negative.

Luke was registered disabled on account of longstanding mental health problems for which 3 possible scenarios were offered by different respondents: diagnosis at birth with severe foetal alcohol syndrome and drug addiction; as a small child he accidentally OD'd[4] on social drugs left in the fridge by his mother; he became heroin addicted himself and started having seizures following an accidental OD. Luke, one of 3 siblings and an unknown number of stepsiblings, was a 'cared for' child until the age of 10 when he was reunited with his rehabilitated birth mother who lived locally. She supported the young couple & greatly assisted their adjustment to parenthood. Tracey & Luke had been going out with each other for 8 months prior to conception.

Jasmine, also a teen mum & one of 12 children, experienced living in care and foster homes during her formative years. Her income was currently benefit derived although she had recently been in part-time employment. She was in £900 in rent arrears & owed £1500 in interest to a doorstep lender.

Tracey was recruited to the study when she was 9 weeks pregnant; her oldest son was 13 months old & her youngest son 6 days old when the study concluded. A total of 61 contacts were made during the study period.

CHRIS (Clare's mum) lived with her three daughters in a small, but comfortable, suburban house. Chris had been briefly employed after she left school but had not worked outside the home since becoming a mother in her late teens. She had recently divorced her alcoholic husband after many years of separation. Shortly before I met her, Chris had suffered the sudden, and tragic, loss of her two brothers in separate accidents within months of each other. She had no other siblings but both her parents lived nearby and helped out whenever they were needed. The two households took it in turn to cook and eat a traditional Sunday lunch together. The atmosphere in Chris's all-female household was very relaxed; the women were all very good-humoured and, for the first year of my research, they seemed to really enjoy each other's company. Things changed, however, when Clare's older sister Laura, followed the female pattern of teenage childbearing and had a child with an extremely violent and abusive young man. Chris eventually decided to have nothing more to do with her older daughter and more than once she had threatened to involve social services with a view to having her grandson removed from Laura's care and adopting him herself. Chris adored both her grandchildren but increasingly saw very little of her grandson. She continued to provide most of the child-care for her granddaughter and this enabled Clare to sustain full-time work. Chris's financial situation was very tight but despite being in debt by a few thousand pounds, and in arrears with her mortgage, she never seemed particularly bothered about her inability to repay what she owed.

JASMINE (Tracey's mum) had experienced a very chaotic upbringing. Abandoned by her alcoholic mother shortly after she was born, she spent the next 16 years in a series of foster and care homes where she was periodically subjected to sexual abuse and emotional cruelty. Her first child, born when she was just 17, was removed by social services and placed for adoption. Jasmine subsequently had four more children by three different fathers; three children, including Tracey, were living with her at the time I conducted my research. A younger child had died in suspicious circumstances some years earlier. Her oldest daughter was addicted to crack cocaine; she lived on the streets and survived by prostitution, petty crime and drug dealing. Jasmine had finally banned her from the house after she discovered that she was servicing clients in her bedroom. Over the course of my research Jasmine had a number of boyfriends who not infrequently moved in to live with her and her children in the family home. Sometimes they bought their own children with them and this created considerable tensions, not the least because it resulted in severe overcrowding and additional pressures on scarce resources. Jasmine displayed a somewhat ambivalent attitude towards her children and regularly left the younger ones in Tracey's care - a practice which had started when Tracey herself was still a relatively young child. Towards the end of my study Jasmine secured a part-time job which had followed on from voluntary work she had been doing. Jasmine was in considerable debt and lived in terror of having her home repossessed and the family being made homeless.

MARG (Susan's mum) differed from the other mothers in the study in that she had been in paid employment most of her adult life. Prior to her present job managing a local nursing home near to where she lived, much of this work had been of a temporary nature and poorly paid. Although her present post was reasonably well paid and fairly secure, Marg worked very long, and often unsociable, hours. The demands of her job, and her refusal to take holidays, were a source of constant friction between her and her partner Charlie – Susan's stepfather. Marg, a teenage mother herself, had separated from her first husband shortly after Susan's birth and had then moved back home to Yorkshire with her two daughters. Charlie, with whom Marg had lived for 10 years, had a daughter the same age as Susan. She lived with her mother in the same neighbourhood. Both girls had grown up together and attended the same school and, prior to the birth of Susan's baby, had enjoyed a close relationship. Marg's eldest daughter, who had also become a mother during adolescence, lived nearby with her partner and two young daughters. Neither she nor her partner were in paid employment and Marg often succumbed to pressures to bail the family out financially. Marg was the most financially solvent of all the mothers and she and Charlie enjoyed a reasonably comfortable lifestyle.

