

**THE EXPERIENCES OF TEENAGE MOTHERS IN THE
NEONATAL UNIT**

by

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ABSTRACT

The nurse's knowledge of patients' experiences contributes to gaining a deeper understanding of their health process and enables the nurse to develop a caring, therapeutic relationship. There is very little literature that focuses on the experiences of teenage mothers whose babies are in the neonatal unit. Therefore the purpose of this phenomenological study was to enquire into their experiences. The background to the study was outlined including the neonatal environment, family centred care, needs of parents in the neonatal unit, adolescence and teenage mothers. The phenomenological framework of van Manen and its application to this study has been described. The purpose of the study was to hear and value the stories as told by the teen mothers; inform and strengthen health care practice and identify areas of change if change is necessary.

Conversations with four teenage mothers were taped, transcribed and then analysed using van Manen's (1997) approach to researching lived experience. From the analysis two main themes emerged – the need to do [mothering] and being in a safe place. A third theme – the emotional roller-coaster – was also identified and ran throughout the stories. The experiences of the teenage mothers were compared and contrasted with the existing literature. A key finding of the research was that teenage mothers, despite their developmental stage, had similar experiences to those of older mothers in the same situation. Additionally, their competence at mothering was greater than might have been expected.

Recommendations were made related to 'family centred care' in the neonatal unit to ensure all mothers have the support, information and education they need. Additionally, the research supports the development of strong therapeutic relationships with mothers based on partnership in decision making and care giving which, in turn, sees a transfer of power and control to the mother.

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*“One of the greatest gifts we can give to another generation is our experience,
our wisdom.”* Desmond Tutu

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CHAPTER ONE: INTRODUCTION

I work, as a member of the nursing team, in the neonatal unit where we care for sick and preterm babies and their families. Our aim is to provide care that helps the baby to reach his/her optimum wellness and safely integrate into the family. The nurse's knowledge of patients' experiences contributes to gaining a deeper understanding of their health process (Del Barrio, Lacunza, Armendariz, Margall & Asiain, 2004).

Our neonatal unit claims to provide family centred care. This implies that parents are involved in a partnership with staff in planning and delivering care to their infants. How much do we know about teenage mothers' experiences in neonatal units in New Zealand?

This phenomenological study adds to an existing body of knowledge. There is a gap in the literature with reference specifically to teenage mothers and the effect that having a baby in the neonatal unit has on them. The goal of phenomenology is to develop an understanding of a phenomenon through the specific human experience of the phenomenon. The human experience in this research is that of the teenage mothers' own individual lived experience of her time spent caring for her baby in the neonatal unit. Through the insightful understanding and description of the phenomenon, phenomenology offers the researcher a way of getting to know what it is like being a teenage mother in the neonatal unit (van Manen, 1997; Walton & Madjar, 1999.) The aim is to provide rich and full descriptions and interpretations that illuminate what it means to be a person in that life-world (Schneider, Elliott, LoBiondo-Wood & Haber, 2003). The purpose of the study is to hear and value the stories of teen mothers; inform and strengthen health care practice and identify areas of change if change is necessary.

A description of the neonatal unit and the environment, in which it is situated, together with the demographics of the area, sets the scene for this study. This first chapter continues by introducing this research in the context of the researcher's personal background and working environment. It describes how the researcher

arrived at this piece of work, a brief summary of the background and the justification for undertaking the study. The chapter will conclude with an outline of each of the following chapters.

LOCATION OF THE STUDY

The neonatal unit that is the centre of this study is a small unit, eight cots, in a provincial hospital in the North Island of New Zealand. It is specified as a Level 2A unit in that it cares for babies born at 28 weeks gestation, or greater, and over 1000grams birthweight. It operates at a secondary level and those babies who fall outside of the criteria, and extremely sick babies requiring complex cares and/or surgery, are referred out of the region to the tertiary neonatal unit that is 231 kilometres away.

The neonatal unit serves the provincial population of 104,127 (Statistics NZ, 2006) and admits approximately 200 babies each year (District Health Board). There are two main population centres, a number of smaller townships around the whole province and some isolated, rural settlements. The largely rural province with the sea and hill country as its boundaries supports intensive pastoral farming.

BACKGROUND

To work as a registered nurse in the neonatal unit, and care for premature and sick newborns, and their families, is a privilege and a responsibility. It is a privilege to share the experience of a newborn joining the family/whanau. The responsibility of providing a safe environment, experienced nursing care, and help to parents preparing to take baby home is that of the nurse who works with the family/whanau. Holditch-Davis and Miles (2000) describe the neonatal nurse's job as both challenging and rewarding in helping mothers cope with the stresses associated with the birth of a preterm infant. To cope with the challenges, that also bring rewards, a neonatal nurse needs to be continually striving to provide the best of care. Maintaining and updating knowledge and skill is necessary together with continuous reflection on one's own practice. As a nurse, I am always striving to provide the best care for patients, the babies and their families/whanau, and to do so I need to understand how they experience being in the changed life-world that is theirs whilst they are in the neonatal unit. Having a sick baby in the neonatal

unit brings a multitude of distressing emotions. Parents experience disappointment, guilt, sadness and depression, hostility and anger, anxiety, helplessness, grief and loss of self esteem (Jackson, Temestedt & Scholin, 2003; O'Haire & Blackford, 2005; Pearson & Andersen, 2001; Shields-Poë & Pinelli, 1997; Wereszczak, Miles & Holditch-Davis, 1997). If nurses listen to what mothers say about their experiences and feelings, they will better understand how to support them. Mothers are the real experts on mothers' needs.

Neonatal care has developed over the years and the family centred model of care is a preferred model. Parents and family members are included in planning, care and treatment of the hospitalised infant (Thomas, 2008). Family needs are held to be as important as an infant's needs and there is a belief that, over time, parents and other family members have the greatest influence on an infant's health and wellbeing. The central function of family centred care is that the family is a constant in the child's life and that care must focus on supporting the family in their role as caregivers (Thomas; VandenBer, 2000; Holditch-Davis & Miles, 2000). Neonatal care is based on a partnership between parents and professionals. Nurses and hospital staff assume a position of support in relation to parents instead of the previous position of control (Thomas). O'Haire and Blackford (2005) discusses how the balance of power between nurses and parents greatly influences the process of negotiating parental participation and that there is a need for open channels of communication. The study stresses the importance of a nurse's ability to communicate and understand parental stress. Limited experience and education may lead to mothers becoming overwhelmed in communicating with multiple well-educated nurses, doctors and other members of the team and difficulty in understanding complex medical diagnoses and treatments. This, along with the discomfort of being in the hospital environment, may affect parents' ability to ask questions. (Miles, 2007). I wonder how easy it is for teenage mothers to be comfortable in a neonatal unit and participate in the care of their infants.

Transition to motherhood has been described as a process of personal and interpersonal change, which occurs as a woman assumes maternal tasks and appraises herself as a mother (Mercer, 2004). For women who choose to become

mothers, transition to motherhood is a universal developmental experience. Support is very important to parents of normal, healthy babies during pregnancy and the transition to parenthood. The birth of a premature or sick newborn infant is considered to be a major developmental crisis for parents (Miles, Carlson & Funk, 1996). The ability to parent is influenced by a multitude of factors that occur before during and after the birth of the infant. Previous life events, including genetic endowment, cultural practices, being parented, previous pregnancies and interpersonal relationships affect the experience of pregnancy and parenthood (Merenstein & Gardner, 2006). There is a gap in knowledge about what support teenage mothers need and whether it is different from other mothers.

In 2000, Dickson, Sporle, Rimene and Paul reported that in developed countries, there is an increasing concern about teenage births because of adverse consequences for young women and their children. Craig, Jackson and Han (2007) found that whilst New Zealand's teenage birth rate had declined in recent years, the rate was higher than the national average in the Province in this study, and highest among Maori. Teenage mothers make up approximately ten per cent of the annual births in this Province and of these approximately 20 have babies needing care in the neonatal unit (personal communication, April 19, 2012).

High teenage pregnancy rates are a cause for concern as young maternal age has been associated with increase risk of maternal complications during pregnancy and delivery, as well as increased risk of adverse birth outcomes such as preterm birth and small for gestational age (Cassata & Dallas, 2005; Craig et al, 2007; da Silva, Simoes, Barbier et al, 2003; Leiner et al, 2007; Magill & Wilcox, 2007; Markovitz, Cook, Flick & Leet, 2005). Teenage pregnancy may also impact on educational attainment, not only of the young women themselves, but also the aspirations and opportunities available to their children. Mounting evidence links the children of adolescent mothers who reside within poverty with decreased cognitive abilities, physical growth, and future attainment (Cassata & Dallas; Craig et al.).

SmithBattle (2000) challenges some of the assumptions surrounding teenage mothers, one being that teen mothering jeopardises her development. Erickson's

fifth developmental stage, which occurs during the adolescent years, is the time when individuals seek to find out who they are, what they are about, and where they are going in life (Santrock, 2007). Having no adult responsibilities allows an adolescent the freedom and opportunities to differentiate from their family, to develop a career and to eventually form intimate relationships. Combining the tasks of adolescence with mothering is considered detrimental not because of the social disadvantage that precedes many teen births, but because of teen's failure to first achieve autonomy and become a rational thinker (SmithBattle). The discussion continues with many qualitative studies confirming that mothering fosters teenagers' aspirations to become more responsible and mature. Mothering makes sense of the limited life options for some teenagers. Assuming that all teenage pregnancy involves negative health implications may be overly presumptuous (Coleman, Hendry & Kloep, 2007).

Nurses who provide health care to pregnant and parenting teens may believe that deferring parenthood will dramatically improve the life chances of disadvantaged girls and decrease the personal and social costs of poverty (SmithBattle, 2000). Childbearing adolescents represent a vulnerable population with documented health disparities. There is a gap in scientific literature about nurses' attitudes to caring for childbearing adolescents and their families (Cassata & Dallas, 2005) yet, teenage parents should have a say in how they are cared for and what form the health care facilities should take.

The idea for this piece of research evolved through postgraduate study which enabled me to reflect more deeply into my practice working with mothers in the neonatal unit and the processes around my decision making. My personal philosophy states that "I am an advanced practitioner in the area of neonatology and child and family health and I endeavour to make full use of my nursing skills and knowledge. As a senior nurse I recognise that being a good role model to other nurses, patients and their families is important". I believe I practise at an expert level. Benner (1984) insists that holistic care, rather than the ability to conduct a series of tasks proficiently, is the hallmark of expertise. Practising as an expert in person-centred care requires that I use a blend of different knowledge and diverse ways of knowing and being (Titchen & McGinley, 2004). "Patient-

centredness rests in the ethics of care” (Titchen & McGinley, p.110). It requires that care is delivered in a way that addresses the needs and concerns of the particular patient as he or she sees them, as well as being evidence based.

My practice is informed by the knowledge and skills gained over the years working as a nurse and the life experiences gained being a daughter, sister, wife, mother, grandmother and friend. My personal philosophy also states that “as a life-long learner working towards evidence based practice, my nursing knowledge is not static but dynamic”. Elizabeth Domino (2005) challenges nurses to adapt to the great changes that are occurring in health care. She tells us to critically reflect on our levels of knowledge and skills in relation to the increasing demand for more advanced knowledge. Nurses will only adapt if they commit to lifelong learning and the acquisition of new knowledge. We cannot assume that we are always competent and with the Health Practitioners Competency Assurance Act we are obliged to demonstrate our currency and competence.

Dahlgren, Richardson and Kalman (2004), when discussing recognition of competence in practice, talk about professional artistry being demonstrated in advanced professional practice. By using critical thinking, together with intuition, creativity, reflection and lateral thinking, advanced clinicians are able to critique, use and develop knowledge in practice. Professional artistry is a blend of professional and personal knowledge. Expertise requires the professional to use a blend of different knowledges and diverse ways of knowing and being. It involves the blending of self-knowledge and intellectual, emotional and personal maturity with the person’s professional knowledge base. This knowledge base is formed by professional craft knowledge acquired through professional experience, personal knowledge acquired through life experience and propositional or theoretical knowledge derived through scholarship and research. I have always had a desire to learn and as the years have gone by I realise that the more I learn, the more there is to know. There are questions to be answered, practices to be challenged and issues to be discussed and debated. I have a need to know how I can care for my patients better and a desire to inform nursing.

A nursing textbook from the 1960s defines nursing as a science and an art (Price, 1965). Watson (1985) in the opening chapter of her book had a similar view of nursing. I see that a definition of nursing today could be described in the same way. The science is the knowledge that underpins our practice, whether it is physical science or social science. The art is our ability to perform nursing in a skilled and ethical way. The third dimension that Price also mentions is “the spirit” of nursing. This, I believe, is the values and passion that a nurse brings to the caring in nursing. A professional nurse has knowledge, skill and a desire to care. Caring, I believe is the very essence of nursing. Watson’s view “requires the nurse to be a scientist, scholar, and clinician but also a humanitarian and moral agent, wherein the nurse as a *person* is engaged as an active co-participant in human care transactions” (p. 54). Caring in nursing is where there is concern and respect for, and being present with, the individual as a person. Cameron (in van Manen, 2002a, p. 24) describes the nurse being present for someone when “she lives the essence of caring for a person. Being there for someone in deep distress, assisting to relieve that distress, while trying to preserve the dignity of that human being, call for the nurse to be wholly present.” Nurses need to be present with their patient, be able to develop therapeutic relationships with that person and develop an understanding of how ‘their world’ is for them at that moment. I want to give my best nursing to the babies and their families in my care. I want to understand what it is like for them. It is very hard for me to understand how the babies are experiencing their life-world other than by observation and imagination. It is experiential knowledge, compassion and a degree of intuition that enables me to try. However, as I am able to communicate with the mothers and fathers, I can position myself to try and be present in their ‘now’ and experience how it is for them.

How and why did I choose teenage mothers? Whilst reflecting on my practice, and in particular my development of therapeutic relationships and cultural safety, I recognised that teenage mothers in my care had a different culture from me and that there were power and control differences that would affect how and when I would be able to relate to these mothers.

My nursing philosophy states that “I have a strong commitment to fairness, equity, empowerment and cultural safety and incorporate these principles in my practice with those I work with and those families/whanau in my care. This acknowledges that I work in Aotearoa New Zealand and within the principles of Tiriti o Waitangi.”

The Treaty of Waitangi is the founding document of New Zealand, and as such, its place within the health sector is fundamental to the improvement of Maori health (NCNZ, 2005). The principles of partnership, participation and protection are acknowledged, respected and acted on in my practice. Partnership is ‘working together’ with an agreed common purpose. Care and treatment is discussed, planned and delivered in cooperation and partnership with the patient and/or the patients’ families, aiming to achieve positive health outcomes. The integrity and wellbeing of both partners must be preserved. Participation is achieved when pathways of access, that enable Maori to participate across the health sector, are developed. Maori are to be consulted in assessment, decision making and planning of services and service delivery. In the clinical situation, Maori are involved in the planning and delivery of care. Protection is a duty of health services to recognise and respond to Maori cultural beliefs, values and practises. Health is a taonga and worthy of protection in order to achieve positive health outcomes and improvement in health status (NCNZ).

In my practice as a neonatal nurse, I endeavour to provide culturally safe care – individually planned with the baby’s family to best meet the baby’s needs. I acknowledge that Maori are a diverse population and I must not make assumptions around their cultural needs. I work with the Maori Health Workers, alongside the family, as is necessary.

The Nursing Council of New Zealand (2005, p.4), defines cultural safety as:

The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.

Papps and Ramsden (1996) also state that each health care relationship, between a professional and a consumer is “unique, power-laden and culturally dyadic” (p. 494).

Culture is the very being of someone – the way they think, live, speak, their age, values and beliefs and much, much more. The essence of my own practice being culturally safe is for me to identify my own attitudes, values and beliefs and how they impact on the relationship I develop with someone in my care. I must understand their culture and not impart my values and beliefs on them. For example, I have to understand and respect that a young, single mother is in a totally different culture to me, with differing basic beliefs, different value systems and regard differing modes of behaviours as acceptable. Whilst I can guide her with her mothering skills, I am not the one who is going to take the baby home. I cannot live her life for her. Teenage mothers are not a homogenous group and relationships have to develop individually as for all patients and clients in our care. However, the experiences of teenage mothers in the neonatal unit are not reflected in the literature. What is it like for them being young mothers in the neonatal unit and how do they develop relationships with staff and others when they are in, what is for them, a ‘foreign’ space?

If my personal philosophy is based on caring and the desire to continually improve my knowledge and practice, then I need to seek ways of being present with young mothers and their babies, be able to develop a therapeutic relationship with them and an understanding of how ‘their world’ is for them at that moment. I chose phenomenology as my research methodology because it fits my personal philosophy. Phenomenology as a research method is a rigorous, critical, systematic investigation of phenomena. The purpose is to explicate the structure or essence of the lived experience. (Streubert Speziale & Carpenter, 2007). van Manen (1997) states that to do research in a phenomenological way, is always to question the way we experience the world, want to know the world, in which we live as human beings. He continues to suggest that in doing research we are questioning the world’s very secrets and intimacies which make up the world, and being in the world. Research is therefore a caring act and requires a sensitive and

reflective study of the life-world of, in this research, being a teenage mother in the neonatal unit.

In this chapter I have introduced my research in the context of my personal background, my personal philosophy and working environment in which I nurse. A description of the location and a review of the literature, undertaken to provide an orienting framework, provide the background to the study. It is a privilege to work with families and to care for their babies in the neonatal unit. To enable me to give my best care I need to work closely with mothers, and fathers, and try to understand their lifeworld at that time. Therefore I chose phenomenology to provide rich descriptions of the mothers' experiences. Little is written in the literature around the experiences of teenage mothers and as I have a special interest in this group, I chose to investigate their experiences in the neonatal unit.

An initial search of the literature was undertaken to establish how much and what is written about parents' experiences in the neonatal unit. Chapter Two includes a comprehensive review of the literature researched used as part of my data analysis to support or challenge the findings of my study.

Chapter Three aims at explaining why phenomenology was chosen for this research. The historical and philosophical background to phenomenology; and my understanding of van Manen's perspective will be described and how it has been applied to this study. The chapter continues with a description of the method used - selection of participants, data collection, data analysis and concludes with ethical considerations made.

Chapter Four describes the experiences of the teenage mothers in the neonatal unit as told by them. Four teenage mothers were interviewed and their interviews transcribed. These transcriptions provided the experiential data that through reading and re-reading, I have tried to live their experiences. I have endeavoured to be true in describing them in the written word. A thematic analysis uncovered aspects in the life-world descriptions. Thematic statements were isolated and then I have endeavoured to write a true and rich text that tells the young mothers' stories.

Chapter Five provides the discussion on my findings and includes the literature that supports, or otherwise, the findings. I discuss the limitations of the study and suggestions for future research. Finally, I make tentative recommendations for practice based on the findings of the research.

CHAPTER TWO: LITERATURE REVIEW

INTRODUCTION

The opening chapter set the scene of the study being undertaken. It described how I identified and developed the topic to be studied for this dissertation. My desire to gain knowledge, not only about neonatal nursing, but also about my own nursing practice, has enabled me to reflect on being a neonatal nurse and identified an area of particular interest to me, teenage mothers. Chapter one also included background information obtained from an initial search of the literature. This review of the literature, undertaken before the study, provided an orienting framework. This chapter includes the in depth review of the literature searched to support or challenge the findings of my study.

An initial search of the literature was undertaken to establish how much and what is written on the subject of parents in the neonatal unit and more specifically, whether or not there had been any studies including teenage mothers. A search of data bases including CINAHL and Medline was undertaken using search terms “parents or parenting” and “neonatal intensive care unit”; “adolescent parents or parenting”; “teenage mothers”. van Manen (2002) debates whether one should review the literature in the initial or in the later phases of one’s research study. Whilst a wide search of the literature around parents in the neonatal unit, teenage parents and adolescence was undertaken before the study, only a cursory review of the literature around parent experiences and teenage parenting was completed. This review showed the gaps in the literature around teenage mothers in the neonatal unit. However, to reduce the likelihood of developing suppositions or biases about the topic, this literature was put to one side to be reviewed as part of the data analysis. Further, by not developing preconceived ideas about the topic, I hoped to be protected from leading the participants during the interviewing process in the direction of the researcher’s beliefs. (Streubert Speziale & Carpenter, 2007). A further search of phenomenological studies and literature around identified themes was undertaken during the analysis of the data and the details of this review follow.