POLLY (Michelle's mum) was the only mother in the South Yorkshire cohort who had continued to live with her husband, the same man who had fathered all four of her children. In addition to Michelle's son, she also often looked after her oldest daughter's two granddaughters. Although life had been very difficult since her husband had been declared bankrupt the previous year, Polly was a gritty and determined woman; it was only on account of her canny manoeuvring that the family home was not sold to pay off outstanding debts. Polly had suffered with depression since the birth of her first child and periodically visited her GP to request further medication. She had never been engaged in paid work outside the home although she cared for her elderly mother who lived nearby and who had recently undergone heart surgery; she died very suddenly just before the study ended. Polly was someone I thought of as a homemaker: she took enormous pride in having things 'just so'. Whenever I called by there were usually home-made biscuits in the tin and often fresh flowers on the table; the house was always extremely clean and tidy. Although all her children had now left home, they lived close by and every Sunday returned home with their partners and children to enjoy the Sunday dinner which Polly continued to cook. Toward the end of the study Polly's husband found another job and she was looking forward to feeling a less stressed and being less financially cautious than she had been in the recent past.

APPENDIX SEVEN: ABBREVIATIONS

AHA	Area Health Authority
ARM	artificial rupture of membranes (the amniotic sack containing the foetus)
BF	boyfriend
BME	Black and Minority Ethnic
CM	community midwife
CMB	Central Midwives Board
CSA	Child Support Agency
c/s	caesarean section
DE	direct entrant (a student midwife without prior nurse training)
DfES	Department for Education and Skills
DHSS	Department of Health and Social Security
EBC	emergency birth control
GP	general practitioner (family doctor)
IC	informed choice
IOL	induction of labour
NHS	National Health Service
SCBU	Special Care Baby Unit
STI	sexually transmitted infection
SVD	spontaneous vaginal delivery
SY	South Yorkshire
Trimester	Trimesters divide pregnancy into three periods of roughly three months. Pregnancy normally lasts about approximately 40 weeks, from the time of the last menstrual cycle, to the birth of the baby.
TPU	teenage pregnancy unit
VE	vaginal examination
ventouse	an appropriately sized suction cap applied to the baby's head to facilitate birth
W	Wales

TABLE A: SELECTED DEMOGRAPHIC DATA FOR ALL FEMALE TEENAGE RESPONDENTS (n=17)

Pseudonym of teenage respondent + location[1]	Age at conception[2] & whether 1st conception	Dates of first & final interviews + location	Weeks pregnant when recruited	Number of contacts[3] during data collection period	Labour and birth details	Number, sex & birth weights of babies + feeding	Regular contact with father of bab(ies)	Mother's participation in study	Major life events	Health issues	Education / employment & housing at one year > birth (of first child)
Alys [W]	15	Oct 1998 July 2000	20	2	IOL[4] @ 39/40[5] Epidural Ventouse[6] Episiotomy	I boy 8lb Bottle fed	Yes[7]	Yes	Father died suddenly 2 yrs prior to pregnancy	Smoker Cervical cytology: abnormal cells > birth	No educational qualifications. Not in paid work. Living with boyfriend in privately rented accommodation
April [W]	17 No, one child aged 9 months	June 1998 n/a[8]	10	1	Unknown	Unknown[9]	No	No	Adopted by g'parents G'father died just prior to interview	Smoker	Unknown

[1] [W] = Wales based respondents (n=11); [SY] = South Yorkshire based respondents (n=6)

[2] All respondents except for Tracey were 15 years and over by the time they gave birth to their first child.

[3] Contact was made through a range of media including face to face; text messaging, phone & post. The figure shown includes a small number of attempts which failed to achieve contact, most commonly resulting from a mobile phone being out of credit.

[4] IOL = induction of labour

[5] 39/40 is a conventional way of recording pregnancy gestation. The 1st figure (39) refers to the current gestational age of the baby - or the number of weeks pregnant; the 2nd figure (40) is the duration in weeks of an average pregnancy. At 40 weeks, pregnancy is said to be 'at term'.

[6] An appropriately sized suction cap applied to the baby's head to facilitate birth

[7] For respondents living in Wales, this information pertains only to the point in time when the interview was undertaken.

[8] Apart from Alys and her mother Angharad who were interviewed twice, teenage respondents who lived Wales were interviewed on one ocassion only.

[9] Unless indicated, respondents living in Wales were interviewed at a single point in pregnancy and hence birthing outcomes for this cohort are unknown.

TABLE A: SELECTED DEMOGRAPHIC DATA FOR ALL FEMALE TEENAGE RESPONDENTS (n=17)

Pseudonym of teenage respondent + location	Age at conception & whether 1st conception	Dates of first & final interviews	Weeks pregnant when recruited	Number of contacts during data collection period	Labour and birth details	Number, sex & birth weights of babies + feeding	Regular contact with father of bab(ies)	Mother's participation in study	Major life events	Health issues	Education / employment & housing at one year > birth (of first child)
Beca [W]	17 No, previous termination	Oct 1998 n/a	14	1	Unknown	Unknown	Yes	No	Car crash in early teens killed younger sister. Beca sustained pelvic & spinal injuries requiring surgery	Medication for pelvic & back pain from car accident.	Unknown
Bronwyn [W]	17	Dec 1998 n/a	14	1	Unknown	Unknown	Yes	No	Unknown	Unknown	Unknown
Catrin [W]	17	July 1998 n/a	16	1	Unknown	Unknown	No	No	Refugee; no contact with family of origin	Unknown	Unknown

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TABLE A: SELECTED DEMOGRAPHIC DATA FOR ALL FEMALE TEENAGE RESPONDENTS (n=17)

Pseudonym of teenage respondent + location	Age at conception & whether 1st conception	Dates of first & final interviews	Weeks pregnant when recruited	Number of contacts during data collection period	Labour and birth details	Number, sex & birth weights of babies + feeding	Regular contact with father of bab(ies)	Mother's participation in study	Major life events	Health issues	Education / employment & housing at one year > birth (of first child)
Clare [SY]	14	Oct 1999 Dec 2001	38	21	IOL @ 41/40 SVD[10] with episiotomy	1 girl 8lb 3oz Breastfed first 10 days then bottle fed	No	Yes	Parents sep.	None known	7 GCSE's Full-time employment Living @ home
Elenor [W]	16 No, previous miscarriage	Sept 1998 n/a	23	1	Unknown	Unknown	No	No	Unknown	Unknown	Unknown
Jade [SY]	16	Oct 1999 Dec 2001	16	39	Spon. Onset[11] At term X2 Epidural x1 SVD x2	2 girls 1st: 6lb 12oz Breastfed first 12 days then bottle fed 2nd: 8lb 14oz Bottle fed	1st baby: no 2nd baby: yes	No[12]	Physically abused by father of 1st baby Made homeless by mother	Self harm (burning, cutting, restrictive eating) Smoker	No educational qualifications. Not in paid work. Temporary accommodation in pregnancy, re-housed in council flat.

[10] SVD = spontaneous vaginal delivery

[11] Spontaneous onset of labour

[12] Although Jade did not want me to invite her biological mother to participate she did permit me to recruit the female manager of the hostel where she was living.

TABLE A: SELECTED DEMOGRAPHIC DATA FOR ALL FEMALE TEENAGE RESPONDENTS (n=17)

Pseudonym of teenage respondent + location	Age at conception & whether 1st conception	Dates of first & final interviews	Weeks pregnant when recruited	Number of contacts during data collection period	Labour and birth details	Number, sex & birth weights of babies + feeding	Regular contact with father of bab(ies)	Mother's participation in study	Major life events	Health issues	Education / employment & housing at one year > birth (of first child)
Lou [SY]	16 I previous miscarriage	Jan 2000 Nov 2001	12	42	IOL @ term Emergency caesarean under GA[13] > failed ventouse & forceps. Epidural sited.	1 girl 7lb 10oz Breastfed x3 feeds then bottle fed	Yes	No	Parents sep. Fostered/in care. Physical + sexual abuse	Depression Smoker Self harm Asthmatic	No educational qualifications. Not in paid work. Living with BF in council housing.
Lowri [W]	15	Aug 1998 n/a	30	1	IOL Epidural	1 girl 3lb 20z Stillborn	Yes	Yes	Baby died suddenly in utero @ 33 weeks	Unknown	Unknown
Luci [W]	16	July 1998 n/a	20	1	Unknown	1st twin died @ 14 weeks Birth outcome of 2nd twin unknown	Yes	Yes	Twin pregnancy; one baby died suddenly at 14 weeks	Asthmatic	Unknown