PARENTS' EXPERIENCES IN THE NEONATAL UNIT

Infants are admitted to the neonatal unit because they are born prematurely and/or they have an infection, respiratory distress or other medical condition that needs special care and treatment. The neonatal unit presents a challenge for those beginning to parent a baby in this environment. Parents find themselves beginning the parenting experience publicly and in unfamiliar surroundings. The sights and sounds of the high-tech hospital environment, the infant's physical appearance, medical equipment, and the relationship with the health care personnel in the unit all affect parenting behaviour (McAllister & Dionne, 2006; Pearson & Anderson, 2001).

The experiences of mothers who have babies in the neonatal unit are described by several researchers in the literature and common themes emerged. The developmental process that mothers experience on their journey through the neonatal unit is conceptualised in some of the studies. The rich descriptions of the mothers' own stories describe this journey as going from the unfamiliar, stressful and 'alien' world initially to being able to participate and be involved in the familiar world (Heerman, Wilson & Wilhelm, 2005; Jackson, Ternestedt & Scholin, 2003; Shin & White-Traut, 2007). The process is a time dependent process that each of them have to go through. Mothers pass through phases from unfamiliarity with the transition situation to acceptance and shaping motherhood when they develop their confidence and own sense of identity as a mother (Shin and White-Traut). The experience is also described as an alternation between the mothers feeling exclusion or participation (Wigert, Johansson, Berg & Hellström, 2006).

Much of the literature concentrates on the emotional stresses and challenges that parents experience. The birth of a premature baby and admission to the neonatal unit precipitates an unanticipated crisis for the parents. Parents experience intense and distressing emotions and confusion around their role as parents. Parents experience disappointment, guilt, sadness and depression, hostility and anger, anxiety, helplessness, grief and loss of self esteem (Ardal, Sulman & Fuller-Thomson, 2011; Cleveland, 2008; Fegran, Fagermoen & Helseth, 2008a; Holditch-Davis & Miles, 2000; Jackson, Ternestedt & Scholin, 2003; O'Haire &

Blackford, 2005; Pearson & Anderson, 2001; Shields-Poë & Pinelli, 1997; Wereszczak, Miles & Holditch-Davis, 1997). The distress experienced by parents has been associated with a number of factors. Holditch-Davis and Miles identified six major sources of stress – pre-existing and concurrent personal and family factors; prenatal and perinatal experiences; infant illness, treatments, and appearance in the neonatal unit; concerns about the infant's outcomes; loss of parental role and health care providers. Carter, Mulder, Bartram and Darlow (2005) in a New Zealand study, compared the psychosocial functioning of the parents of infants admitted to a neonatal unit with parents of infants born at term and not admitted to the neonatal unit. Their results showed that the majority of parents made a relatively successful adaption to the neonatal environment when their infant was admitted. There was a small group of parents, who had previously had a baby in the neonatal unit or their infant was extremely premature, who experienced significant distress and needed additional support. Having an environment that is parent friendly, with open access to the unit; involvement in clinical decision making; skin to skin contact between parents and infant and having a named member of the nursing staff as the key contact person for the family throughout the stay were all key elements in the successful adaption to the neonatal unit environment.

SUPPORTING PARENTS IN THE NICU

To meet the challenge of providing care that supports the needs of the baby and the mother, nurses must gain an understanding of the mothers' perceptions, expectations and needs (Hurst, 2001a). Parents need support to survive the emotional roller coaster and to gain confidence and skill in caring for their infant. Cleveland (2008) identified a number of needs that parents have in the neonatal unit. These include accurate information, reassurance and inclusion in the infant's care and decision making; vigilant watching over and protecting the infant; contact with the infant; being positively perceived by, and having a therapeutic relationship with, the nursery staff; and individualised care. The behaviours that support parents in meeting these needs are emotional support; parent empowerment; a welcoming environment, and education and supportive guidance and participation in caring for their infant (Cleveland; Moore, Coker, DuBuisson, Swett & Edwards, 2003). The literature also describes how many of the parents'

needs can be met by the nurses practising family-centred care (DiMenna, 2006; Harrison, 1993; Hughes, 2007; Thomas, 2008). For family-centred care to be successful, and support parents of sick infants or children, there needs to be a partnership approach with negotiation and shared care planning that leads to empowerment of parents as the principal carer and advocate for their child (Hughes). The central function of family centred care is that the family is a constant in the child's life and that care must focus on supporting the family in their role as caregivers (Conner & Nelson, 1999; Holditch-Davis & Miles, 2000; Thomas; VandenBerg, 2000).

A need for accurate information, reassurance and inclusion in the infant's care and decision making.

Communication is a source of frustration to parents and caregivers alike (Harrison, 1993). Mothers seek information by asking lots of questions. They need these questions, and unasked ones, to be answered with accurate and understandable information (Cleveland, 2008; Harrison; Hurst, 2001a; Tran, Medhurst & O'Connell, 2009). Hurst, in her research, also describes how the mothers expressed a need for "empowering information and interactional experiences" (p. 69). The mothers needed to become the experts, with the knowledge and confidence that enabled them to mother their own infant. The informational support includes explanations around what is being done to the infant, how a parent can participate in caring for the infant and changes in infant's condition. Parents also indicate that they want to receive the information from either the nurse or the neonatologist and nurses should adopt a more consistent, flexible, responsive and sensitive approach to providing information to parents (Tran, Medhurst & O'Connell, 2009). Parents also request referral to other parents so they can share with those who have had similar experiences (Conner & Nelson, 1999). Receiving a continuous flow of information is an important part of the interaction between mother and caregiver. When there is a lack of information, this leads parents to speculate about the condition of their baby and how he/she is being cared for in their absence. This in turn leads parents to experience exclusion from their infant (Wigert et al, 2006).

A need to be vigilant and to watch over and protect infant.

Parents need to be close to their infant (Conner & Nelson, 1999). Mothers describe their need to watch over their infants, gain information and be alert for situations that signal danger such as poor continuity of care or lack of attention to the baby (Hurst, 2001a; Hurst, 2001b). Some mothers are too afraid to visit the baby until reassured by their husband, partner or other family member, because they have a real fear the baby may die while others do not want to leave their baby because they are so worried (Jackson, Ternstedt & Schollin, 2003). Frequent phone calls to the neonatal unit and being present at the baby's bedside are strategies used by parents to safe guard their infant (Hurst, 2001b). Mothers found that through vigilant watching, and negotiation with the nurse, they are able to identify ways to provide love and comfort to their infants and learn how to care for their infants and maximise every opportunity to do so (Hurst, 2001a). As the mothers develop a trusting relationship with the nurses, they become more relaxed about the need to be watchful all the time (Cleveland, 2009).

A need for contact with the infant.

During pregnancy, a mother develops a relationship with her unborn child and immediate physical contact between the mother and her newborn child after delivery promotes the attachment (Wigert et al, 2006). Mothers whose babies are admitted to the neonatal unit often have missed out on the skin to skin immediately after birth and may not have been able to see their baby much less hold or touch their infant, due to the critical and fragile nature of the baby's condition (Lemermeyer, 2007). Mothers feel a real desire to hold or touch their babies. This is very important to them but they do find some comfort sitting beside the incubator and touching or stroking their baby (Cleveland, 2009; Holditch-Davis & Miles, 2000). Kangaroo care, or skin to skin holding, is one of the most beneficial developmental interventions parents can perform with their newborn and has benefits to both parent, in particular the mother, and infant (DiMenna, 2006). However, it may not be implemented because of concern about the infant's safety and stability and level of support from the neonatal team. Nurses need to discuss this intervention and support its use when appropriate (DiMenna).

Providing breast milk is seen as a form of contact with their baby and is one way that only they can provide for their baby (Cleveland, 2009). It is a way of forming a connection to their baby and establishing a relationship (Lupton & Fenwick, 2001).

A need to develop a therapeutic relationship with nursing staff.

Parents express a need to be positively perceived by the staff in the neonatal unit and to be empowered in caring for their infant (Cleveland, 2009). In order to achieve this, a strong, trusting, therapeutic relationship needs to develop between the nursing staff and the parents (Cleveland; Hughes, 2007; McAllister & Dionne, 2006). A therapeutic relationship between patient and nurse requires a change in the traditional role of dominant expert and passive recipient of care (Hughes). Hughes also states that a relationship, based on mutual respect, trust and equality of worth is necessary to empower parents, and continues by stating that empowerment needs to be evident on both sides of the parent-nurse relationship for family-centred care to be meaningful.

Mothers describe feeling intimidated and overwhelmed by the technological environment and the expertise of the nurses (Heerman, Wilson & Wilhelm, 2005). Lupton and Fenwick (2001) describe how mothers saw nurses as 'gatekeepers' between themselves and their infant and they felt they had to gain permission to interact with their babies. Having to seek permission to interact with their babies and appearing to be constantly supervised results in mothers feeling frustrated and resentful (Cleveland, 2008). Nurses must consider how to minimise stress and intrusiveness while providing care. A trusting relationship with parents is essential to reduce the stress as is involving mothers, and fathers, in the care of their infants (McAllister & Dionne, 2006). Holditch-Davis and Miles (2000) describe the loss of parental role that mothers experienced. Mothers were unable to hold, feed and bathe their infant which they saw as expected maternal experiences. The loss of parental role affected the mothers' ability to advocate and make decisions for their infants. Parents describe feelings of inadequacy and helplessness and want to be recognised for the family values that they bring and a willingness to be involved in the decision making process in the management of their infant (Conner & Nelson, 1999; McAllister & Dionne, 2006). When parents

observe nurses engaged in nurturing and vigilant behaviours towards their baby – showing affection, caring, watching and protecting – they feel that they are being respected and supported in the parental role (Haubaugh, Tomlinson & Kirschbaum, 2004).

Fenwick, Barclay and Schmied (2001) identified the importance of the nurse-mother relationship in the NICU. Those nurses who employed ‘chat’ effectively, opened up a two way dialogue as they shared their knowledge and expertise with the women. From this a strong relationships developed that gave mothers confidence and self-esteem in their ability to care for their babies.

A need for individualised care.

Individualised care can be achieved through the development of a partnership between the neonatal team, who assess the readiness and willingness for parents to be involved in assessing, planning and delivering care, and the parents who develop trust and confidence in the team (Fenwick et al, 2001; McAllister & Dionne, 2006). Creating an environment where the care is individualised to each parent’s particular needs is important in parents feeling empowered and supports the facilitation of attachment between mother and baby (Cleveland, 2008; Wigert et al., 2006).

Emotional support.

Emotional, physical and spiritual supports contribute to parent satisfaction of care in the neonatal unit (Conner & Nelson, 1999). Parents need to be able to express their feelings and be able to talk with nursing staff, to feel accepted and cared for and some appreciate having a chaplain available (Conner & Nelson). Nurses need to convey to parents that they are concerned about the parents’ wellbeing; and by also being aware of how they are coping and how having a baby in the neonatal unit is impacting on their lives (Tran, Medhurst & O’Connell, 2009). Through participation in support groups, parents experience additional support and through sharing common experiences are able to overcome perceived obstacles in the neonatal unit and experience an increase in positive parenting behaviours (Cleveland, 2008; Hurst, 2006; Pearson & Anderson, 2001). Parents also find

comfort from keeping photos of their baby and a journal of baby's progress (Cooper, Gooding, Gallagher, Sternesky, Ledsy & Berns, 2007).

A welcoming environment with supportive unit policies.

Tran et al (2009) describe mothers' feelings of exclusion, not being cared for and falling between maternity care and neonatal care, and therefore not belonging. Nurses need to look after the parents' wellbeing. Parents identify that they need the physical environment of the neonatal unit to be both supportive to their infant's needs – protecting them from noxious stimuli such as noise and bright light – but also to meet their own needs of having a quiet place to rest, a waiting area, food available and a place to stay overnight (Conner & Nelson, 1999; Harrison, 1993).

Parent education and supportive guidance in caring for the infant.

Providing a supportive and non-judgemental environment for parents enables them to develop their role as parents (Cleveland, 2008). Active participation in the care of the infant and consistency of advice when teaching parenting skills promotes bonding and helps parents prepare for discharge (Conner & Nelson, 1999; Wigert et al., 2007). Nurses play a key role in supporting parents' educational and informational needs by providing educational material in the form of brochures and booklets which enables the parents to read the material at their own leisure (Tran et al., 2009). Mothers feel guided and best prepared for their life at home with the infants when they have developed a close relationship with nurses who have encouraged their participation in care and have conveyed important information to them and the home health care team alike (Fenwick et al, 2001; Scherf & Reid, 2006). However, Cooper et al. (2007) found that some parents experienced lack of preparedness for discharge, confusion of information and late commencement of discharge planning which nurses stated should begin on admission. Parent participation in baby's care from the earliest possible time is the best preparedness for home (Cooper et al.).

ATTACHMENT

The contact with her child that a mother develops during pregnancy and the desire to be a mother promotes the beginning of a relationship between the woman and

her unborn child. To experience early contact with the baby promotes the attachment to the child, not just in the early days but throughout the first year (Wigert et al., 2007). Mercer (2004) found that those mothers who spent time thinking and daydreaming about their baby during pregnancy were found to be more involved and connected to their baby after birth. Figueiredo, Costa, Pacheco and Pais (2009) describe two related aspects of maternal bonding; the mother's concerns and actions about the safety and well-being of the infant, as well as the mother's emotional tie with the baby and the unique place he/she holds in her world. It is also a bi-directional process of mother to baby and baby to his/her mother. Novak and Peláez (2004) state that physical and behavioural characteristics of the infant elicit positive maternal responses and that mothers, intuitively know how and what to do to take care of their infants. When the infant's proximity- and security-regulating behaviours become organised around one or more particular caregiver, Novak and Peláez describe the infant as developing an attachment. However, women who have not been well mothered, often find it difficult to interpret their babies needs (Mercer). When a baby is admitted to the NICU, the fears and feelings about the unfamiliar environment and the mother's separation from her infant may cause difficulty in the establishment of mother-infant attachments and attainment of the maternal role (Fegran, Helseth & Fagermoen, 2008b; Shin & White-Traut, 2007).

MOTHERING – BECOMING A MOTHER

In biological terms, becoming a mother occurs when a woman finds she is pregnant, carries the child and gives birth to her son or daughter. There are not only physical changes that occur in the mother but emotional and developmental changes also (Claiborne & Drewery, 2010). Transition to motherhood is a major developmental life event described as a process of personal and interpersonal change, which occurs as a woman assumes maternal tasks and appraises herself as a mother (Shin & White-Traut, 2007). Establishing a maternal identity in becoming a mother contributes to a woman's psychosocial development (Mercer, 2004). Successful adjustment leads to satisfaction in the mothering role expressed through self-confidence, self-esteem and her ability to nurture and care for her infant (Emmanuel, Creedy, St John, Gamble & Brown, 2008). Mercer (2004) describes how becoming a mother is a continually changing process as she learns

how to mother a newborn, a toddler, a school-age child or an adolescent. She adjusts her mothering to fit herself and her family according to her past experiences and future goals.

Transition to motherhood in the NICU can be delayed due to mothers' separation and inability to make contact with their infant and uncertainty and anxiety over the infant's welfare (Fegran et al. 2008b; Shin & White-Traut, 2007). Those nurses who take control and do not allow parents to participate in care are causing the mothers to experience negative emotional responses as the mothers feel helpless and worthless (Fenwick et al., 2001). The nurses who develop a close and caring relationship with mothers enable these women to take up their role as mothers and feel connected to their infants (Fenwick et al.). Nurses can also be supportive to new parents by providing positive meaning to even the smallest moments and giving credit for being the mother (or father) (VandenBerg, 2000).

If the parents of babies in the NICU are teenagers, nurses, and other members of the neonatal team, may need to consider other aspects as they relate to the young parents, and in particular the young mother. I have therefore included a section that endeavours to define adolescence and one that endeavours to summarise what is written about teenage mothers.

ADOLESCENCE

Adolescence refers to the period of physiological, personal, psychological and social maturation that occurs in individual humans between the ages of approximately 11 and 18 years and it is also known as the teenage years (Claiborne & Drewery, 2010; Novak & Peláez, 2004). However, adolescence is not the same experience everywhere in the world (Berk, 2004; Claiborne & Drewery). Many of the expectations of adolescents in the Euro-Western world are produced by cultural and historical processes related to industrial and post-industrial societies, rather than by processes of biological growth. Adolescence is a relatively new phenomenon in the history of humankind, and is sometimes seen as a by-product of the process of industrialisation. Places of work were centralised away from the family home and families no longer worked together. As machines took over more of the menial jobs, the level of training to obtain

employment increased, as did the age for leaving compulsory schooling. In twentieth century New Zealand, adolescents were increasingly seen as being focused on preparing for adulthood (and paid employment) through ongoing education and training (Claiborne & Drewery; Drewery & Bird, 2006). Durie (1998) identified that Maori, and adolescent Maori in particular, have historically had limited success academically, and are over represented in the untrained labour force, and have a very high incidence of drug and alcohol abuse. Durie was writing this in the context of colonisation and Maori not accessing education or health systems that were established by the dominant culture. Mertens, Anfara and Roney (2009) report that adolescent Maori display the lowest level of engagement at school with stand-down, suspension, exclusion and expulsion rates higher in Maori than pakeha, and a high incidence of Maori students leaving school before the age of 16. However, Te Puni Kōkiri (Ministry of Maori Development) (2010) reports a steady increase in educational attainment of Maori in recent years. The report continues by highlighting how higher educational attainment has a positive influence on various aspects of wellbeing, including improvements in health.

Adolescence is the transition from childhood to adulthood, marked by puberty and the flood of biological events associated with the physical changes of physical growth and sexual maturity (Berk, 2004; Santrock, 2007). The “mysterious work of hormones” (Claiborne & Drewery, 2010, p. 211) is often thought to be responsible for the effect on adolescents’ behaviour and that one has to just wait until the hormones settle down for behaviour to be modified. The psychological impact of puberty, as a result of dramatic physical change, may affect the adolescent’s self-image, mood, and interaction with parents and peers (Berk). However, Santrock cautions that the adolescent’s world involves cognitive and social changes as well as physical changes.

The developing power of thought opens up new cognitive and social horizons (Santrock, 2007). Their thought becomes more abstract, logical, and idealistic and the adolescent is more capable of examining not only their own thoughts but those of others around them (Claiborne & Drewery, 2010; Santrock). However it is a time of egocentricity and adolescent thought is around how they are viewed by

others (Santrock). It is also a time when the adolescent's vision of self transforms into a more complex, well-organised and consistent picture (Berk, 2004).

In New Zealand the media are regularly accused of creating negative stereotypes of young people but media depictions of adolescence tend to reflect what we read in the textbooks of psychology and adolescent development – a period of turmoil, hormonal upheaval and unpredictability (Claiborne & Drewery, 2010). Adolescence is seen as a period of life that is difficult for both the adolescents and for the people around them (Arnett, 1999). This difficult time is described in the concept of storm and stress, which includes three key elements – conflict with parents; mood disruptions and risk behaviour. Novak and Peláez (2004) describe antisocial behaviour in adolescence manifested as extreme physical aggressiveness, losing temper, arguing with adults, refusing to comply with adults' requests, deliberately doing things to annoy others, and being angry and spiteful, touchy or vindictive. However, this antisocial behaviour is not the norm in all adolescents. Personal experience tells me that there are many young people experiencing adolescence in a confident and stable way and are focused on defining their future. Arnett continues that even though there is storm and stress, the adolescents also experience great pleasure in many aspects of their lives and it can be seen as a time of "exuberant growth" (p. 324).

Emerging adult is a distinct period of life course for young people in industrialised societies that is focused on ages 18 – 25 years – the period between adolescence and young adulthood (Arnett, 2000; 2007). Arnett continues by stating that it is a period in which there is change and exploration for most people as they examine the life possibilities open to them and gradually arrive at more enduring choices in love, work and worldview. Claiborne and Drewery (2010) suggest that responsibility for the child's development moves from the parents to the child during the period of late adolescence early adulthood.

TEENAGE MOTHERS

Becoming a parent can be challenging and stressful for any person, but it can be especially difficult for adolescents (Berk, 2004; Lowenthal & Lowenthal, 1997; Thomson, 2010). Adolescent motherhood is often referred to as a social problem

in most Western societies (Rawiri, 2007) and in developing countries it is also identified as a social issue (Kaye, 2008). Wilson and Huntington (2006) and Coleman et al (2007), suggest that in terms of societal issues, disadvantage associated with teenage pregnancy is a product of the society we live in. Financial hardship is common among teenage mothers and there is an impact on educational attainment and employment opportunities (Berk; Santrock, 2007; Thomson). Of concern is the increased risk to teenage mothers because of adverse consequences for young women and their children (Dickson, Sporle, Rimene & Paul, 2000). The New Zealand Perinatal and Maternal Mortality Review Committee (2011) in their recent report highlighted that teenage mothers are at higher risk of stillbirth and neonatal death compared to mothers aged over 20 years. They reported perinatal deaths were more often the result of spontaneous preterm birth, foetal growth restriction and perinatal infections. Incidence was high in teenage Maori mothers; and smoking and social deprivation were also factors. A high percentage of babies born to teenage mothers require admission to a NICU (Abeywardana, 2007). Coleman et al. caution that assuming that all teenage pregnancy involves negative health implications may be over-presumptuous.

SmithBattle (1994; 1995) stated that although there was extensive literature and research on teenage pregnancy and parenting, little attention had been paid to the stories of young mothers. Their stories capture the difficulties, conflicts, successes and the possibilities for development experienced by young mothers. She continued by challenging some of the assumptions surrounding teenage mothers and suggests that for some teens, mothering makes sense of the limited life options that precede their pregnancies (SmithBattle, 2000). Teenage mothers express positive rewards such as achieving independent adult status; receiving love, attention and recognition; proving one is capable of caring for a child; and changing direction in their lives by seeking further education or employment (Herman, 2008; Seamark & Lings, 2004; SmithBattle, 2005). Mothering is a struggle and the support a young mother receives from family and networks plays an important role in facilitating or undermining the teenager's attempts to become a responsive self and parent (Hanna, 2001; SmithBattle, 2003; Wahn, Nissen & Ahlberg, 2005). In Maori culture, family – rather than the individual – is seen as the unit of development and therefore young Maori mothers and their babies are

supported by the whanau – the extended family (Drewery & Bird, 2006). If she is supported and cared for, this enables the young mother to learn how to look after her baby, develop responsive skills and habits, form a deep connection with and know her baby best.

In a phenomenological study undertaken by Arthur, Unwin and Mitchell (2007), teenage parents expressed a need to be treated as individuals and be involved in planning their care. In maternity care, they reported that poor relationships with staff had a negative impact on the birth experience and when midwives demonstrated a personal approach – in their manner, values, attitude and empathy – they instilled confidence in the young mothers and they felt valued. However, there were times when they felt, because of their age, they were ignored, not informed and talked at rather than involved in the discussion. This lack of personal interaction and understanding appeared to have been more distressing to young mothers than inadequate practical instruction.

Adolescent mothers who are parenting are not a homogeneous group of women and therefore it is important for caregivers to consider each adolescent woman as knowledgeable about her own life and what her health needs are (Stevens, 2006). First time adolescent mothers may need extra guidance, education, and support, as well as acceptance and reassurance (DeVito, 2010). DeVito continues by suggesting that nurses should listen and understand what adolescent mothers need and want to know regarding how to care for their newborn and how to become an effective parent. Cassata and Dallas (2005) and Chaudhuri, Easterbrooks and Davis (2009) suggest that cultural awareness and sensitivity will help nurses to support adolescent mothers. The event of childbirth can be traumatic to teenagers and some teenage mothers may be at special risk for posttraumatic stress (PTS) or postpartum depression (PPD) because of the birth experience (Anderson & McGuiness, 2008). They continue by suggesting that the psychological sequelae of childbirth may be diminished through experienced caregivers supporting the teenage mother – through expressing concern, a non-judgemental attitude, education and involvement of the teenager in the decision making.

CONCLUSION

This chapter summarises the literature review undertaken as part of the data analysis. A review of the literature identified the needs of parents when they have a baby in the neonatal unit and how the parents can be supported. A summary of adolescence enabled me to try and place teenage motherhood in a developmental context. I did not find any studies of the experiences of teenage mothers with babies in the neonatal unit, but there is a great amount written about teenage pregnancy and teenage motherhood, the needs of teenage mothers and how health professionals can support them. This literature review is used in chapter five to challenge and support the findings of this research.

Chapter three outlines the methodology used for this research.

CHAPTER THREE: METHODOLOGY

INTRODUCTION

The previous chapters gave the background to the study and an insight into my own nursing experience working in the neonatal unit. This chapter aims at explaining why phenomenology was chosen for this research. The historical and philosophical background to phenomenology; and my understanding of van Manen's perspective will be described and how it has been applied to this study. The chapter continues with a description of the method used - selection of participants, data collection, data analysis and concludes with ethical considerations made.

Nursing research is systematic enquiry designed to develop knowledge about issues of importance to nurses, including nursing practice, nursing education, and nursing administration. My nursing has its grounding in the scientific medical model and my research, then, would have been quantitative in design – gathering empiric evidence. In more recent years, as I reflect on my own practice and the relationships with families and colleagues, I need to explore human complexity and how my nursing impacts on these relationships. The understanding and interpretation of subjective experience and the creative development of nursing care are based on an appreciation of subjective expression. Carper's (1978) seminal work on the patterns of knowing in nursing, describes this as aesthetic knowing, the art of nursing. Aesthetic knowing in nursing provides a framework for the exploration of qualitative research methodologies (Streubert Speziale & Carpenter, 2007). Qualitative research methodologies, such as phenomenology, also provide empirical knowledge, particularly descriptive and explanatory theory, knowledge relevant for ethical action, and personal knowledge. Through phenomenological inquiry, we perceive a person's particular situation and context and come to know the place in which the individual lives, the beliefs, values and culture of the individual's world, and in this way, phenomenology gives detail to socio-political knowing of the larger environment (Van der Zalm & Bergum, 2000).

Working in the neonatal unit with families/whanau at times of stress makes me ask the questions – what effect is the stress having on the families, and in particular teenage parents, and how does it affect their life? What is it like for young mothers having a baby in the neonatal unit? Naturalistic enquiry in qualitative research emphasises understanding the human experience as it is lived (Polit & Beck, 2006). For this reason my chosen framework for the research is phenomenology – the lived experience. What is the lived experience of teenage mothers in the neonatal unit?

PHENOMENOLOGY

Phenomenology has its disciplinary roots in philosophy, psychology and sociology and is concerned with the lived experience of human beings. Phenomenological inquiry seeks to understand and acknowledge the concept that people are physically tied to their world by how they think, see, hear, feel and are conscious through their bodies' interaction with the world. Phenomenology is as much a way of thinking or perceiving as it is a method (Streubert Speziale & Carpenter, 2007). The primary objective is the direct investigation and description of phenomena as experienced in life by using the practice of phenomenological reflection and writing to understand the forms of life (van Manen, 1997).

Phenomenology as a philosophical movement has its origins in Greek philosophy. The modern phenomenological movement was founded in the early 20th century and is credited to the German philosopher Husserl (1859-1938). He first established phenomenology as a kind of descriptive psychology and later as a transcendental and eidetic science of consciousness. He described human beings as subjects in a world of objects and it was the study of consciousness of those objects that he called phenomenology. His philosophy emphasised descriptions of human experience – careful descriptions of everyday life – a description of “things” such as hearing, seeing, believing, feeling, remembering, deciding, evaluating, as people experience them. This descriptive phenomenology, as developed by Husserl, asks the question: What do we know as persons? Descriptive phenomenological studies often involve the following four steps: bracketing, intuiting, analysing and describing. Husserl aimed to separate out

(bracket) mood, thoughts, memories, and emotions – preconceived beliefs and opinions – about the phenomenon being studied. Reflexivity in the effectiveness of the bracketing, through evaluation and systematic feedback, is important and reflexive journals are often maintained by researchers. Intuiting occurs when researchers remain open to the meanings attributed to the phenomenon by those who have experienced it. Phenomenological researchers then proceed to the analysis phase (extracting significant statements and identifying essential themes). The describing occurs when researchers come to understand and define the phenomenon. (Polit & Beck, 2006; Schneider et al., 2003; Streubert Speziale & Carpenter 2007)

Heidegger (1889-1976), a pupil and colleague of Husserl, criticised Husserl's epistemological theory of phenomenology. He questioned the relationship between consciousness and objects. He argued that people do not relate to their worlds in a theoretical way, but as concerned human beings, historically situated with many more ways of relating to their worlds than 'knowing'. Heidegger described the mode of being using the German verb 'dasein' meaning 'to exist', 'to be there', 'to be here' and referred to both the human being and to the type of 'Being' humans have. People are aware of their own existence and question what it means to be. They question the meaning of their experience of being and can thus interpret their worlds. The world is not made up of objects but of a context with meaning (Heidegger, 1927). Heidegger's 'hermeneutic circle' describes the historical, cultural and personal preconceptions from which understanding is developed. However, the hermeneutic circle is not a static entity; it is dynamic. He believed that life as lived now cannot be divorced from the historical experience of living a life and the potential for that life in the future. He described this as temporality which is intrinsically involved in the meaning of life experience (Schneider et al., 2003). One of the differences between descriptive phenomenology of Husserl and interpretive phenomenology of Heidegger is that in the latter, bracketing does not occur. According to Heidegger, it was not possible to bracket one's being-in-the-world.

The French school of phenomenology evolved during World War II. Key figures in this era were Gabriel Marcel (1889-1973), Jean-Paul Sartre (1905-1980) and

Maurice Merleau-Ponty (1905-1980). Sartre was more interested in the practice or method of phenomenology than its theory. His goal was to balance objectivity with subjectivity to more fully understand essences as described by Heidegger. Merleau-Ponty wanted to show that a science of human beings was possible and that a phenomenological approach added valuable insights to positivistic understanding. He believed that human existence is imbued with personal sense and experience; and perception was the access to human experiences. Hermeneutic or interpretive phenomenology supports the idea that all experiences are mediated by interpretation and understanding involves an exploration of language. The French phase influenced psychology and psychiatry. Phenomenological descriptions were used to assist in understanding patients' realities. Nurse theorists stress that understanding patients' perspectives is central to providing individualistic and holistic care (Dinkel, 2005; Streubert Speziale & Carpenter, 2007). Thomas (2005) discusses the appropriateness of Merleau-Ponty's philosophy in nursing as she sees that only in existential phenomenology has emotion been given a central place in human existence. Heidegger focused on the abstract nature of being, whereas Merleau-Ponty was concerned with a science of human beings. The specific aim of his phenomenology was to give a direct description, not a causal explanation, of experience. "He urged us to be astonished by the world, to see it with open and wondering eyes" (Thomas, p.65). Thomas concludes that she finds phenomenology transformational for those who practise it.

As phenomenology became more popular in nursing research there was much discussion on the interpretation of phenomenology as a methodology. While phenomenological assumptions are congruent with principles of holistic nursing, interpretations of the various forms of phenomenology have lead to controversy Crotty (cited in Barkway, 2001) argued that this nursing research was a subjective description of the phenomenon rather than a critical examination of the phenomenon and not in the philosophic tradition of phenomenology. Thomas (2005) also argues that phenomenological nursing research could be strengthened by greater attention to its philosophical underpinnings. She goes on to say that many research reports devote more page space to procedure than to the philosophy that purportedly guided it. Dreyfus (1994) found that nurses, who

studied in his courses in interpretive methodology for the human sciences, did not have the usual philosophical background, but discovered new ways of describing and understanding what it means to be human being, who is finite and always situated in a world with a history and concerns. van Manen (2002b) states that phenomenology continues to evolve. He encourages human science scholars, who are primarily interested in applying phenomenological method to their professional practice or to aspects of their life-world, to take an eclectic approach to the tradition of phenomenology. He describes the phenomenology of practice that could also be called experiential phenomenology, life-world phenomenology, or applied phenomenology. He continues by saying that professional practitioners tend to be less interested in the philosophy of phenomenological method than its practical application. Benner (1994) challenged her readers “to consider the power of understanding for becoming more effectively, skilfully, or humanely engaged in practice” (p. xv). She described interpretive phenomenology as a relatively new research tradition within nursing, nursing ethics, health and illness.

As described in chapter one, my personal philosophy is based on caring and the desire to continually improve my knowledge and skill. To work with mothers and their babies and to be able to form a therapeutic relationship with them I need to understand what the experience is like for them. Phenomenology is a research method that seeks to understand the life world, in this study, of teenage mothers in the neonatal unit. I chose phenomenology because when research is undertaken in a sensitive and reflective way, it is a caring act (van Manen, 1997).

METHOD

Phenomenology as a research method is a rigorous, critical, systematic investigation of phenomena. van Manen (2002) states that phenomenological inquiry methods cannot be formalised into a series of technical procedures. In his book “Researching Lived Experience” (1997) he describes six research activities involved in the interpretive phenomenological research and suggests that one may work at various aspects intermittently or simultaneously. These six activities will be summarised in this section and there will be further discussion around other aspects of the research framework including the role of the researcher, the participants, and data collection and data analysis processes.

The research activities involved in interpretive phenomenological research, as described by Van Manen (1997) are as follows.

1. Van Manen (1997) suggests that every phenomenological inquiry is driven by a commitment to investigating something that concerns us. Turn to the lived experience which is of serious interest and formulate the question to be asked. Clearly identify the phenomenon. It is suggested that the researcher become totally involved in the phenomenon under investigation so that biases, beliefs and assumptions are acknowledged (Dinkel, 2005). Clancy (2007) suggests that participants are more likely to share their experience of the phenomenon because of the researcher's own experience and expertise and goes on to suggest that the researcher, recognising their own experience, can contribute to the value of the study.

The lives of teenage mothers and an understanding of their needs are of particular interest to me working with parents in the neonatal unit. What is the lived experience of a teenage mother with a baby in the neonatal unit? The phenomenon to be investigated is "being a teenage mother in the neonatal unit"

2. Investigate the lived experience by exploring the phenomenon. Generate data by obtaining experiential descriptions from participants. The researcher needs to live the experience through the participants to fully understand it (van Manen, 1997).

3. Engage in phenomenological reflection, which involves conducting thematic analysis, uncovering thematic aspects in life-world descriptions, isolating thematic statements, composing linguistic transformations, and gleaning thematic descriptions from artistic sources. Consult the literature including phenomenological studies that may give insight and help with interpretation (van Manen, 1997).

4. Engage in phenomenological writing, which includes attending to the speaking of language, use of words. Phenomenology is the application of language and thoughtfulness to an aspect of lived experience. The text should be rich and true. However, it is only one interpretation and no single interpretation of human

experience will ever exhaust the possibility of yet another complementary, or even potentially richer or deeper description (van Manen, 1997, 2002b).

5. The researcher must remain strong and focused to the phenomenon. It is easy to become side-tracked or lose direction and become involved in preconceived opinions and speculations. To be oriented to an object means that the researcher is animated by the object of the investigation in a full and human sense.

6. As van Manen (1997) describes the sixth activity as balancing the research context by considering parts and wholes. The researcher can become so involved in one aspect of the phenomenon under research that the whole picture of the total work becomes hidden. It is important to occasionally take a step back and view the total piece of work and clearly identify how each part fits in the complete picture.

The role of the researcher.

Schneider et al (2003) state that the researcher should have an attitude of care and it is because of the interest in, and concern about, the phenomenon, that the research occurs. The researcher is the data collector as well as the creator of the analytic process and therefore, the researcher's training, qualifications, and experience are important in establishing confidence in the data. Before starting a qualitative study, it is in the researcher's best interest to make clear his or her thoughts, ideas, suppositions, or presuppositions about the topic, as well as personal biases. This activity brings to consciousness and reveals what is believed about a topic. Thus the researcher is in a better position to approach the topic honestly and openly (Streubert Speziale & Carpenter, 2007).

I am a novice researcher and chose phenomenology because it fits my personal philosophy of caring as described in chapter one. I work as a senior member of the nursing staff in the neonatal unit. This I consider to be a strength as I have the skills and experience to work closely with teenage mothers and gain their trust. I have a particular interest in adolescence and particularly adolescent pregnancy. I have a good understanding of the neonatal environment and I am also in the

position to manage any criticism of the organisation that may have evolved, and make changes and improvements if necessary.

The selection of participants.

Phenomenological research is an interactive involvement of both the researcher and the research participant. Participants are chosen because of their experience of the phenomena being studied and because of their ability to articulate the experience (Schneider et al 2003; Streubert Speziale & Carpenter 2007). van Manen (1997) suggests that to gain a rich account of the experience immediacy is necessary. However, sensitive to the possible vulnerability that the young mothers may have experienced, having had a baby in the neonatal unit, I wanted to give them time and space to adjust to being at home with baby. Having time to reflect on their experience, I hoped that the young mothers would be able to be open and honest in their accounts. In this study I invited teenage mothers (16 – 19 years of age) who had spent at least one week with their baby in the neonatal unit in the previous 12 – 18 months, to take part. Seven days in the neonatal unit would provide the mother with the experience of the acute illness, progress to wellness and preparation for and discharge home. Mothers whose baby had died were excluded. An initial approach was undertaken by an intermediary – the Neonatal Homecare Nurse, who extended an invitation to participate and provided a letter of invitation and information leaflet. Those participants, who were willing to take part, contacted me through phoning or texting. I had hoped to recruit five participants. However of the thirteen young mothers identified, only eight fitted the criteria and four of those agreed to participate. Maggs-Rapport (2001) discusses sample size in terms of two criteria: the depth of the experiential knowledge available and the pragmatic evaluation of the time and effort needed to undertake a particular piece of research. Mapp (2008) suggests that the sample size needs to be small so that each experience can be examined in depth, mindful that transcribing and interpretation will take time. Four participants were recruited for this study. Although it was a small sample, it would give enough detail to gain data for analysis. It was acknowledged that claims, though modest, would add to the body of knowledge with the potential for a larger study in the future.

Information and consent.

“Informed consent means that participants have adequate information regarding the research; comprehend the information; and have the power of free choice, enabling them to consent voluntarily to participate in the research or decline participation” (Polit & Beck, 2006, p. 93). The letter of invitation (Appendix 1, p. 91) and the information leaflet (Appendix 2, p. 92) provided introductory information around the purpose and scope of the research; the interview process and how the information would be used. The researcher spent time at the beginning of the interview, answering questions and providing clarity before the consent form (Appendix 3, p. 94) was signed. Informed consent was obtained, confidentiality was assured, permission obtained to audiotape the interviews and to publish the findings, before the interviews proceeded. Ethical considerations around informed consent are discussed later in this chapter.

Data collection.

Phenomenology is based on acceptance of language as the only tool with which to develop a shared world of meaning (Schneider et al, 2003). Phenomenology investigates the lived experience by exploring the phenomenon – “being a teenage mother in the neonatal unit”. The phenomenological interview is a conversational process between the researcher and the participant(s). For van Manen, interviews have a dual role. They help develop conversational relationships about the meaning of an experience; and the data that is generated by participants’ experiential descriptions of their experiences and stories, anecdotes and examples enables the researcher to gather narrative material that will enrich understanding of the human phenomenon - an understanding of the experience as lived (van Manen, 1997). Successful interviewing requires engagement and sensitivity. Participants are ‘co-researchers’ who with the researcher jointly explore the participant’s experience and co-create a meaningful description. (Donalek, 2004). The conversation that emanates from the interview relationship provides a means of collecting descriptive material that can be used to understand and interpret the experience of the phenomenon. The interview material needs to be specific to the phenomena being studied and to contain sufficient material in stories, anecdotes and examples to provide the reader with an understanding of the experience as lived (van Manen, 1997).

The interviews were held in a location agreed to by the teenage mother – a place where she felt safe and where confidentiality could be secured. Mindful that the participants had a small baby to care for, the interview process was made as easy and comfortable as possible. The interview process was unstructured. The researcher engaged in conversation with the teenage mothers, inviting them to tell their stories by asking open ended questions – how did you feel when that happened?; tell me how you learnt; describe how you got on with the staff and other mothers.