[13] General anaesthetic

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TABLE A: SELECTED DEMOGRAPHIC DATA FOR ALL FEMALE TEENAGE RESPONDENTS (n=17)

Pseudonym of teenage respondent + location	Age at conception & whether 1st conception	Dates of first & final interviews	Weeks pregnant when recruited	Number of contacts during data collection period	Labour and birth details	Number, sex & birth weights of babies + feeding	Regular contact with father of bab(ies)	Mother's participation in study	Major life events	Health issues	Education / employment & housing at one year > birth (of first child)
Megan [W]	14	Sept 1998 n/a	38	1	Unknown	Unknown	No	Yes	Unknown	Unknown	Unknown
Michelle [SY]	15	Mar 2000 Nov. 2001	17	19	IOL @ 41/40 SVD 6lb 10oz	1 boy Breast fed for 2 days then bottle	Yes	Yes	Horse died 1yr < preg. Granny died when baby 6/12 old. Dad declared bankrupt. Mum on medication for Depression.	Repeated urinary tract infections in pregnancy – hospitalised x2.	5 CSE's 2 O levels F/t work Owner occupied accommodation
Nia [W]	17	Oct 1998 n/a	40	1	Planned c/s under epidural for breech presentation	1 boy 7lb 1 oz Fully breastfeeding @ 6 weeks	Yes	No	Unknown	Unknown	Unknown

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TABLE A: SELECTED DEMOGRAPHIC DATA FOR ALL FEMALE TEENAGE RESPONDENTS (n=17)

Pseudonym of teenage respondent + location	Age at conception & whether 1st conception	Dates of first & final interviews	Weeks pregnant when recruited	Number of contacts during data collection period	Labour and birth details	Number, sex & birth weights of babies + feeding	Regular contact with father of bab(ies)	Mother's participation in study	Major life events	Health issues	Education / employment & housing at one year > birth (of first child)
Rhian [W]	15	May 1998 n/a	36	1	Unknown	Unknown	Yes	No	Unknown	Unknown	Unknown
Susan [SY]	15	June 2000 Dec 2001	16	19	IOL @ T^{+3} Epidural SVD	1 boy 7lb Bottlefed	Yes	Yes	Parents sep.		Part-time employment. work Owner occupied accommodation.
Tracey [SY]	14	May 2000 Dec. 2001	9	47	1st: IOL Emergency caesarean under epidural. Baby in SCBU for 5/7 2nd: planned caesarean under epidural	2 boys 1st: 5lb 2oz 2nd: 7lb 2oz Both babies admitted to SCBU[14]. Both bottlefed	Yes BF suffers serious mental health problems - receives invalidity benefit.	Yes	Parents' sep. Sexual abuse Domestic violence Exp. of care & foster homes	Frequent hospital admissions for symptoms of unknown causation. Gonorrhoea, chlamydia & genital herpes diagnosed in pregnancy	Not in paid work. Council housing.

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[14] Special Care Baby Unit. Tracey's 1st baby, Josh, was admitted for prematurity and remained in SCBU for 2 weeks; Ricky, her 2nd child, was admitted overnight following the diagnosis of mild torsion (twisting) of one testicle. This resolved of its own accord within the first week of birth.