The interviews were recorded. This helped to avoid the distraction of the interviewer taking notes and enabled her to interact with the participant. Reflective notes were made, particularly at the end of the interviews. This helped the researcher to identify strengths and weaknesses in the interview process and also gave some prompts which helped in the transcribing (Whiting, 2008). Each of the interviews lasted about one hour. I felt that this was long enough for a young mother with a young baby to be able to concentrate and take time out of her busy day. There was a natural conclusion to the interviews - when the information gathered was saturated – that is, repetition started to occur. The audio record of the interview was transcribed by the researcher. This helped the researcher in the analysis of the data as the language of the participants was used to reflect, as accurately as possible, the meanings embedded in the experience. The transcriptions also highlighted my inexperience as an interviewer. In one interview in particular, I seemed to want to ‘push’ the interview along, anxious to get information. The participant was also telling me how angry she was. This I didn’t hear at first, or if I did I became defensive. I will be able to reflect on this in future interviewing.

Analysis of data.

The taped interviews were transcribed, verbatim, into a printed form. These transcriptions were an attempt to reflect, as closely as possible, the experience of the conversations. The process of interpretation involves both an awareness of the pre-understandings that the researcher brings to the study and close reading of the text. The meaning or essence of a phenomenon is never simple or one-

dimensional. Meaning is multi-dimensional and multi-layered. The human science researcher is engaged in the reflective activity of textual labour. Reflecting on lived experience becomes reflectively analysing of the structural or thematic aspects of that experience (van Manen, 1997).

Thematic analysis refers to the process of recovering structures of meanings that are embodied and dramatised in human experience represented in the text. It is a complex “process of insightful invention, discovery or disclosure. Grasping and formulating a thematic understanding is not a rule-bound process but a free act of ‘seeing’ meaning” (van Manen, 1997, p.79). van Manen (2002b) describes taking a macro and micro approach to thematic investigation of a text – looking at the text as a whole, or by examining it line-by-line or phrase by phrase. Each selected sentence must be considered for the manner in which it is thematic of the experience under review. Themes are defined as “essential aspects of the experience that provide illumination and meaning” (Schneider et al., 2003, p.198).

Another step of inquiring into the phenomenon is to reflect on the literature. Phenomenological literature may contain material which has already addressed in a descriptive or an interpretive manner, the very topic or question that one is focused on. van Manen (2002b) debates whether one should review the literature in the initial or in the later phases of one’s research study. Whilst a wide search of the literature around parents in the neonatal unit, teenage parents and adolescence was undertaken, only a cursory review of the literature around parent experiences and teenage parenting was completed. This review showed the gaps in the literature around teenage mothers in the neonatal unit. However, to reduce the likelihood of developing suppositions or biases about the topic, this literature was put on one side to be reviewed as part of the data analysis. Further, by not developing preconceived ideas about the topic, I hoped to be protected from leading the participants during the interviewing process in the direction of the researcher’s beliefs (Streubert Speziale & Carpenter, 2007). The literature review conducted after the inquiry, as described in chapter two, was to prove to be helpful in supporting my findings and identifying themes.

Writing.

Phenomenological inquiry is practised as phenomenological writing. Creating a phenomenological text is the object of the research process. (van Manen, 1997). It is a creative process that reaches beyond narrative description to reveal meaning and understanding. (Schneider et al., 2004). The methodology of phenomenology requires a dialectical back and forth among the various levels of questioning. To be able to do justice to the fullness and ambiguity of the experience of the life-world, writing is a complex process of “rewriting (re-thinking, re-flecting, re-cognizing) (van Manen, 1997, p.131). van Manen (2002) continues by reminding one that no text is ever perfect, no interpretation is ever complete, no explanation of meaning is ever final or beyond challenge. The emerging narrative needs to reflect the context and time frame of the experiences, the understanding of the research, and the context of meanings contained in other sources (Schneider et al., 2003). The final document should be a rich text that describes the phenomenon in context and adds to the body of knowledge on the subject and inform practice.

Rigour and phenomenological research.

In order to contribute to knowledge, research must be scholarly and rigorous. Rigour and trustworthiness in qualitative research require credibility, dependability, conformability, and transferability (Schneider et al., 2003; Polit & Beck, 2006). Findings of the research are judged by participants and others within the discipline as being true. Researcher credibility is essential – that faith can be put in the researcher’s knowledge, application and experience or that the researcher identifies limitations. An audit trail is critical in establishing authenticity and trustworthiness of the data. The reader can clearly follow the line of thinking of the researcher used during data analysis. There are clear connections between how the research moved from raw data to interpreted meanings are made through clear examples. The final descriptions are prepared in such a way that the line of thinking and interpretation that occurred is clear to the reader and true to the data (Streubert Speziale & Carpenter, 2007). Rolfe (2006) emphasises the importance of reflexivity in assuring rigour of the research. He urges the researcher to leave an audit trail of the rationale, process, actual course of the research and ongoing self-critique and self-appraisal, including the moral, social and political stance of the researchers themselves. Watt (2007) maintained

a reflexive journal throughout her research which she found invaluable and enabled her to view her research holistically. I tried to keep a journal of reflection throughout and noted are my thoughts and feelings about the research and my progress in completing the study.

ETHICAL CONSIDERATIONS

Caring is the moral foundation of nursing. It is experienced rather than measured and defies a neat definition (New Zealand Nurses' Organisation, 2010). "Caring is about people. It is done with people, for people, to people and as people." (Tschudin, 2003, p.1.) It is a philosophical base for practice and has application in nursing research. In applying the ethics of care to nursing research, one must consider the concepts of compassion, commitment, competence, congruence, confidence, conscience, culture, collaboration, communication and consultation (NZNO; Tschudin.).

As a nurse undertaking research, I have a professional responsibility to have designed the project in a way that upholds sound ethical principles and protects human rights. These ethical principles include beneficence, respect for human dignity, and justice and attention to issues related to informed consent, participant-researcher relationships, gaining access, confidentiality and anonymity. The researcher must also remain open to the possibility of new and previously unexamined ethical concerns due to the dynamic nature of qualitative research (NZNO, 2001; Polit & Beck, 2006; Streubert Speziale & Carpenter, 2007; Tschudin, 2003) The Health Research Council (HRC) (2005) expects researchers to "conduct and report their work with objectivity and scientific honesty" (p. 8). As a registered nurse I am legally responsible to adhere to the Nursing Council of New Zealand (NCNZ) Code of Conduct (2012) and the New Zealand Nurses' Organisation (NZNO) Code of Ethics (2010).

The research proposal was submitted and approved by the Programme Committee at Waikato Institute of Technology (Wintec). Approval and support was sought, and obtained, from the researcher's employing organisation. Access was negotiated to facilities, records and statistics and support which were all important, as the research is about clients' experiences in one of the hospital's

facilities. Ethical approval was obtained from the Regional Ethics Committee and the Wintec Human Ethics Committee.

The Treaty of Waitangi and Maori cultural and ethical values.

Every endeavour was made to ensure that the research was conducted in a culturally safe manner, with respect to people of different cultures holding differing basic beliefs, different value systems and regarding differing modes of behaviour as acceptable and ensuring that I, as the researcher, did not impose my own values or beliefs. The Treaty of Waitangi is the founding document of New Zealand. The principles of partnership, participation and protection for all participants were considered and incorporated in the research proposal. Whilst this research is not specifically about Maori, or for Maori, a convenience sample was obtained by approaching Maori mothers along with non-Maori mothers. Participation was voluntary. The principle of partnership requires the researcher to work together with all participants, and for Maori, collaboration with iwi, hapu, whanau and Maori communities to ensure Maori individual and collective rights are respected and protected. Participation involves Maori in the design, governance, management, implementation and analysis of research. The principle of protection requires the protection of Maori individual and collective rights, Maori data, Maori culture, cultural concepts, values, norms, practices and language in the research process. (Cram, 2001; Health Research Council, 2005, 2008; NZNO, 2010.) The Chief Maori Advisor and the Maori Health Department for the District Health Board were given an outline of the proposed research and consulted for advice on the inclusion of Maori participants. The Maori Health Department, through their relationship with Te Whare Punganga Korero, offered support to the researcher through any consultation process with the local Iwi and also provided support both to the researcher and to Maori participants (personal communication, October 20, 2009). Whilst the inclusion of Maori in the research may have required extensive consultation and negotiation, to exclude these young mothers refuses them the right to be heard and participate in changing health practices.

Minimisation of harm.

Phenomenology was chosen as the research methodology to gain insight into the lived experience of teenage mothers. The nature of the enquiry was to search for truth and understanding from the perspectives of young mothers. Two of the most fundamental ethical principles applicable to research are beneficence and non-maleficence, which encompass the maxim 'above all, do no harm'. (Walker, 2007). The participant's sensitivity related to the experience and the researchers awareness that the interviews may raise very personal and sometimes painful memories must be carefully assessed and monitored (Polit & Beck, 2006; Walker). Whilst interviews may prove to be therapeutic and affirming to participants, they may also raise issues and emotions that could cause distress. Therefore, during interviews, I used my experience as an advanced practitioner in the neonatal field to monitor and recognise distress and respond appropriately. Interviews would have been terminated if necessary. Participants were asked if they wanted a support person available during the interviews and one of the participants had the support of the Maori Health Worker. The Social Work Team at the District Health Board were available for referral of participants and would offer counselling services and/or access to other appropriate services as needed.

Informed consent.

"Informed consent means that participants have adequate information regarding the research; comprehend the information; and have the power of free choice, enabling them to consent voluntarily to participate in the research or decline participation" (Polit & Beck, 2006, p. 93). Participants were given the minimum information about the purpose and scope of the study, the types of questions that would be asked, how the results would be used, and how their autonomy would be protected. I was also aware that because of the nature of the research, sensitive subjects may have changed the direction of the research or revealed information that was not related to the original purpose of the study. Information was to be sufficient to help participants decide whether or not they wished to participate (Streubert Speziale & Carpenter, 2007). Consent should be voluntary and be informed. Consent is voluntary only if it is obtained without coercion or force. Respecting the value of autonomy requires allowing people to make their own decisions about participating. It also requires that they know what they would be

getting into, so they would need to be given and to understand relevant information. With adequate information and ability to make their own choices, subjects' well-being will be advanced (Walker, 2007; Wilkinson, 2001). A further consideration is that the lived experience of those who are recruited to participate may render them vulnerable and less able to act autonomously. It is therefore imperative that the researcher avoids exploitation of people's vulnerability, and respects the individual's right to self-determination. (Walker.) To avoid coercion because of my position of authority, the Homecare Nurse initiated the approach to potential participants. A letter of introduction (Appendix 1, p.91) and an information leaflet (Appendix 2, p.92) was given to these young mothers. Once a young mother agreed to participate, a meeting was arranged for the interview to take place. At the start of this meeting, the information leaflet was explained fully and the study outlined, questions answered and if the participants agreed, the consent form (Appendix 3, p.94) was signed. A copy of this was left with the participants and the original retained with other research documentation in a secure file. Maori participants could choose to consult with Whanau, hapu or Iwi and that consent given via a kaumatua or other person of authority in the group if required (HRC, 2005).

Legal age of consent must be considered. The legal age for leaving school, living with a partner, leaving home without parental consent and the age of consent for sex is 16 years old. It is lawful to leave a 14 year old alone in your house and 14 years is the minimum baby sitter's age. For medical procedures and other health and disability services, the law sees children as individuals, and under the Code of Health and Disability Services Consumers' Rights there is no age of consent (cited in Johnson, 2004). This means that a child (or adolescent), as a consumer, is presumed competent until otherwise assessed and therefore has a right to make an informed choice, and give or refuse consent. In research involving children, the New Zealand Bill of Rights Act 1990 has a provision that every person has the right not to be subjected to medical or scientific experimentation without that person's valid consent, and if the subject is a child then parental consent should be sought (Johnson). Johnson continues by stating that ethics committees are trying to ensure that where research involves children and the child is competent to consent, the child makes the choice whether to participate or not. Adolescence is

a time of both increasing maturity and increasing risk taking. Adolescents are capable of making decisions, but tend to underestimate personal risk and vulnerability (Tillett, 2005). I see informed consent as a grey area for teenage mothers participating in research. They are legally responsible for consenting for treatment and health care for their children and I concluded that the teenage mothers could consent to participate.

Confidentiality and anonymity.

The principles of beneficence, doing good and preventing harm, applies to providing confidentiality and anonymity for research participants. Measures to ensure confidentiality of personal information includes secure storage of data and the use of a system of coding to protect the individual's identity during the process of data and subsequent publication of findings. Participants were assured that audio tapes were also stored securely until such time that the study is complete and can be destroyed (Polit & Beck, 2006; Streubert Speziale & Carpenter, 2007; Walker, 2007). Data is stored in a locked filing cabinet in the researcher's office. Participants chose the pseudonym by which they were to be known during the study. However, Tolich (2001) argues that even with complex processes in place to preserve confidentiality and anonymity of participants in research study, and ethical committees to ensure such processes are adequate, these can be undermined by "the smallness of New Zealand" (p. 10). Similarly, because of the nature of the research, one on one interviews with the participants, it is almost impossible to maintain anonymity at all stages (Streubert Speziale & Carpenter, Walker). As the research was conducted close to home and the sample is familiar to others, the details given in the rich descriptions that are the data may reveal research participants' identities. The researcher made every effort to ensure confidentiality is a promise kept.

Audit trails, commonly used to establish the confirmability of research findings, require that other researchers read the raw data. Participants were informed that this would occur within the context of analysing the data. Audio-tapes were transcribed by the researcher for two reasons, firstly to maintain confidentiality and secondly, as part of the reading and re-reading for analysis of the data, listening to the tapes was important.

The process of publishing may also result in a breach of confidentiality or anonymity (Streubert Speziale & Carpenter, 2001). The researcher must gain permission to use direct quotes and also ensure that examples of raw data will not reveal the participant's identity. This was discussed with participants during the consent process.

The researcher-participant relationship.

At the start of the research, the relationship between the researcher and participant is unequal. Professional stereotypes or prejudices may affect access to certain groups (Smith, 2008; Walker, 2007). In this research, I am a professional nurse who holds a position of authority in the neonatal unit. I probably would have cared for the family/whanau whilst they were in the neonatal unit. This may have some limitations on the relationship because of how the participants see me. However, it appeared to be a strength in that the participants knew me and that I have great experience and knowledge of the neonatal unit and neonatal nursing and have some understanding of their experience. It appeared that because they knew me from their time in the unit there was a trust between participant and researcher that may not have been there if the researcher was an outsider. The researcher is the tool for data collection and so comes to know participants in a personal way. It may have been possible for the boundaries of the relationship to become blurred which might have led to ethical concerns. The researcher's role must not be confused with that of a social worker, nurse or caregiver. The interview is not a therapeutic intervention (Eide & Kahn, 2008; Streubert Speziale & Carpenter, 2007). A short time was spent at the end of the interview to recap and debrief and identify any issues that may have needed follow up or referral. As a nurse I am responsible for protecting the health and welfare of those in my care, even if this isn't a truly nursing relationship. The District Health Board Social Workers had made themselves available for referral if this had been needed. If any issues around clinical practice within the neonatal unit or the care that they had received, these would have been referred to Customer Services at the District Health Board. I see teenage mothers as vulnerable in this relationship and ensured that I was aware and sensitive to their needs.

Authenticity of data.

Walker (2007) states that describing the experiences of others in the most faithful way possible is the most critical ethical obligation of the qualitative researcher. She continues by saying that in phenomenology, there must be a commitment on the part of the research to identify beliefs, assumptions and preconceptions about the research topic at the beginning of the study for the purpose of self-reflection and external review. This avoids influencing both the collection and interpretation of data. The researcher has an obligation to be truthful and honest in the data analysis and reporting of findings. I limited the reading of the literature to generalisations rather than specifics around mothers' experiences in neonatal units; teenage mothers impressions of care in maternity units and similar literature, to try and avoid any biases and to be open to hearing the teenage mothers' stories as accurately as possible. Participants were given the choice to receive feedback on the study in the form of a newsletter or report. A second person in this study, my supervisor, reviewed data and verified categories as a validity check (Streubert Speziale & Carpenter, 2007).

CONCLUSION

In this chapter I have explained why I chose phenomenology for this research. I described the historical and philosophical background to phenomenology and how I have tried to apply van Manen's perspective on phenomenological enquiry. The chapter also gave a description of the research method used – selection of participants, data collection, data analysis and ethical considerations.

Chapter four describes the experiences of four teenage mothers in the neonatal unit, as told by them. The chapter continues with a thematic analysis from which themes were identified through the thematic statements that were isolated.

CHAPTER 4: FINDINGS

INTRODUCTION

This chapter will describe the experiences of the teenage mothers in the neonatal unit as told by them. Four teenage mothers were interviewed and their interviews transcribed. These transcriptions provided the experiential data that through reading and re-reading, I have tried to live their experiences. I have endeavoured to be true in describing their experiences in the written word. A thematic analysis uncovered aspects in the life-world descriptions. Thematic statements were isolated and then I have endeavoured to write a true and rich text that tells the young mothers' stories.

Firstly, each of the participants is introduced before I continue to describe the themes as they emerged.

PARTICIPANTS

Four young women agreed to participate in this study. The length of time since their babies had been in the unit varied from four months to nearly two years. I will introduce each of the participants in the order that I undertook the interviews.

Sara-Marie, a New Zealand European, was 19 years old when she had Baby H. Although unplanned, once Sara-Marie confirmed her pregnancy, she was both pleased and apprehensive. She was living with her boyfriend in their own rented flat.

Sara-Marie agreed to participate in my research and chose for the interview to be held in her home and during the afternoon when she expected Baby H to be asleep. She welcomed me into her home, offered me a cup of coffee and a seat in her lounge. Baby H. was still up having just had a visit from his grandmother, and at times, his contribution to the interview can be heard on the tape. Sara-Marie was comfortable in her own home and calmly managed her active wee boy during the interview. She did not appear to be embarrassed or shy by me watching her with him. He played and explored the lounge as his mother

supervised him and interacted with him, during the interview. After a short while, he had a breastfeed and then went down for a nap.

Sara-Marie communicated openly in her interview. She had a story she wanted to tell. She was able to articulate her feelings, her experiences and observations very well. As I sat and listened to her story and observed her caring for her little boy, Sara-Marie appeared to be an extremely confident young woman – confident in her ability to be able to tell me how her experience was for her and what effect it had subsequently had on her; confident in her thought processes, decision making and actions that had got her to this point.

She shared with me the labour and birth, which was not how she had planned or hoped it would be. She told me that the effects of the pain relief, including an epidural, were such that she really did not remember his birth and that she was sleepy and unable to walk for a few hours afterwards. This sedation and immobility had an effect on her ability to be able to visit her baby once he was admitted to the neonatal unit at four hours of age when he was having difficulty with his breathing because of anaemia and was also becoming jaundiced to a dangerous level. She shared with me her feelings and experiences during the time that her baby was sick and described the changing experiences as Baby H became well and was able to be cared for by his mother. The interview continued through to how the new family experienced going home and how it was for them at home.

Sixteen year old **Rawinia** is a young Maori woman who had an extremely premature baby – Baby T. This was an unplanned pregnancy. Rawinia was living at home with her mother and younger brothers and sisters. Her extended whanau were supportive throughout her time in neonatal units – Rawinia and Baby T experienced three different neonatal units around the North Island. After his birth, mother and baby were transferred to a tertiary hospital and then to a second tertiary hospital before being transferred back to the regional neonatal unit where they spent a few weeks before going home. The other two neonatal units are included in her experiences as I believe it shows how Rawinia adapted to the different experiences and matured as a young mother that enabled her to cope.

Rawinia had clearly identified as Maori during her stay in the neonatal unit and subsequent care provided by the Homecare Nurse. She had been well supported by her whanau, some of whom travelled long distances to be with Rawinia and her baby. Rawinia had also received support from the Maori Health Unit at the time of birth and sudden transfer of mother and baby to a tertiary centre and also, later, when the family returned to their local neonatal unit. The Maori Health Worker was known to Rawinia, and once she had agreed to participate, I asked the Maori Health Worker if she would arrange the interview time and location. I thought it ethically and culturally appropriate to involve the Maori Health Department at this stage. The Maori Health Worker made contact with Rawinia and then went to her home, where she met with Rawinia's mother, before bringing Rawinia to a room in the Maori Health Unit where the interview would take place. The Maori Health Worker remained throughout the interview as both a support person for Rawinia and for me also.

During the interview Rawinia appeared shy and sometimes unable to express or describe her feelings or events. This may have been Rawinia's perception of me being in a more powerful position, being older, pakeha and a nurse who was the manager of the unit in question. It may have seemed that the environment and process were mine, not hers and that maybe she was under scrutiny. Also to consider at this time is the issue of whakama – used to describe the behaviour of Maori in a cross-cultural setting - sometimes expressed as feeling inferior, inadequate, with self-doubt, shyness, modesty and withdrawal (Sachdev, 1990). It may simply have been that she was young and shy. My questions were open, encouraging her to explore her experience and to try and share it with me. Sometimes she answered with one word – *“happy”*, *“sad”* and *“scared”*. But I also think that it was the unspoken word that loudly described how she was feeling and how she remembered different events. For example, when I ask her how she felt when she was taken to visit her baby for the first time, there was silence. As I quietly waited for her to speak I saw silent tears rolling down her face as she remembered. We stopped the tape and continued on only when Rawinia was ready. As she remembered happier times she became more animated and confident about telling that part of her story. She brought Baby T with her to the interview and he slept in his car-seat. After the interview, Rawinia asked if

she could go in to the neonatal unit to see the staff who had cared for her and her baby. This we did and she proudly showed off her beautiful healthy son.

Chrissie, a New Zealand European, invited me to her home for the interview. She was 17 years old when she had Baby P. A young single girl who found herself pregnant and who, with the support of boyfriend and both sets of parents, decided to continue the pregnancy and keep the baby. Baby was found to have a congenital anomaly that would require surgery after birth and for this reason, when Chrissie went in to premature labour; she was flown to a tertiary neonatal unit in the North Island where Baby P was born. After a very brief cuddle with mum, Baby P was transferred to the neonatal unit and he underwent surgery within hours of birth. Chrissie said that it was a shock to be transferred away from home. She had visited the neonatal unit at her local hospital, and that had made her feel more comfortable seeing the incubators, rooms and some of the equipment. She had expected to deliver at this hospital. During the interview, Chrissie described the loneliness and fear she experienced when transferred away from home without family support. She remembered being unable to hold her baby for so many days after her surgery. She transferred back to the local neonatal unit when Baby P had recovered from his surgery and was learning to feed. Mother and Baby P then spent two weeks in the neonatal unit as Chrissie become more confident in caring for her baby. Chrissie is a confident young woman who willingly shared her story and clearly articulated her experiences.

MaryAnne is an 18 year old European woman, living with her mother. Baby N was her second baby. She was not happy about the pregnancy, because she was not with the baby's father at that time. She described being "pretty sad" during pregnancy, because she had to go to [tertiary unit] for blood transfusions to her unborn baby and so was separated from her older child. She delivered Baby N by elective Caesarean Section, in local hospital and she told me "I prepared myself because I thought he was going to be dead". MaryAnne agreed to participate and the interview was held in her home, in the lounge where her mother, sister and her two sons were also present. MaryAnne and I sat on the sofa with the tape recorder between us and ignored what was going on in the background. MaryAnne was honest and forthright as she described the delivery of her second

child and the experiences she had whilst he was being treated in the neonatal unit. She had experienced some very strong feelings and had a story that she wanted to tell me. Someone was going to listen to her and hear her story as she relived it.

FINDINGS

The phenomenon under investigation is “being a teenage mother in the neonatal unit” and as I read and re-read, listened and re-listened, I identified three themes. There were two main themes – mothering and being in a ‘safe place’ and there was the third theme of the emotional roller coaster that each of the mothers experienced, and that ran as a thread throughout. Sub-themes emerged. Within ‘mothering’ I heard stories that described how the mothers experienced separation from their babies; how they bonded and connected with their babies and the ‘need to do’ mothering – the emotions and acts that they felt confirmed them as being a mother. Sub-themes of separation, the visiting mother, being a mother, family and friends and a safe place described the young mothers’ experiences.

THE EMOTIONAL ROLLER-COASTER.

As I read and re-read and then reflected on the interviews, I identified key words that described feelings or emotions and seemed to describe an experience that was like a roller-coaster ride for these young women – *happy, sad, heartbroken, stressed, cared for, frustrated, devastated, angry, nurtured, upset, depressed and safe*. The roller-coaster journey started dramatically for each of the mothers during labour, delivery and subsequent transfer of their baby to the neonatal unit. They each experienced a period of separation from their baby.

Separation.

The emotional journey for Rawinia was very much a roller-coaster ride. She told me she had been “*scared – when the baby was coming [prematurely]*”. I could imagine the fear of being in an unfamiliar place, in the middle of the night, experiencing the pain and worry of labour and birth knowing that it was too early for this little baby to be born. Baby was supposed to be safe inside mum’s womb for a few months yet. Rawinia was fearful for herself and fearful of the unknown. What was happening? What was going to happen to her baby? Would he be all

right? When I asked her how she felt when she first held her baby, her reply was a simple “happy” - said with a shy smile on her face, but I could see that this had been a very important moment for Rawinia as she described, “*the nurse wrapped him up on my chest*”. She described looking at and holding her newly born son and I could see a softness in her eyes as she remembered; her demeanour implied pride in becoming a mum and I sensed the joy she was feeling. However, shortly afterwards, as we talked about her baby being taken to the neonatal unit and the time that she went to visit him some time later, I asked her how she had felt and what it was like for her visiting him for the first time. There was a long pause and silence. I looked up and realised that Rawinia was quietly crying. Rawinia, head bowed and slumped had tears rolling down her face. She was back in that place remembering that night. Though no words were spoken, I could *hear* and feel her pain and sadness. I could see her sitting beside her fragile new born baby, who she had held and fallen in love with just a short time before, only to have him taken from her arms and placed in this foreign place. I sensed that she was remembering the fear and worry. I could feel the heartache and tension and anxiety as she tried to understand what was happening.

When I asked Sara-Marie to think about when baby first went to the neonatal unit and how she felt, about herself and about the baby, her reply was immediate, “*I was heartbroken. I was heartbroken he was there.*” She went on to describe her very difficult labour and delivery that did not go the way she had planned. She told me

I don't remember ... anything. I mean, I remember actually pushing him out and um, having him put on my chest, but then I passed out. So I never got that first... the first time with him..... And the next thing - they were coming to take him [to the neonatal unit]. Yeah, when they took him away I was devastated. I couldn't go with him because I couldn't walk. So that was all. Yeah – that was all hard.

Some very strong emotions were being expressed as she recalled the experience. A broken heart is a common metaphor used to describe the intense emotional pain or suffering felt when one loses a loved one, through death, break-up, moving, being rejected and in this case separation by Sara-Marie's baby being taken away

from her. *“Yeah, it was just not how I pictured it to go. Yeah, and I wanted my baby with me.”* What had she pictured? With baby growing inside her and feeling him move, had she pictured what he would look like? She would perhaps have undertaken the excited preparations for his birth and had probably imagined going in to labour, experiencing some pain, but proceeding to a normal delivery of a healthy baby that would not be separated from her at all. She may have pictured her baby dressed in his own, new clothes and tucked up in the crib beside her bed when he wasn’t in her arms. She would not have anticipated these hopes and dreams being dashed - the need for so much medication that she was unable to experience the joy of birth; or that her baby would be taken away to the neonatal unit before she had had a chance to see him properly and cuddle him. It conjured up a picture of Sara-Marie’s love for her baby being already firmly attached in her heart and I felt the tug in my heart as these ‘heart strings’ were pulled when her baby was separated from his mother.

MaryAnne described that during her pregnancy, she became quite depressed because she had to go away, to another city, for treatment for her unborn baby. She described how

he could have died even after he was born, so it was very hard. So I was depressed just right through once I was 20 weeks and found that he only had 20 per cent chance of living. I was depressed right through after that. ... And for the C section, I had prepared myself that he was going to be dead. So when he was born from C section, and I saw him, I broke down in tears because I thought he was going to be dead. I think it was kicking in.

This young woman had gone through her second pregnancy, so different from the first, and had been through a raft of feelings and emotions – the unexpected condition of her unborn baby that necessitated her being transferred away from her family and familiar surroundings to experience a procedure to try and save the baby but that in fact could have caused his demise. She had prepared herself that her baby might be born in the tertiary hospital, be transferred to the neonatal unit at that hospital and that he might not survive. She had developed a relationship with, and trusted, the medical and nursing staff that were caring for her there. She had visited the neonatal unit so that it would be more familiar to her. However,

she returned to her local hospital under the care of a new team of doctors and midwives and was informed that she would have an elective Caesarean Section. Because she had experienced the fear of losing her baby whilst she was in the tertiary hospital, and had now returned to her local region, she had lost hope of her baby being born alive. She protected herself from connecting with her unborn child and prevented herself from planning with hopes and dreams of what might be. She prepared for her baby to be born dead. So I can imagine the turmoil of emotions – joy, relief, disbelief, panic, fear, and hope – that MaryAnne probably would have experienced when her baby boy was lifted out of the womb and presented to her wrapped in a towel. *“Straight after the C section, when they were doing me back up, mum was holding him and he was laying there sucking my nose and stuff, so ... we started bonding straight away. It was quite nice.”* Then after half an hour her baby was *“rushed”* to the neonatal unit. She continued *“we were all allowed to go down with him, and then once the nurses and stuff, took over, we all had to go up to [the] room and weren’t allowed back in.”* When I asked her how it felt at that time, having had him and then having to lose him she replied *“Sort of pissed off. Really down because with my first son I was allowed him straight away and was allowed him always so ... being taken away from your child is really hard and upsetting.”* She continued

They told me it was going to happen but I didn’t ... I didn’t know how it was going to feel – until it happened. ... I had him around nine [in the morning] and I wasn’t allowed to see him again till about four or five in the afternoon.

How long this time must have seemed. As MaryAnne was recalling this experience she was upset and angry. MaryAnne was also on an emotional roller-coaster. There were ups and downs of emotions. The sadness and fear because she didn’t expect him to be born alive and then the joy and relief to be handed this little baby, only to have him seized from her arms when she was just getting to know him and rushed to the neonatal unit to be placed in an incubator and have monitors and tubes attached to him. When she could visit him all she could do was sit there with her hands in the incubator.

Chrissie described being scared and panicky during her labour. Frightened because she couldn’t feel baby moving and *“I thought [Baby P] was actually dead”*, until the midwives reassured her that baby appeared well but was coming

early. She was also frightened, because she was still a young teenager, and had gone to the maternity unit with only her boyfriend's little sister and was therefore without the support of her mother or boyfriend who were at work and unable to be contacted at that time. Chrissie's fear and anxiety were compounded by her being transferred, without family support, by helicopter, to a large tertiary hospital in a city that she had not visited before. *"No one could come with me, so I went by myself in the helicopter and my boyfriend had to drive up and I was there for a long time by myself and that was quite hard."* Chrissie was told that she would have to be transferred to a tertiary hospital, because her baby was going to need specialist neonatal care. When she arrived at this "massive" hospital, she was taken to and left in a room by herself. *"That was quite scary"*. Whilst she implied that the midwives had greeted her and taken her to her room she described it as being different. *"Yeah. It's definitely different to [local] hospital there. Quite – not in touch with you – more professional. Not personal."* I could see Chrissie, lying on a hospital bed in a clinical room, alone. I tried to imagine what she might have been thinking at this time – 'Am I going to be all right?' 'Is my baby all right?' 'What happens next?' 'Who is going to look after me?'

Chrissie went on to describe the care and attention she received as she laboured overnight. Her boyfriend arrived safely and was there at the birth of their son. She described the feeling of relief because labour was over. *"And then it was just weird, I can't even explain it. It's a weird feeling afterwards."* She told me that I would understand what she meant because I had had children. I tried to understand. Chrissie then had the disappointment of only having a short hold of her baby *"but it wasn't normal and it wasn't nice"* [because of the medical condition he was born with]. Disappointment because she wasn't able to do things in the way she had thought it would be if everything had been normal. *"You know, most mums have them cuddling and breastfeeding."* It seemed that her expectations, even though she had been fully informed about her baby's condition, and the reality as it happened were so different.

He got rushed off ... like, I got to hold him for ... like ... a minute. Then he was rushed off and I didn't get to see him. I went to sleep and then they took him off for his surgery. They tried to get me to see him before his surgery but here was some sort of complication, like, I don't know breathing or something

so I couldn't get to see him. Then I went to see him in the morning when [his operation] was all done and there were tubes everywhere and stuff. Yeah. I wasn't allowed to touch him for like 18 days or something. That was quite difficult. I think I was allowed to hold his fingers but I wasn't allowed to cuddle him or anything it was quite hard. (Chrissie).

It was several hours before Sara-Marie could visit her baby, because she had to wait until she felt well enough and for someone to take her in a wheelchair. She described how she felt when she first saw him in the neonatal unit.

Um ... I remember thinking, I knew he was safe, and I was satisfied with the care that he was getting, but I was just shattered and ...cords everywhere and I couldn't hold him or anything. And yeah ...he was in a closed-in incubator. So ...yep, that hurt a lot. And there was nothing I could do about it. I think the really good thing, when he was first admitted, when [Baby H's father] took him down, and they brought me up a pamphlet and within half an hour they had given me photos. I had photos straight away, so I remember that being really, really good, cos I read it in the pamphlet and just after I read it they brought in the photos. So, I thought that was really good.

Sara-Marie experienced the sadness and loss of being separated from her baby and appeared to get reassurance through the information leaflets she was given as well as the photos of her baby in the neonatal unit, so that she was able to gaze on them and see her baby. These items were a small step to connecting with him. She was happy to see photos of her baby but these feelings of joy were dashed again when she actually visited him but could not get close to him. He was separated from her by the Perspex walls of the incubator. There was an artificial barrier between her and her baby that was preventing her from making the re-connection with him. Her baby was in unfamiliar surroundings that were not of her choosing.

Each of the teenage mothers experienced wildly swinging and extreme emotions during their labour, birth and subsequent separation from their babies. Rawinia had been “scared” during labour; “happy” once baby was born and then was so emotional when thinking of that first time she saw him in the neonatal unit that she just cried silent tears. Sara-Marie was “heartbroken” that her baby was separated from her and Chrissie said of her first, short cuddle with her baby “it

wasn't normal. It wasn't nice". MaryAnne, having had a half hour to get to know her baby and start to bond with him before he was rushed away, was "*pissed off*" because she was not allowed to go down to the unit to be with him.

These young mothers all experienced fear and anxiety even before the baby was born and then to have baby taken away from them, to the neonatal unit caused more heartbreak and sadness. Hearing their stories I felt the loss and despair. They were bereft. I felt that these young mothers had all experienced symptoms and signs of grief when their babies were separated from them at birth or shortly afterwards. From my own experience I knew and felt the emotions of loss, despair, sadness and anxiety and physical symptoms of pain and tension that they were describing. Hard, sad, hurt, angry, heartbroken and devastated – as the young mothers used these words I could feel the tightness and pain inside and I felt really sad for them. It must have felt like their babies had been physically wrenched from them leaving them physically broken, crushed and with empty arms.

Connection and Re-connection.

Having heard the experiences of each of the mothers being separated from their babies I asked each of them at what stage did they feel that they had bonded, connected, become attached, fell in love, (or however it was described) with their baby? Was this during pregnancy, at the birth or some time later? And how did this feel? When did the connection, or re-connection, of mother and baby happen? Sara-Marie was quite definite. When talking about finding out that she was pregnant, she told me that her baby was "*so wanted from that first moment.*" She went on to tell me "*I gave up smoking then and that's it. I never had another one. I gave up everything for my pregnancy. I gave up coffee, everything.*" Sara-Marie saw it as being very important to be healthy and to care for her unborn baby. So for her, the connection occurred in utero. However, after the baby was born, she found it really hard to re-connect with him because of the nature of her delivery and subsequent separation from him as previously described.

MaryAnne has already told us that after realising that her baby was alive and well, she started to bond with Baby H during the short time she had him close after he

was born. *“Mum was holding him and he was laying there sucking my nose and stuff, so ... we started bonding straight away. It was quite nice.”*

Rawinia told me that she *“fell in love”* with her baby as soon as she saw him. Chrissie, however, having just a very brief cuddle with Baby P, immediately after birth, told me *“I thought you needed to bond straight away with baby, but it took probably a week, a couple of weeks.”* She continued

I think proper bonding with [Baby P] happened when we went home, properly, because you are in your own surroundings and you can just look at them and things. But I did bond with him [in hospital], not properly. Not properly – just cuddling him and ...

Each of the mothers had immediate contact with their baby shortly after birth. For Rawinia and Chrissie, this was a brief, tentative hold of their babies. Although it was a few hours before Sara-Marie’s baby was taken to the neonatal unit, she does not remember much about holding her baby or having him close to her in his cot. MaryAnne described the thirty minutes that she had her baby so close that *“he was lying there sucking my nose”*. However it was some time after this that they actually saw their baby again. During the six or seven hours that MaryAnne was separated from her baby, she was told that she wasn’t allowed to see him and when she did visit him after this time she continued *“I wasn’t allowed to feed him or anything. I wasn’t allowed to hold him for a few days, so I just sat there and had my hands in the incubator”*. Chrissie told me that it was 18 days before she could hold her baby. *“I wasn’t allowed to cuddle him or anything”*. So, with everything that was going on around them I still sensed that for them, that to be able bond and connect, or to retain bonding and connection with their babies, they had a need to touch; to hold and cuddle them. *“Being able to see him and hold his hands – just being able to touch him made me feel a lot better”* (MaryAnne). The need to just simply touch their baby’s hand produced a real longing deep inside them. Any physical contact with the baby would fill the need for that sense of touch. There was a frustration expressed in not being able to feel the warm, soft skin of the newborn baby; to stroke his hair and feel the shape of his head. They just simply wanted to cuddle their baby so that they would be able to see and examine their son – that little baby who was a mystery until such time as he was

born – the shape of his nose; colour of his eyes; colour of his hair and consider which family member he might look like. They wanted to be able to take in his smell and listen to his little snuffles; the way he breathed and even to hear him cry. *“The way I think is you’ve got to show your baby love so that they know you love them and hugging them is definitely a way to show them”* (MaryAnne). It was a mothering thing to do.

Sara-Marie told me

I think the big bonding thing for me, in my head, was that once he’s latched [for breastfeeding], everything will be OK. So that was something I pushed for a lot, and I was always saying that I wanted to feed him – ‘when can I feed him? When can I feed him?’ Cos he was having my milk through the feeding tube and everything, but yeah, I wanted him to latch.

So even though Sara-Marie was providing breast milk for her baby, it was the desire for skin contact and a real closeness as Baby H latched on to her breast and suckled the milk made especially for him by his mother that was so important to her. She appeared to need the intimate contact to re-connect with the feelings that she had had whilst pregnant. To feel him moving and for her baby to hear his heart beat.

I could sense that the mothers felt that the physical contact of skin on skin was the medium by which the connection and re-connection with their babies would occur. This connection, and re-connection, did not happen for these mothers straight away but over time as they were able to do mothering tasks.

THE NEED TO DO [MOTHERING].

I asked each of the young mothers to tell me when the moment was that they felt that they were a mother to their baby. I also asked them what it was like for them being a mother in the neonatal unit. I wanted to understand not just the emotions but how and what they associated with being a mother. Describing their experiences in the neonatal unit I found that the participants were describing what they did, or wanted to do, for their baby. The one that kept recurring was the need to hold their baby. Other words used were cuddling, feeding, making decisions – and the stories also revealed that in most cases, they had to seek permission for

doing those things that they would probably have done spontaneously if they were at home.

The visiting mother.

Being able to make independent decisions for their babies and to be able to act on their desire to care for them was also important. When I asked MaryAnne if there was any time in the neonatal unit that she did not feel in control of her baby boy, her reply was

Yes definitely. Most of the time... Just when I had to ask if I could touch my own child, and stuff, I felt that I wasn't the mother at all. It felt like I was asking one of my friends if I could hold their baby, basically.

She went on to say that changed "when I was allowed to hold him whenever I wanted."

I asked Sara-Marie whether she felt the lack of control over the care her baby received.

When he was really sick, I think I was probably glad not to have control over what was going on. I was happy that there were people who knew what they were doing and as long as I was informed, and I knew what was going on and why, that was ok. It was when he started being able to come out [of the phototherapy lights] and I'd say 'ok, I want to give him a bath' and they'd [the nurses] say 'well he's been out for 15 minutes and he doesn't really need a bath every day at this point'. And I would feel, well, I just wanted to bath my baby. That was the only ... yeah ... that was the only times I'd get frustrated with the lack of control. But I mean, there were reasons for it. I was just ... eager.

So Sara-Marie was eager to do things for her baby. She saw that the bathing would give her control over her decision making to do mothering tasks and she wanted the pleasure and enjoyment of bathing him and wanted to demonstrate that she was able to care for him.