SOUTH YORKSHIRE COHORT (longitudinal data set, n = 6)

	number of observations [1,2]	number of solo interviews	number of joint[3] interviews	number of midwife[4] interviews	number of independent contacts[6]
Clare (Chris's daughter)	1 (D)	6 (D)	4 (D)	3 (H + D)	21
Jade (Bev's surrogate daughter)	2 (H + D)	11 (D)	4 (D)	2 (H + D)	39
Lou (mother not recruited)	2 (D)	4 (D)	10 (D + H)	4 (H + D)	42
Michelle (Polly's daughter)	3 (H + D)	7 (D)	3 (D)	3 (H)	19
Susan (Marg's daughter)	2 (D)	8 (D)	3 (D)	1 (D)	19
Tracey (Jasmine's daughter)	1 (H)	9 (D + H)	5 (D)	2 (H)	47

WALES COHORT (cross-sectional data set, n = 11)

	number of observations	number of solo interviews	number of joint interviews[3]	number of midwife interviews[5]
Alys (Angarad's daughter)	0	0	2 (D)	0
April (mother not recruited)	1 (D)	1 (H)	0	1 (H)
Beca (Glenys's daughter)	1 (H)	0	1 (D)	1 (D)
Bronwyn (mother not recruited)	1 (H)	0	0	0
Catrin (mother not recruited)	0	1 (D)	0	0
Elenor (mother not recruited)	0	1 (D)	0	0
Lowri (Dilys's daughter)	0	0	1 (D)	1 (H)
Luci (Elain's daughter)	1 (D)	0	1 (D)	1 (H)
Megan (Anwen's daughter)	0	0	1 (D)	1 (H)
Nia (mother not recruited)	0	1 (H)	0	0
Rhian (Gwyneth's daughter)	1 (D)	0	1 (D)	1 (D)

[1] This includes only formal observations of interactions between respondents and health professionals. The majority of these interactions occurred between midwives and young women although occasionally I observed interactions between respondents and obstetricians and/or health visitors and/or social workers. I also carried out informal observations, for example when I accompanied respondents to appointments, visited them in hospital, or was present when professionals visited them at home.

[2] Different locations for observations and/or interviews are indicated thus: C = clinic; H= hospital; D= domestic.

[3] Joint interviews were usually undertaken with mothers (or surrogate) and daughters. Boyfriends and other family members, and less often friends and/or health and related professionals, were present during part of an interview. The exception was Lou whose boyfriend Pete was often present, at least for part of interviews.

4 Interviews were undertaken with midwives involved with care provision at key points in respondents' childbearing trajectories: midwives who undertook the first 'booking' consultation, the 'birth plan' visit (a home visit normally carried out around thirty-six weeks of pregnancy and intended to prepare women for birth), and those who attended young women in labour.

5 Such contacts were in addition to those generated by observations and interviews. They included phone conversations, text messages and occasional written correspondence, and 'off record' conversations as occurred when I gave respondents lifts in my car or accompanied them on 'official' business to benefit offices etc. The most marginalised young women generated more independent contacts due to the difficulties I experienced in maintaining on-going contact with them, because they required more overall assistance, and because they generated more concern from professionals involved with care provision.

SOUTH YORKSHIRE COHORT (longitudinal data set, n = 5[1])

	number of observations [2,3]	number of solo interviews	number of joint[4] interviews	number of independent contacts[5]
Bev (Jade's surrogate mum)	0	4 (D)	3 (D)	39
Chris (Clare's mum)	1 (D)	3 (D)	4 (D)	21
Jasmine (Tracey's mum)	1 (H)	6 (D)	5 (D)	47
Marg (Susan's mum)	1 (D)	6 (D)	2 (D)	19
Polly (Michelle's mum)	1 (D)	5 (D)	3 (D)	19

WALES COHORT (cross-sectional data set, n = 6)

	number of observations	number of solo interviews	number of joint interviews
Angarad (Alys's mum)	0	1 (H)	2 (D)
Anwen (Megan's mum)	0	0	1 (D)
Elain (Luci's mum)	1 (D)	0	1 (D)
Dilys (Lowri's mum)	0	0	1 (D)
Glenys (Beca's mum)	1 (H)	0	1 (D)
Gwyneth (Rhian's mum)	1 (D)	0	1 (D)

[1] Includes Bev, the manager of the hostel in Jade was resident throughout both her pregnancies, and who mothered her in a surrogate capacity.

[2] This includes only formal observations of interactions between respondents and health professionals. The majority of these interactions occurred between midwives and young women although occasionally I observed interactions between respondents and obstetricians and/or health visitors and/or social workers. I also carried out informal observations, for example when I accompanied respondents to appointments, visited them in hospital, or was present when professionals visited them at home.

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