Chrissie told me that she understood why she was not permitted to hold her baby for 18 days. She knew that because of his critical condition and all the intravenous lines, monitors, drains and ventilator tubing following his surgery,

that it was not feasible to get him out of his incubator. It was a difficult time for her. As she sat with him, beside his incubator, she was not even permitted to hold his hand but she did go on to say that after a few days, when he was less sedated and opened his eyes, she enjoyed him being able to see her. She felt she was making a connection with her baby when she looked in to his eyes. She told me

I think after a few days we got to change nappies. But that was about all. We weren't allowed to hold his hands, we weren't allowed to touch him or hold him. Not really any bonding. I can't even remember if ... I think he was unconscious for a few days and then he could look around a little bit, which was quite nice and looking at us at least.

Rawinia spent time visiting her baby and she would just sit beside his incubator to be near him. She told me that the nurses were helpful and *"they usually told me ... like what was going on and stuff ... yeah."* I asked if she had felt that she had been caring for her baby or was somebody else. She replied *"Like ... I was looking after him and stuff and so were they."* She told me that although she was used to handling babies as she has younger brothers and sisters, looking after Baby T was different *"Cos he was so little. And ... the other babies were little but he was ... different."* I understood from this that because of Baby T's prematurity and size, she was not confident in handling him initially because she felt that he was fragile.

Visiting baby and being with him was important to each of the mothers. MaryAnne told me about visiting her son in the neonatal unit. Initially, when Baby N first went there she told me *"we all were allowed to go down with him, and then once the nurses and stuff, took over, we all to go up to [the] room and we weren't allowed back in."* This was during a time when the doctors and nurses were undertaking various tests and procedures for Baby N. All this she understood. The nurses explained to her *"they wanted to do blood tests and all that ... and they wanted it sterile. They told me it wasn't a good time for me to go down there"*. It seemed like forever for MaryAnne and it was a long time from baby being born in the morning and then not being able to see him again until late afternoon. I asked her if she felt free to come and go to see her baby after this time. Her reply was *"Sometimes I wasn't allowed to but most times I could."*

MaryAnne was not in control here at all and I could sense the anger and frustration and could feel tenseness in my own body as I tried to understand what this had been like for her. She went on to say *“I wasn’t allowed to feed him or anything. I wasn’t allowed to hold him for a few days. So I just sat there and had my hands in the incubator.”* Whilst she had been informed of the reasons for these actions she still saw it as her right to be there. *“Every time I went to see him in the neonates, I wanted to hold him.”* As MaryAnne described this she appeared angry and frustrated. I pictured this young mother, sitting beside an incubator with her baby, isolated in a plastic box and his mother’s hand through one of the small ‘doors’ that enabled her to tentatively hold his tiny hand as he slept. I could feel the longing deep inside as she was trying to reach out and express love to her baby without being able to open the incubator and just pick him up and draw him in close. She was angry too, because she *“wasn’t allowed”* to do motherly things for him. I felt a tension in my neck and tightness inside as she tried to explain how it was. She appeared to understand the reasons and that the medical and nursing team were doing their best for her baby but it was still very difficult for her and she may have felt that the situation was being controlled by the neonatal staff because she was a young mother.

Sara-Marie found some confusion over the advice she was being given.

Every change over, all the nurses would do it differently. So, I get used to having particular nurses on and they ... you know like [would say] ‘cuddle him’ and ‘you can take him out for 15 minutes’ or ‘you can take him out for half an hour’. And other nurses would like, ‘well, no because he had 15 minutes this morning and he really, really needs it [the phototherapy], and if you think of it this way, the longer he stays in there, the sooner he’s going to get out’. So, I think that that was probably frustrating. Cos everything. So everyone does things differently, um and just getting used to how all the different nurses are. And some really encouraged me ... ‘you can’t spoil a baby – cuddle him as much as you can’. And others are ... ‘well, no, he’s asleep, so put him down’. I was a first [time] mum and I didn’t know who to look to. Yeah, that was all I was frustrated with.

Frustrated and confused, Sara-Marie was trying to do the best for her baby and trying to learn what was expected of her. Was she seeking approval from the nurses that she was doing mothering well?

Sara-Marie talked a lot about frustration. She was “*frustrated*” about not being able to cuddle her baby and about the conflicting advice she was being given. “*Frustrated*” was a word she used frequently and as she said it I could feel the tenseness and almost anger or impatience at not being able to do what she wanted. All Sara-Marie and MaryAnne wanted to do was to show their babies love and affection. I remember thinking that I was seeing these young mothers as having definite ideas about being a mum. It was instinctive for them to want to hold their baby whenever they could but they didn’t know the ‘rules’ of this foreign place or know how they should be.

It seemed that the young mothers felt powerless because they could not just ‘do’ what they desired and longed to do. I sensed, in the way they each told this part of the story that they felt they had to ask to do what they saw as mothering and indeed some of them said this explicitly. They wanted to hold baby; to bath baby; to cuddle or to feed him, just whenever they liked. Someone else had the power and control to decide if and when they could do these things. I think they each had in their mind an understanding or picture of what it would be like and what they needed to do. Three of the mothers had had previous experience with babies – either younger siblings or, as in the case of MaryAnne, has had a baby previously. Her desire to pick up her baby and cuddle him and show him off to family and friends, and not have him in a Perspex box as if he was something on show to all was palpable. I felt quite maternal towards these young mothers as I listened to their stories. I was quite proud of them and wanted to reach out and give them a hug. This shift of power and control between mothers and the medical and nursing team has been identified as a sub-theme and will be discussed further on in the chapter.

Being a mother.

The mothers each told me that once their baby came out of the incubator into a normal crib, they started to be able to do more for their baby and even more so

when they moved in to the rooming in rooms, where baby was with them all the time. *“I got sent home ... for a little while. Then a room opened up [in the unit] so I ended up going into the room. Later on that night I was allowed to have him [in my room].”* This is what MaryAnne told me, with much pleasure and excitement. I could see by her animation and smile on her face that this had been an exciting moment for her. At long last she had her baby in her room. She was alone with him with no observers and able to see him all the time, and give him the hugs that she needed to do to show him the love she had to give. She told me that she was happy being a mum and I asked her if she had needed any help in preparing to go home. *“I never done all those ... any of those mother classes”. “I already knew about never sleeping [baby] on the stomach and I knew how to bath because ... basically exactly like my older son. So the burping and feeding was all the same with him.”* I can remember feeling quite impressed by her confidence when she was in the unit and proud that she was doing so well.

Sara-Marie told me she was quite confident looking after her baby. She had a two year old brother and a baby sister and helped her mother to look after them. *“The only difference was that they were big, healthy babies and they were home within hours. My baby was little ... and fragile, so that was the only difference. But I think they’re still ... [the same].”* She told me that she had needed help with feeding. *“I had no problems with my milk, but, to get him to latch properly that was ... that was difficult and then I used the shield and that really helped. ... I was determined to breast feed.”* She also told me that because she had seen her mother ‘mothering’ she had developed some definite ideas around how she was going to care for her baby.

I don’t think I learned my mothering, I learned what I didn’t want to do. ... I had seen Mum so, you know, I had the ‘well I’m not going to it like that and ...’. You know, my baby is going to be woken to feed and he is going to sleep when he sleeps and he’s [she giggles], he’s going to have this routine and never mind this demand feeding. He will be woken. Because my ... I thought he was going to be a perfect little angel. You know ... I was going to have everything absolutely fine. And it doesn’t work out like that [laughing now]. They create their own little routine.

I shared the laughter with her. She was telling me that it had not quite worked out in the way she had expected. Although her baby had a routine in hospital, it all changed a week or two after going home. However, she loved being a mother and said

I loved the newborn stage. ... I just wanted him to stay a little baby forever. I loved the newborn phase. I dealt with that ... that was fine. I had no problems with that at all. No ... I love it. Yes, I certainly loved it.

As I listened to her, and watched her with Baby H, throughout her interview, I felt warm and soft towards her and felt a need to show her that I cared. I gave her words of encouragement and I knew it was important for her to know that she was doing a great job.

Chrissie told me that she started doing ‘mothering’

Once he came out of the neonatal unit, or the intensive care unit [at the tertiary hospital]. We went up to the baby floor where the mums are with all their babies. ... I got to hold him and I got to go into the room and breastfeed him, or try and breastfeed him, cos it was quite hard doing that at the start, for him.

I asked her when she transferred back to regional neonatal unit whether she thought it was the right place for her to learn to do ‘mothering’ and for getting ready to take her baby home.

Yeah. I think ... because I feel if I went home with a newborn, even if he was normal, it would be more daunting, sort of. You don’t know what to do. You know. They showed me ... I didn’t even know how to bath a baby or change a nappy. Yeah. They showed me all that. They showed me how to bath him properly and yeah, it was sort of like a kick start to be a mum. It was helpful.

Chrissie was a first time mother but had had little or no experience with babies and really needed to learn how to do mothering.

Family and friends.

I sensed that doing ‘mothering’ and being a mother for the young women not only included the cuddling, feeding and bathing but also sharing the experience with and being supported by their families. Each of them expressed that they had received comfort from having their boyfriend and/or mother with them during labour, delivery and the immediate postnatal period. Rawinia mentioned several

times that her family were with her and some had travelled long distances. They were supported during their time in the neonatal unit and then when they went home. All of the young mothers and their babies went home to their mothers' homes initially.

Rawinia told me she was "*happy*" when she was visiting her son and then "*sad*" when she had to leave him to go home. At this time I felt her being torn between her need to be with her baby but also her loyalty to her whanau. She told me that her grandmother had travelled some distance to be with her and that she chose to spend time travelling between seeing her baby and being at home with the extended whanau. Rawinia had to rely on a relative to bring her to and from the hospital, a distance of 20 kilometres.

Chrissie had a moment when she said she was "*overwhelmed*". She went on to explain. "*I think I broke down one night and I was crying because he wouldn't feed and it was just so stressful. I needed someone there to pat my back and say 'it's all right'.*" She continued "*They let my partner come and stay for one night, for support, which I really appreciated. Cos I needed that. I didn't think they would let him. I thought 'no', but they did.*"

Sara-Marie told me she also had a "*melt-down*".

The way I see it is that mothers get the third day blues and stuff but I didn't have my baby on the third day. My baby was in an incubator on the third day and the fourth day and the fifth day. So the second week, when I actually had him [in my room] was when I got my big ... hormonal eruption. I'm going to have to take him home and deal with him myself. And ... I wasn't so much worried about dealing with him on my own, I was just worried that he was more fragile than other babies. And I was just so worried that he was going to get sick or that something was going to happen. I just think the whole situation got to me. So I had that big 'I don't want to go home. I want to stay longer.' You know, 'I want to stay here forever' in the safety of the neonatal unit. But I got over that. The nurses were really good; as soon as I started having my little meltdown one of them came in and then got straight on the

phone without even asking me and got [her boyfriend] and Mum in straight away.

Both Chrissie and Sara-Marie needed their family close by and although they were challenged by the experiences, I felt they had a mature, inner strength and resilience. I had felt the strong emotions of joy and happiness, then heartbreak and sorrow that they had ‘survived’ and there had to be an outlet for all these pent up feelings. And then Chrissie and Sara-Marie both went through a particularly tough time and were comforted by their families.

Sara-Marie described the time when she was living in one of the rooming-in rooms. *“I was in my room most of the time ... reading and sleeping I think”*. She told me that she didn’t really interact with the other mothers who were staying.

I was the youngest of the mums that were in the neon [natal unit] at the time. ... I just preferred to keep to myself. They were all older and talking about different things and going through different things. ... My family was always with me. Someone was always with me pretty much.

Later in the interview, when she was talking about visiting in the unit,

That’s the only difficult thing about being ... [in the unit]. You know, if you were at home and people would be coming and fussing and being all clucky and things. But because you are there it’s ... I mean, you can still be clucky and people can be clucky but within certain hours and all those little stipulations, which you can understand but it is frustrating as a new mum wanting to show off her baby to everyone.

I heard Sara-Marie describing how she tried to connect with ‘normal’ things; with home and important people in her life. She described to me that she had a strong desire to show off her baby to these people, as a proud new mother. Chrissie expressed a similar experience as she talked about getting home.

It was good to be home with my family and [it was] comforting. You feel like you can bond with your baby more because you can cuddle him more and talk to all your family. Everyone can gush over him.

The need to do mothering was expressed in several ways. There was the bonding and re-connecting with their babies; the needing to do mothering tasks such as

feeding, cuddling and bathing; and then there was 'being a mother' – wanting to make decisions and also share the joy they felt with their baby to family and friends.

A SAFE PLACE

Parents, when they are expecting and planning the birth of their baby, would not usually consider their baby's admission to a neonatal unit. Most parents are unaware of the existence of the neonatal unit, unless they, or friends and family, have had babies there previously. It is an unfamiliar environment for most people. It is an intensive care unit with incubators, monitors and other technological equipment where premature or sick babies are nursed. Only two of the participants in this study had been alerted to their baby needing neonatal care. Both MaryAnne and Chrissie had visited a neonatal unit before their babies were born. MaryAnne had visited the neonatal unit in the tertiary centre where her baby had received in-utero blood transfusions and where she had been expecting her baby to be born. She had been prepared that her baby might need to be born by emergency Caesarean section during or after the transfusion procedure.

They take you into the unit and show you what a baby your ... the baby would be like - the same age as your baby. They showed us an actual baby. They asked the mum and dad if it was ok, and they show us the baby and say this is what will happen, this is how it will look and this is the size. That was really good. Being able to see the actual size your kid will be even if it might be smaller or bigger, it's still nice to see a baby around that size.

She went on to say that although she became familiar with incubators, tubes, monitors and what might happen for her baby, coming in to the neonatal unit in the local hospital was still a shock.

[The tertiary hospital] is a lot bigger. Heaps more nurses and stuff. I thought we'd have more nurses [in local hospital] ... They all told me it was going to happen but I didn't I didn't know how it was going to feel – until it happened.

Once her baby was born and she had become more familiar with her surroundings and the staff that were caring for him, she went on to explain “*It felt for me and my son that it was safe. For my son it was safe.... So I knew that if anything went wrong, no matter what, a doctor, someone, would come rushing to him.*”

MaryAnne was able to say this even when she had been very angry about not being able to hold him or touch him.

Chrissie described how, on the first scan she had, that she found out that her unborn baby had a problem that would require immediate surgery once he was born. Chrissie continued

...so I knew what I was going in for. Then I went for a tour, before I had [Baby P], of the neonatal unit in [local hospital] to see where everything was and to meet nurses and things. So I knew what I was going in for and it wasn't a sort of shock like some mums have.

Each of the mothers told me that they were anxious and frightened when they first entered the neonatal unit to visit their baby. Sara-Marie described being taken in a wheelchair, down to the neonatal unit, by her family.

Several times through MaryAnne's story she told me that she had not been allowed to go down to the unit to visit her son and she said *"I got very angry about that. I [was] really upset. [I was] crying my eyes out because I wasn't allowed to go and see him"*. She was angry and upset because the situation had been completely beyond her control and she was being separated from her baby but also understanding that her son required immediate medical intervention.

As the place, the routine and the people became more familiar it was easier and more comfortable for the mothers, and their families, to be there. They repeatedly told me that they were not allowed to do ... and even though they felt powerless at this time and there was anger and frustration, each of them told me that they understood the reasons. Sara-Marie, as previously quoted, said that she was happy that there was someone else in control that knew what they were doing in caring for her son. MaryAnne explained why she was unable to cuddle her baby boy *"yeah, cos of all the tubes and just in case they needed to do stuff to him. It's not that nice moving him around with those tubes [in case] they fall out and stuff."* And later on in the interview she elaborated on this *"... because if you rip them out, they're gonna have to get it put back in and you don't want to really put the baby in pain again"*. So even though she was angry about not being able to

cuddle her baby, she also accepted that the medical and nursing team were looking out for him.

The mothers all had differing experiences in the neonatal unit. Their babies were each admitted for a different reason. They experienced a wide range of emotions from “happy” to “sad”; “heartbroken” and “devastated”. Whilst they had differing experiences, all of the mothers described that being in the neonatal unit felt like being in a safe place. Safe because their baby was safe, being looked after by skilled staff, particularly when they were so sick and also safe and nurturing for themselves.

For Sara-Marie the neonatal unit was her “safe place” – safe because she came to trust the staff and the environment.

They [the staff] were all really, really good. When they were explaining things to us, you know they would explain it and then give us a chance to ask any questions. And then, you know, if we didn't understand something, they would go into more detail to make sure we knew exactly what was going on; and why this had to happen like this, and the outcome of it and everything. No. That was really, really good. We always knew what was happening and why and we were given an option of it too. It wasn't just 'this is what we are doing to your baby', it was 'can we do this?' and 'this will benefit him because ...'.

Despite the powerlessness she felt at times Sara-Marie's ‘safe’ was being able to place her trust in the people and the environment where her baby was. As she spoke about it I could sense that this trust lessened the worry and the physical anguish associated with having a sick child.

She continued

I found it [the neonatal unit] really, really nurturing. Really nurturing. I felt someone was looking after me as well and that people were concerned about my feelings if I wasn't ok. They weren't just going to help my baby they were going to help me through it. And I wasn't being rushed out of the door in any way, whatsoever.

I asked Sara-Marie if she had found the neonatal unit to be a stressful environment. She replied

Neonatal wasn't stressful Having people there to help you all the time if you need something and you know being able to just rest and having people tell you that you should be resting all the time. Yeah, that is not stressful.

As she was describing her stay in the unit, when she was living in one of the mothers' rooms, I remember a very vivid picture developing in my head as I was trying to understand how it felt for her. I could feel a warm, soft 'blanket' wrapped around me in this quiet, calm place and I felt protected. I explained to Sara-Marie that I visualised this place she described, being like a nest – soft and supportive and asked her if that was what I was hearing from her description. She told me that it definitely was for her. I really did conjure up a picture of a large round nest, lined with soft, cotton wool that enveloped mother and baby and where there was security and nurturing. For Sara-Marie, 'safe' was also being nurtured; being cared for and understood.

I loved it there. I mean...after I left, even when he was a few months old, and he had got sick, it was the neo [natal unit] that I called first. That was my safe place ... and I knew that they would check my baby and look after my baby, so even though I wasn't there, my first instinct was to call 'neonatal'.

The neonatal unit was a place of safety that Sara-Marie knew and trusted, and the people there knew her and her baby.

As Chrissie described returning to the local hospital she told me

It [the neonatal unit] had a nice, homely feel; I suppose it's not like a big hospital. The nurses were really lovely. They all welcomed ... I came really late at night and I thought they would be a bit, like, grumpy, but no they were lovely. And they gave me another big tour and showed me everything I needed and came and had a big chat with me about how things were going to happen with [Baby P], with feeding and that. I just feel, when you have a sick baby it feels safer there. You know, nurses are always there to help you. It felt safe.

Chrissie appeared surprised at the welcome she and her baby received after their long journey from the busy, tertiary unit and the nervousness and fatigue of having to come in to a new place. She was welcomed and made to feel

comfortable. This would have been reassuring for her. In a place she had only seen briefly, before, on her visit prior to her baby being born. She had been through a lot since then. Chrissie was shown where her baby was going to be cared for and she told me that just across the corridor was her bedroom, with a big soft divan bed in a room by herself where she could be herself and learn to look after her baby. For Chrissie, her 'safe' was being welcomed home. Like arriving back home after a journey that has had a few stops and starts; detours; a few breakdowns or cancellations on the way; and you finally arrive, travel weary, at your destination to find that they are expecting you and have the home warm and well lit, food on the table and a soft bed for you to sleep in.

As Rawinia described her time in the tertiary unit she became more animated and confident. She told me that she and her boyfriend stayed in the hostel close by to the hospital and

We went out to do heaps of fun stuff while we weren't looking after him. We got to go and see him anytime we wanted. So we would go up and stay with him till three in the morning sometimes. And then go back and go to sleep, go out and ... stuff and then go back and visit him again.

She appeared to have been comfortable and trusting of the neonatal unit where her baby was and felt that she could leave him in their care and return whenever she wanted to.

Within an environment where the mothers experienced heartache, worry, frustration, confusion and anger, each of them described it as caring and nurturing and that it was a safe place to be. Despite issues around loss of power and control, they each experienced safety. Their baby was safe and that was important.

CONCLUSION

This chapter has introduced the participants in the research and their experiences of being teenage mothers in the neonatal unit. Three themes emerged. The need to do mothering and a safe place were the two main themes with the third theme of the emotional roller-coaster running throughout. Sub-themes of separation, the visiting mother, being a mother, family and friends and a safe place emerged as

part of the young mothers' experiences. Chapter five will discuss the findings and compare or contrast the themes with the literature.

CHAPTER FIVE: DISCUSSION

INTRODUCTION

The use of phenomenology for this study produced rich descriptions of the phenomenon 'the experiences of teenage mothers in the neonatal unit'. The mothers' stories of what it was like for them were coloured with strong emotions. The thread of the emotional roller-coaster was evident throughout. It also appeared that whether the story was told four months or two years after the event, the emotions felt, particularly when the mothers had been separated from their babies, remained very powerful. The experiences were still very real and alive. The mothers expressed the emotions they were feeling through tears, their tone of voice, use of words and their demeanour, as they remembered their experiences. I saw and heard anger, sadness, frustration and quiet reflection. For three participants, once the interview started, the narratives just flowed with great detail and enthusiasm. For Rawinia it was more difficult because the emotions were still so deeply felt. This suggests that the neonatal experience was critical experience for the mothers, that remains with them. This study supports the findings of similar studies of mothers' experiences in neonatal intensive care units and perhaps suggests that teenage mothers share many of the experiences of older mothers in this context (Wigert, Johansson, Berg & Hellström, 2006).

As I was writing the chapter on my findings I had to reflect again on the personal view of teenage mothers I had prior to undertaking this study. When my own daughters were teenagers, completing school and going on to gain a university education, my view was that teenage mothers had limited their future, become dependent on welfare and were going to experience challenges in their life if they were to succeed. Reflecting on the experience of caring for them in the neonatal unit over recent years changed my view. I discovered that for some young women mothering came easily. Motherhood was the life path they had chosen and with support from family, health professionals and/or social services, they were making a success of parenting. I had also thought that they needed help, advice and parenting skills education because they were young. I observed them sitting quietly with their babies and believed them to be naïve and vulnerable. Yet, for some teenagers mothering is a restorative process that allows them to forge new

identities and fosters aspirations of becoming more responsible and mature as they develop in their role as a carer to their infant (Maxwell, Proctor & Hammond, 2011; SmithBattle, 2000).

Overall, the findings from this study demonstrate that the experiences of the four teenage mothers interviewed are comparable to older mothers' experiences as described in the literature. The participants described similar journeys through the neonatal unit and expressed similar needs.

EMOTIONAL ROLLER-COASTER.

I have seen all mothers experience the ups and downs of having a baby in the neonatal unit. I have heard myself talking with parents and explaining that sometimes it seems like two steps forward and one step back. The emotions experienced by mothers are well documented in the literature. Parents experience disappointment, guilt, sadness and depression, hostility and anger, anxiety, helplessness, grief and loss of self esteem (Jackson, Temestedt & Scholin, 2003; O'Haire & Blackford, 2005; Pearson & Anderson, 2001; Shields-Poë & Pinelli, 1997; Wereszczak, Miles & Holditch-Davis, 1997). Whilst I know and understand these experiences, my findings of the extreme and dramatic way the young mothers expressed their emotions was new. They spoke using very strong words as they described how they had felt in the neonatal unit – devastated, heartbroken, angry, "*pissed off*" as well as sad and "*it was hard*". Silent tears coursed down Rawinia's face. I think it would have been hard for any nurse not to empathise with these mothers in the neonatal unit and realise they were experiencing quite extreme 'ups and downs' in their emotions.

What effect did the emotional roller coaster have on these young mothers? Did it have an affect on the way they did, or did not, make good relationships with the nurses and doctors during their baby's stay in the neonatal unit? The relationship between nurses, doctors and the teenage mothers will be discussed later in the chapter. However, childbirth can have a traumatic impact on the psychological wellbeing of all mothers, to a lesser or greater degree. Anderson and McGuinness (2008) found that the event of childbirth can be traumatic to teenagers, resulting in posttraumatic stress or postpartum depression. The experiences of possibly losing

their baby and the birth being an emergency procedure in a strange and alien environment are traumatic events, as MaryAnne and Sara-Marie attest to, and would have had a much more profound effect. MaryAnne stated that she was depressed during her pregnancy and for a while when she was visiting her baby in the unit. However, once she was able to fully care for her son and once she got home, she appeared to recover well. Sara-Marie however, shared with me that she had to seek help in the months after birth and had been counselled for Post Birth Traumatic Stress. She was recovering well when I interviewed her. It is not clear how much assessment, if any, they had had in terms of vulnerability to post partum depression. However, it has been shown that such an assessment and overall concern for the wellbeing of the teenage mother, and her family, may help diminish the psychological sequelae of childbirth (Anderson & McGuinness).

Did the mothers find it therapeutic to talk about their feelings and emotions in the interviews? Did they use language that they thought would make me sit up and listen? MaryAnne certainly did and I did not hear her anger straight away, or if I did hear it I was unsure what to do with it. Each of the mothers told me that they had experienced complexity of feelings and emotions. They talked about being scared, frightened and anxious before the baby was born; happy on seeing their baby for the first time; feeling devastated, heartbroken and sad when separated from their newborn baby; angry because they couldn't hold their baby; acceptance that the baby was safe because of the care and explanations given by the nursing and medical team to who they had entrusted their baby; and the feeling of love towards their baby as they began to care for them. A study by Fenwick et al. (2001) showed that when a mother is denied the opportunity to mother her child she is left confused and anxious. Conversely VandenBerg (2000) found that mothers received positive feelings when they were supported in undertaking the smallest of care activities for their baby.

A lot of the interview was centred on the pregnancy, labour and delivery and subsequent separation. There was anxiety, anger, worry, heartbreak and a sense of not belonging, to the postnatal ward or the neonatal unit, when mothers were separated from their baby. Wigert et al (2006) describe mothers' feelings of exclusion at this time and that when mothers are nearby, breastfeeding and taking

care of their infant's daily needs, there was a feeling of participation. I felt that once the teenage mothers described becoming involved in their babies care and decision making; and being a mother, the emotional roller-coaster ride became smoother. They became calm as the interview progressed and they recalled their experiences of progress with their baby.

I believe that most neonatal nurses are aware of the emotional roller coaster that mothers, and fathers, experience when they have a sick baby in the neonatal unit and it has been well documented in the literature (DiMenna, 2006; Harrison, 1993; Hughes, 2007; Thomas, 2008). Time must be taken to plan care of the baby with the mother, and father, and at the same time have an awareness of how the mother is emotionally to ensure she is both fully informed and supported at a difficult time (Conner & Nelson, 1999; Holditch-Davis & Miles, 2000; Thomas; VandenBerg, 2000). It is common practice in our unit to introduce all families to the hospital social workers, so that they can develop a relationship, with mothers especially, and are able to provide timely counselling if necessary. Each of the mothers I interviewed had contact with a social worker during their stay in the neonatal unit and Rawinia also had support from the Kamahi Hauora (Maori Health Worker).

Separation

The first big dip on the emotional roller-coaster appeared to occur at the time that the young mothers were separated from their newborn babies. Each of the babies needed special care in the neonatal unit. For many mothers, the attachment and bonding process begins at the time that they find out they are pregnant. The woman becomes attached to the idea of being pregnant and gradually develops an attachment for the child inside her. An interaction between mother and her unborn child develops at a cognitive level (Wigert et al, 2006). Mothers become attuned to the growing baby inside of them and some start dreaming, anticipating and thinking about what might be once baby is born (Figueiredo et al., 2009). For the teenage mothers in this study, connection had started during pregnancy. MaryAnne, however, also experienced the anxiety that her baby would not survive and I think she tried to protect herself through not becoming attached and believing that her baby would be born dead. They all experienced fear and worry

during the labour and delivery and then relief and happiness as they held their baby for the first time. These emotions were quickly exchanged for fear, heartbreak, devastation, sadness and anger as a result of mothers being separated from their babies without having had a long enough period of physical contact. They were really hurting. When I asked Rawinia how she felt when separated from her baby, her response was very clear. As she relived the experience she silently cried and the distress that she felt recalling this time was palpable. Separation from the child was found to be the most difficult aspect for mothers when their baby was admitted to the neonatal unit. The literature describes the emotional strain for the mother being left outside of care of the baby with feelings of despair, powerlessness, homelessness, lack of control and disappointment (Tran, Medhurst & O'Connell, 2009; Wigert et al, 2006).

The length of time that the young mothers were separated from their baby and not allowed to visit was significant. How did each of these mothers perceive time? For Rawinia, she held her baby for a short time and then he was whisked away in an incubator and she appeared to be very sad as she was crying when she remembered visiting him a short while later. However, for each of the other young mothers, they were not allowed to see their baby for several hours. For Sara-Marie, she found the commentary and photos that her aunt was able to give her as the doctors were undertaking various procedures, kept her fully informed and she understood what was happening. This was so different to MaryAnne's and Chrissie's experiences, who were just told that they were not able to visit their baby because they were being treated by the medical team. How frightening this would have been, waiting for what seemed like all day, when they could not imagine what was happening and why. I noticed in the interviews that the descriptions of labour and delivery and the first few hours that their babies were in the neonatal unit were very detailed minute by minute, hour by hour. Time for them was in the moment during this early time. The mothers told me that the doctors and nurses had explained what treatments and procedures their babies were receiving but the neonatal unit, with the sights, sounds and routines; and all of the technical equipment, was a totally unfamiliar place. This waiting time would have been like holding one's breath and waiting for everything to be all right whilst in complete contrast, time appeared to be speeding by for the medical

and nursing team, undertaking routine and very familiar procedures in a swift and methodical way.

Once the young mothers became more comfortable and familiar with the neonatal unit, the detail of time, as they described their experiences, was more general. Perception of time was less obvious as they recalled caring for their baby over a day or days rather than hour by hour.

Connection and Re-connection.

Having heard about their experiences of being separated from their baby, I was trying to understand when was the moment, or at what stage they felt they bonded, connected, became attached, fell in love, (or however it is described) with their baby? I have already alluded to the fact that, for some mothers, this does happen during pregnancy. Mercer (2004) found that those mothers who spent time thinking and daydreaming about their baby during pregnancy were found to be more involved and connected to their baby. Immediate physical contact between the mother and her newborn child after the delivery further promotes the attachment (Wigert et al, 2006). Each of the mothers had the briefest of contact with their babies at birth before baby was taken to the neonatal unit. From then on it seemed that the desire to hold, to touch and to be with their baby was an important part of the re-connection and bonding. Sara-Marie was quite definite in that she said that once her baby latched onto her breast for a feed, and she could feel skin on skin and baby's sucking the milk made especially for him, she started to bond with him.

Figueiredo, Costa, Pacheco and Pais (2009) describe two related aspects of maternal bonding; the mother's concerns and actions about the safety and well-being of the infant, as well as the mother's emotional tie with the baby and the unique place he/she holds in her world. It is also a bi-directional process of mother to baby and baby to his/her mother. Attachment is an interactive process between mother and baby and maternal emotional involvement is restrained when the infant is admitted to the neonatal unit. This can be explained by the fact that mother and infant are separated, by the fact that the infant may not survive so the mother is highly preoccupied and confused about her involvement with him/her,

and by the fact that the newborn is not as able to participate in the interaction with the mother. Each of the babies was admitted to the neonatal unit very soon after birth and each needed a varying degree of intensive care. Babies were separated from their mother by the Perspex of the incubator and the invisible barrier due to the babies' fragility; being connected with tubes and wires; the sounds of the monitors and the beeps of alarms; the subdued environment that is the neonatal unit – dimly lit, hushed voices and a sense of busyness. The mothers needed not only information and reassurance about their baby's condition (Cleveland, 2008; Harrison, 1993; Hurst, 2001a; Tran, Medhurst & O'Connell, 2009) but to be able to experience and feel skin on skin with their baby (Cleveland; Holditch-Davis & Miles, 2000). Skin to skin, especially Kangaroo care is promoted in most neonatal units. It stabilises the infant and promotes bonding and attachment as well as aiding lactation (DiMenna, 2006). However, this is not always possible as some babies are too unstable or, as in the case of MaryAnne and Sara-Marie, their babies had tubes and wires attached that might have become dislodged if the baby was held. Whilst understanding the mothers' needs, the nurses need to gently explain why it is not possible. At the same time they need to encourage and show the mothers how to touch their baby and talk to their baby and how to connect in this simple way giving them reassurance that they are helping their baby through this connection.

The mothers' journey through the neonatal unit and the reconnection with their babies occurred over a period of time and through stages I have termed 'the visiting mother' and 'being a mother'.

THE NEED TO DO [MOTHERING].

During the interviews, I had asked each of the mothers to tell me what it was like for them being a mother in the neonatal unit. I wanted to try and understand how the teenage mothers saw mothering and when did they feel that they had 'become' a mother? Each of the mothers expressed both a desire and a physical need to do practical things and care for their babies. MaryAnne was angry because she just "*wanted to hold him*" and was not allowed to. Sara-Marie expressed frustration because she "*just wanted to give him a bath*". Each of the mothers wanted to hold, to cuddle, to feed and to bath their baby and became frustrated when they

were unable to do so. I believe this was what mothering was for each of the young mothers – showing a mother’s love by acts of caring. Attachment continues and is aided when the mother is enabled to touch her baby and care for him/her. The ‘need to do’ mothering is part of bonding and attachment.

Transition to motherhood is a major developmental life event described as a process of personal and interpersonal change, which occurs as a woman assumes maternal tasks and appraises herself as a mother (Shin & White-Traut, 2007). Transition to motherhood in the neonatal unit can be delayed due to mothers’ separation and inability to make contact with their infant and uncertainty and anxiety over the infant’s welfare (Fegran et al. 2008b; Shin & White-Traut).

The following sections will describe the mothers’ journey through the neonatal unit – from ‘visiting mother’ to ‘being a mother’ and how the transfer of control is made through the relationship between mother and nurse.

The visiting mother.

The young mothers in this study had each been separated from their baby shortly after birth as their baby was whisked away to the neonatal unit. Only MaryAnne had any experience of visiting a neonatal unit prior to birth. She told me “*they take you into the unit and show you what a baby your [gestation] ... the baby would look like. ... They showed us an actual baby and this is what will happen.*” MaryAnne continued that she knew what an incubator looked like and that she had been shown “*what tubes they will use and if they had to have a breathing tube, they show you on the computer what they have to do with it.*” None of the other mothers had experienced a neonatal unit before. For most parents, entering the neonatal unit for the first time is like going to a ‘foreign country’ where you no longer know your way around; do not understand the language or understand the routine and how things get done. Mothers describe feeling intimidated and overwhelmed by the technological environment and the expertise of the nurses (Heerman, Wilson & Wilhelm, 2005). Each of the mothers spoke about seeing their babies with tubes, wires and monitors, not being allowed to be with or touch their babies and feeling a lack of control. However, they also acknowledged that

their baby was being cared for by “*people who knew what they were doing*” Sarah-Marie).

The mothers sought permission to visit for the first time and then were asked to leave when the medical team needed to undertake care and procedures. Even though we emphasise that parents are not visitors and are welcome 24 hours a day, and that there are designated visiting times for family and friends, there is a great deal of anxiety and stress for parents when they are not permitted to be with their baby. Initially, each time the mothers came to the unit, they experienced feeling like visitors because they were not allowed to actively do things for their baby – to touch them, change nappies, or hold them. MaryAnne definitely thought of herself as a visitor at this time. She explained

just when I had to ask if I could touch my own child, and stuff, I felt that I wasn't the mother at all. It felt like I was asking one of my friends if I could hold their baby, basically.

Each of the mothers described sitting beside their baby and asking permission to touch their baby and experiencing frustration because they just wanted to be able to pick up their baby and give him a cuddle. They talked about the frustration of not being able to care for their babies and at times I sensed that they felt powerless. There appeared to be an imbalance of power and control with the neonatal team taking control of caring for the baby. Although Sara-Marie did say

I was probably glad not to have control over what was going on. I was happy that there were people who knew what they were doing and as long as I was informed, and I knew what was going on and why, that was ok.

Lupton and Fenwick (2001) describe how mothers see nurses as ‘gatekeepers’ between themselves and their infant and having to seek permission to interact with their babies and appearing to be constantly supervised results in mothers feeling frustrated and resentful (Cleveland, 2008). Parents also express a need to be positively perceived by the neonatal staff and to be empowered in caring for their infant (Cleveland). The young mothers each had wondered if they would be ‘judged’ by the staff because of their age. However, each of them stated that this had not been their experience and that they were able to develop a relationship with staff members and start sharing the care of their baby.

If nurses practice family-centred care then many of the parents' needs can be met and parents supported (DiMenna, 2006; Harrison, 1993; Hughes, 2007). Nurses need to develop a strong, trusting and therapeutic relationship that enables the planning and delivery of care to the infant to be negotiated and shared in partnership with the parents (Cleveland, 2008; Hughes, McAllister & Dionne, 2006). This relationship between parent and nurse requires a change in the traditional role of dominant expert and passive recipient of care (Hughes). A relationship that is based on mutual respect, trust and equality of worth is necessary to empower parents, and this empowerment needs to be evident on both sides of the parent-nurse relationship for family-centred care to be meaningful (Hughes). Mothers who gain knowledge and confidence through being kept informed about their baby's condition and how they can participate in caring for the infant become the expert and this enables them to mother their own infant (Tran, Medhurst & O'Connell, 2009).

Being a mother.

In biological terms, each of the four teenagers were being mothers from the time that they found out they were pregnant, during their pregnancy and the giving birth to their baby. Sara-Marie explained

The second I found out I was pregnant ... I thought it was all over [my former life]. I didn't care. I didn't want a bar of it [the way I was living before]. ... I gave up smoking then and that's it. I never had another one. I gave up everything for my pregnancy. I gave up coffee, everything.

However, once the baby was born, they wanted to 'be' mothers. They wanted to undertake caring and nurturing activities and take up the role of being a mother.

Transition to motherhood in the neonatal unit can be delayed due to mothers' separation and inability to make contact with their infant and uncertainty and anxiety over the infant's welfare (Fegran et al. 2008b; Shin & White-Traut, 2007). When parents observe nurses engaged in nurturing and vigilant behaviours towards their baby – showing affection, caring, watching and protecting – they feel that they are being respected and supported in the parental role (Haubaugh, Tomlinson & Kirschbaum, 2004). Those nurses who take control and do not allow parents to participate in care may cause mothers to experience negative

emotional responses and feel helpless and worthless. However, when nurses develop a close and caring relationship with mothers, this enables these women to take up their role as a mother and feel connected to their infants (Fenwick et al., 2001). Nurses can also be supportive to new mothers by providing positive meaning to even the smallest moments and giving credit for being the mother (VandenBerg, 2000). Rawinia describes how she helped to change her tiny baby's nappy and Chrissie also changed her baby's nappies and held his hand and there was an exciting moment when he looked around for the first time, having been unconscious.

Each of the mothers told me that once their babies came out of the incubator into a normal crib they started to be able to do more for their baby and even more so when they moved in to the rooming in rooms, where baby was with them all the time. They had definite ideas about what they wanted for their babies. Three out of the four mothers had previous experience with small babies. Maybe this was what gave them confidence. Chrissie told me that she had "*read all the books*" and admitted that the help and support that she received whilst in the neonatal helped and gave a "*kick start*" to her new role of motherhood. MaryAnne was very comfortable asking questions "*when it came to the care of her son*". I was both surprised and impressed by the confidence the young mothers showed in their ability and knowledge. Prior to the study I had assumed that young mothers did not know anything, or very much, about caring for babies but these mothers had previous experience or 'had read all the books'.

During this time there was a transfer of power and control from the nurses to the mothers and how smoothly this happened depended on the relationship that is formed.

Family and friends.

To survive the emotional roller-coaster and to gain confidence in caring for their infant, mothers need the support of the hospital staff and also family and friends (Cleveland, 2008). Adolescents bring their unique developmental and emotional needs to their childbirth experience and nurses and midwives need to understand how the mothers are coping and offer the appropriate support to facilitate positive

outcomes for the adolescents and their newborns (Sauls & Grassley, 2011). The coping skills that adolescents may draw on include problem solving skills, social skills and the social support of friends and family (Sauls & Grassley). Each of the mothers expressed that they had received comfort from having their boyfriend and/or mother with them during labour, delivery and the immediate postnatal period. Rawinia mentioned several times that her family were with her and some had travelled a long distance to support her and her whanau. Sara-Marie was supported by her boyfriend and an aunt during the time that Baby H was receiving care and they were unable to visit the neonatal unit. Sara-Marie was kept informed and felt reassured through photos of her baby and information leaflets that had been provided, as well as regular updates from the doctors.

The support of family and friends was important to each of the mothers and I sensed that doing 'mothering' included sharing the experience with and being supported by their partner, mother and friends. How a mother 'mothers' her own child is often a reflection of her own personal experience of being mothered and in Sara-Marie's case, there were aspects of how her own mother had 'mothered', not only herself but her brothers and sisters, that gave her definite ideas of what she 'would not be doing'.

Sara-Marie told me that she did not interact with the other mothers that were staying in the unit. *"I was the youngest of the mums at the time ... I preferred to keep to myself"*. She continued by explaining that she had someone from the family with her for most of the time. This was important for her as she tried to connect with 'normal' things in her life – family, friends and home. She also expressed a need to 'show off' her baby to those people close to her. Peer relationships and friendships are very important during adolescence and being part of a group provides adolescents with a sense of acceptance, socialisation and stability (DeVito, 2010).

Chrissie remembered a moment when she became 'overwhelmed' and was comforted and felt supported when her boyfriend was phoned and came and was able to stay the night with her. She said she *"needed someone there to pat my back and say 'it's all right'"*. Similarly, Sara-Marie had a 'meltdown' and was

really grateful that the nurses recognised this and phoned her boyfriend and her mother who came straight away.

Wahn, Nissen and Ahlberg (2008) describe how the support from family networks was most important to parenting teenagers, especially the practical support from their own mothers. Each of the young mothers experienced the support of family and friends during her time in the neonatal unit and also when she went home. All of the young mothers, and their babies, went home to their mothers' homes initially which enabled the support to continue as the mothers became more confident in caring for their baby.

A SAFE PLACE

The experiences of these young mothers took place in a neonatal unit that eventually became a 'safe place' for each of them. When planning the birth of their baby, most parents would not usually consider their baby's admission to a neonatal unit. Two of the mothers in this study had previously been alerted to their baby's probable admission to a neonatal unit. However, all of the young mothers had told me that they were anxious and frightened when they first entered the neonatal unit to visit their baby. For their newborn baby to be there he must be really sick. This was not the postnatal ward where they would have dreamt that their healthy newborns would be in a crib alongside their mother. Parents with babies in the neonatal unit start their parenting experience publicly and in unfamiliar and challenging surroundings (McAllister & Dionne, 2006; Pearson & Anderson, 2001). As I reflected on hearing their stories, I could feel the nervousness of entering a new environment; the shyness of meeting new people and the questions that I would want to know about what was happening to my baby. Sara-Marie described being taken down to the neonatal unit, by her family, in a wheelchair. I felt that vulnerability of this situation – dressed in a hospital gown, having to reach up to the taps to wash her hands and then to be sitting below the level of her baby in the incubator and with doctors and nurses speaking down to her. This was an alien place where the new mothers had to learn to navigate through the routine, the rules and the language. Similar experiences are described in the literature where mothers experience the journey through the neonatal unit as going from the unfamiliar and alien world to participating and

being involved in familiar surroundings (Heerman, Wilson & Wilhelm, 2005; Jackson, Temestedt & Scholin, 2003; Shin & White-Traut, 2007)

Earlier in this chapter I described Sara-Marie's frustration in not being able to bath or cuddle her baby when she wanted; and MaryAnne appeared really angry because she "*was not allowed*" to hold her baby. It appeared to me that there was a 'power struggle' between the nurses and the mothers as the mothers negotiated their way through the neonatal experience. Each of them understood that their baby needed specialised nursing and medical attention. Sara-Marie felt powerless at times but her 'safe' was being able to place her trust in the people and the environment where her baby was. She explained that she was kept fully informed of her baby's condition and what care was being given. She said

We always knew what was happening and why and we were given an option of it too. ... It wasn't just 'this is what we are doing to your baby', it was 'can we do this?' and 'this will benefit him because ...

There was an understanding by the mothers that their baby had medical and nursing needs that required skilled care. There was an acceptance by the mothers even though they themselves became angry and frustrated at times. Providing a supportive and non-judgemental environment enables parents to develop their role as parents (Cleveland, 2008). In order to achieve this, a strong, trusting therapeutic relationship needs to develop between the nursing staff and the parents (Cleveland; Hughes, 2007; McAllister & Dionne, 2006). Hughes continues by saying that such a relationship between patient and nurse requires a change in the traditional role of dominant expert and passive recipient of care and that for family centred care to be meaningful, empowerment needs to be evident on both sides of the relationship. In time the mothers became more familiar with their surroundings and routines, and they developed trust in the staff caring for their baby. They became more involved in baby's care and started making decisions, even though sometimes they were frustrated because they received conflicting advice. This can be reduced if family centred care is implemented.

Each of the mothers found that the neonatal unit was also a safe place for them. They each felt that they were looked after as well as their babies. They described

feeling nurtured. They were provided with an environment where they could get rest, as well as support and education in how to care for their babies and felt prepared for taking their baby home when the time came. Nurses need to listen to teenage mothers and establish how they can help them learn to care for their baby and become an effective parent (DeVito, 2010). Parents' needs for emotional support, a welcoming environment and parent education and supportive guidance in caring for the infant appeared to be met (Cleveland, 2008; Connor & Nelson, 1999; Harrsion, 1993; Wigert et al., 2007).

CONCLUSION

The experiences of being a mother in the neonatal unit have been described by the four teenage mothers who shared their stories. The young mothers found it to be a critical experience that stayed with them. The themes of 'the emotional roller-coaster', 'the need to do [mothering]' and 'a safe place' have been highlighted and discussed in this chapter and compared with the literature. The literature identified that parents need support, in the form of therapeutic relationships with staff and through family centred care, to survive the emotional roller coaster and to gain confidence and skill in caring for their infant. This study suggests that teenage mothers have the same needs as older mothers who have babies in the neonatal unit.

LIMITATIONS OF THE STUDY

This was a small study, with just four participants. However, this is in keeping with the phenomenological research. Mapp (2008) suggests that the sample size needs to be small so that each experience can be examined in depth, mindful that transcribing and interpretation will take time. Claims, though modest, will add to the body of knowledge with the potential for a larger study in the future. I also acknowledge that I am a novice researcher and this may have limited the interpretation. However I work as a senior member of the nursing staff in the neonatal unit and consider this to be a strength as I have the skills and experience to work closely with teenage mothers and gain their trust.

STRENGTHS OF THE STUDY

Phenomenological research aims to produce rich and full descriptions and interpretations that illuminate what it means to be a person in that life-world (Schneider, Elliott, LoBiondo-Wood & Haber, 2003). The young mothers shared their experiences with me and I endeavoured to be true in describing them in the written word. Their stories have been heard and valued and I believe that this piece of research can add to the body of knowledge that exists, strengthen health care practice and identify areas of change if change is necessary.

IMPLICATIONS FOR NURSING PRACTICE

In this small study of the experiences of teenage mothers in the neonatal unit there were no new findings. The experiences described strongly suggest that the young mothers share many of the experiences and needs of older mothers in this context.

The importance of family centred care and strong, trusting therapeutic relationships between nurses and mothers is evident. If nurses understand the stress and emotional roller-coaster that mothers experience, and adopt the principles of family centred care, mothers will feel supported throughout their journey through the neonatal unit and it may alleviate power and control struggles that were evident in this study.

Kangaroo care is seen as an important part of family centred care and provides parents with skin to skin contact that is beneficial to both baby and parent. Nurses

should be encouraged to support this practice where possible and be sensitive in how they explain to parents when it is not possible because of the condition of the baby. Kangaroo care is one of the most beneficial interventions parents can perform with their newborn (DiMenna, 2006).

Mothers want and need information and education in how to care for their babies and they also want consistent advice (Conner & Nelson, 1999; Wigert et al., 2007). To avoid conflicting advice, care needs to be individualised and a lead carer may assist in this. A lead carer, who the mothers can rely on to formulate a plan, outline care and prepare for discharge, will provide a constant even though other nurses may, at times, look after their babies.

SmithBattle (2000) talks about the cultural blindness to strengths and vulnerabilities of teenage mothers. The essence of my own practice being culturally safe is for me to identify my own attitudes, values and beliefs and how they impact on the relationship I develop with someone in my care. In this study, I reflected on my own views of teenage mothers. From a view that teenage mothers are young and therefore vulnerable, needing help and advice, I discovered that for some young women mothering comes easily and that motherhood is a life path they choose, allowing them to forge new identities and foster aspirations of becoming more responsible and mature. If nurses' practice is culturally safe they can ensure that care given is appropriate to each of the families in their care. Services such as antenatal and postnatal care, parenting support services, developed specifically for teenage mothers may need to be considered. For example, a new initiative by Plunket in Hawke's Bay is providing a unique support system for teenage mothers through a parenting programme that has a lead carer and starts before the baby is born and continues throughout the Well Child programme (Kai Tiaki, 2011).

FUTURE RESEARCH

I believe there is scope to repeat this study through other neonatal units in New Zealand. There is also an opportunity to research how nurses experience caring for mothers and babies in neonatal units.

CONCLUDING STATEMENT

I undertook this study because I have a personal interest in teenage mothers and a desire to provide the best care I can. I aimed to try to understand what it was like being a teenage mother in the neonatal unit. Whilst it was a small study with just four participants, each of the mothers provided rich and full descriptions of what it was like for them, being a mother in the neonatal unit.

Using van Manen's process for undertaking phenomenological enquiry and analysis of the data – reading and re-reading, reflection, writing and re-writing, two main themes emerged – the need to do [mothering] and being in a safe place. There was a third theme of the emotional roller-coaster that each of the mothers experienced and ran as a thread throughout. Researching the literature I found that much is written about the support mothers need when they have a baby in the neonatal unit. My study found that the teenage mothers had similar experiences and needs to other mothers who have babies in the neonatal unit.

If we are to value their stories and be honest to the four young mothers who so willingly shared their experiences then it is important that the study is used to inform nursing practice as described earlier in this chapter and there is scope for further research.

APPENDIX 1



DHB LOGO

LETTER OF INTRODUCTION

Neonatal Unit
XXXX
XXXX
Phone: 021 XXX XXX

Date

Dear

The experiences of teenage mothers in the Neonatal Unit at [Named Hospital]

I am completing my Master of Nursing degree by undertaking research into the experiences of teenage mothers who have had babies in the Neonatal Unit at [named hospital]. I am being supervised in this research by my tutors at the Waikato Institute of Technology, Hamilton.

As you are a young mother, who has had a baby in the Neonatal Unit, I would like to invite you to consider participating in this research. Your involvement would be a one off interview of about one hour, in a location of your choosing, during which time you will be asked to share your story of the time you spent in the Neonatal Unit. Your story is important to me. The aim of the study is to hear and value your story and those of other young mothers, maintaining your anonymity at all times. With this knowledge it is hoped that nurses and other health professionals can be informed so that we can try and make services for teenage mothers more appropriate.

Please read the Information Leaflet and if you are willing to participate, please phone or text me on 021 xxx xxx. I am happy to talk with you further and answer any of your questions before you make your decision. You are free to choose whether or not you wish to participate in the study.

I look forward to hearing from you.

Thank you.

Yours sincerely,
JANE BOCOCK

APPENDIX 2



DHB LOGO

INFORMATION SHEET

The experiences of teenage mothers in the Neonatal Unit at [Named Hospital]

RESEARCHER: Jane Boccock,
Masters Student at the Waikato Institute of Technology,
Hamilton.
Neonatal Unit, [Named Hospital]
Phone: 021 xxx xxx

You are invited to take part in a research study to find out what it is like being a teenage mother caring for your baby whilst in the Neonatal Unit. This will involve one interview with me that will last for about one hour. You will be asked to sign a consent form, when I have answered any questions you may have, and then I will ask you to tell your story – how was the experience for you, how did you feel, did you get the help you and your baby needed? This interview will be audio-taped so that I may listen to what you have to say and then write your story down afterwards. We can meet either at your home or at a place you choose. You may choose to have a support person with you.

The second meeting will give me an opportunity to go through the transcripts (written story) with you, so that you can confirm that it is accurate. The audio-tapes and all data collected will be stored in a secured place.

Your participation is entirely voluntary (your choice). You do not have to take part in this study, and if you choose not to take part this will in no way affect your future healthcare. If you do agree to take part, you are free to withdraw from the study at any time, without having to give reason.

You have the right, at any time, during your participation:-

- To ask any question about the research
- To refuse to answer any question
- To ask the researcher to leave at any time

- To ask that the cassette recorder be turned off
- To examine any notes taken
- To read and amend any subsequent transcription
- To terminate the meeting at any time
- To be informed of the results (on completion of the research).

No material which could possibly identify you, or people or place mentioned by you in the interview will be used in any reports on this study. I will be transcribing the audio-tapes which further ensures confidentiality. My supervisor will have access to the information in order to assist me in my project. Every effort will be made by the researcher to maintain your anonymity throughout the research project. Each participant will be referred to only by a pseudonym (which may be selected by you) or by a number.

I ask that when telling your story you do not name or identify specific staff members. If, at any time, you have concerns about your rights as a participant, or if issues raised cause you distress, or need follow-up, you may wish to contact the Health and Disability Services Advocate, a Social Worker or the hospital's Customer Services [Named DHB and phone number].

The aim of the study is to hear your story, to inform healthcare workers and make changes in practice if change is necessary to ensure that services provided in the neonatal unit are appropriate and supportive for teenage mothers. It is also hoped that the results of the study will be shared with nurses at conferences and in nursing publications.

This study has received approval from the Regional Ethics Committee and Waikato Institute of Technology Human Ethics Committee.

More information on the study can be obtained from the study supervisor (*Sallie Greenwood, Wintec, 07 834 8800, Ext: 8461*).

Thank you for your interest in this project and for taking the time to read this information.

APPENDIX 3



DHB LOGO

CONSENT FORM

The experiences of teenage mothers in the Neonatal Unit at [Named Hospital]

RESEARCHER - Jane Bocock

- I have read and understood the information sheet for volunteers taking part in this study.
- I have had the opportunity to discuss this study with Jane Bocock and I am satisfied with the answers I have been given. I have also had the opportunity to use whanau support or a friend to help me ask questions and understand the study.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my continuing health care.
- I understand that my participation in this study will be anonymous and that no material which could identify me will be used in any reports of this study.
- I have had time to consider whether to take part and I know who to contact if I have any questions about the study.

I wish to have an interpreter. YES / NO
E hiahia ana ahau ki tetahi kaiwhaka Maori/kaiwhaka pakeha korero. Ae / Kao

I consent to my interview being audio-taped. YES / NO
I wish to receive a summary of the results. YES / NO

I(Full Name)
hereby consent to take part in this study.

Signature

Date

This project has been approved by the Regional Ethics Committee and the Human Ethics Committee of WINTEC. This means that the Ethics Committees may check that this study is running smoothly, and has followed appropriate ethical procedures. Complete confidentiality is assured.

Contact phone number of researcher: 021 xxx xxx

A copy of the consent form will be retained by the participant.

REFERENCES

- Abeywardana, S. (2007). The report of the Australian and New Zealand Neonatal Network, 2005. Sydney: ANZNN.
- Anderson, C., McGuinness, T.M. (2008). Do teenage mothers experience childbirth as traumatic? *Journal of Psychosocial Nursing*, 46(4), 21-24.
- Ardal, F., Sulman, J., Fuller-Thomson, E. (2011). Support like a walking stick: Parent-buddy matching for language and culture in the NICU. *Neonatal Network* 30(2), 89-98.
- Arnett, J.J. (1999). Adolescent storm and stress, reconsidered. *American Psychologist* 54(5), 317-326.
- Arnett, J.J. (200). Emerging adulthood: a theory of development from late teens through the twenties. *American Psychologist*, 55(5), 469-479.
- Arnett, J.J. (2007). Emerging adulthood: what is it and what is it good for? *Child Development Perspectives*, 1(2), 68-73.
- Arthur, A., Unwin, S., Mitchell, T. (2007). Teenage mothers' experiences of maternity services: a qualitative study. *British Journal of Midwifery*, 15(11), 672-677.
- Barkway, P. (2001). Michael Crotty and nursing phenomenology: criticism or critique? *Nursing Inquiry*, 8, 191-195.
- Benner, P. (1984). *From novice to expert: Excellence and Power in clinical nursing practice*. , New York: Addison Wesley Publishing.
- Carper, B. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science*, 1(1), 13-23.
- Carter, J.D., Mulder, R.T., Bartram, A.F., Darlow, B.A. (2005). Infants in a neonatal intensive care unit: parental response. *Archives of Disease in Childhood. Fetal and Neonatal Edition*, 90, F109-F113.
- Cassata L., Dallas C. (2005). Nurses' Attitudes and Childbearing Adolescents: Bridging the Cultural Chasm. *ABNF Journal* July/August 2005.
- Chaudhuri, J.H., Easterbrooks, M.A., Davis, C.R. (2009). The relation between emotional availability and parenting style: cultural and economic factors in a diverse sample of young mothers. *Parenting Science and Practice*, 9, 277-299.

- Claiborne, L.B., Drewery, W. (2010). *Human development – family, place, culture*. North Ryde, NSW: McGraw-Hill.
- Clancy, K. (2007). Experiences of a novice researcher. *Nurse Researcher*, 14(4), 27 – 38.
- Cleveland, L.M. (2008). Parenting in the Neonatal Intensive Care Unit. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 37, 666-691.
- Coleman J., Hendry L.B., Kloep, M. (Eds). (2007). *Adolescence and Health*. London: Wiley.
- Conner, J.M., Nelson, E.C. (1999). Neonatal Intensive Care: satisfaction measured from a parent's perspective. *Pediatrics*, 103(1), 336-349.
- Cooper, L.G., Gooding, J.S., Gallagher, J., Sternesky, L., Ledsy, R., Berns, S.D. (2007). Impact of a family-centred care initiative on NICU care, staff and families. *Journal of Perinatology*, 27, S33-S37.
- Craig, E., Jackson, C., Han, D.Y. (2007). *The Health of Children and Young People in Taranaki*. Auckland: New Zealand Child and Youth Berk, L.E.
- (2004). *Development through the lifespan* (3rd ed.). Boston: Allyn and Bacon.
- Cram, F. (2001). Rangahau Maori: Tona tika, tona pono – The validity and integrity of Maori research. In M. Tolich (Ed.), *Research Ethics in Aotearoa New Zealand* (pp. 35 – 52). Auckland: Pearson Education.
- Dahlgren, M., Richardson, B., Kalman, H. (2004). Redefining the reflective practitioner. In J. Higgs, B. Richardson, M.A. Dahlgren (Eds.), *Developing practice knowledge for health professionals*. London: Butterworth-Heinemann.
- Da Silva, A.A.M., Simoes, V.M.F., Barbieri, M.A., Bettiol, H., Lamy-Filho, F., Coimbra, L.C. (2003). Young maternal age and preterm birth. *Paediatric and Perinatal Epidemiology* 17, 332-339.
- Del Barrio, M., Lacunza, M.M., Armendariz, A.C., Margall, M.A., Asaian, M.C. (2004). Liver transplant patients: their experience in the intensive care unit. A phenomenological study. *Journal of Clinical Nursing*, 13, 967 – 976.
- DeVito, J. (2010). How adolescent mothers feel about becoming a parent. *Journal of Perinatal Education*, 19(2), 25-34.

- Dickson, N., Sporle, A., Rimene, C., Paul, C. (2000). Pregnancies among New Zealand teenagers: trends, current status and international comparisons. *New Zealand Medical Journal*, 23 June 2000, p 241-245.
- DiMenna, L. (2006). Considerations for implementation of a neonatal kangaroo care protocol. *Neonatal Network*, 25(6), 405-412.
- Dinkel, S. (2005). Phenomenology as a nursing research method. *The Kansas Nurse*, 80(5), 7-10.
- Domino, E. (2005). Nurses are what nurses do – Are you where you want to be? *AORN Journal* 81(1):187-201.
- Donalek, J.G. (2004). Phenomenology as a Qualitative Research Method. *Urologic Nursing*, 24(6), 516-517.
- Dreyfus, H.L. (1994). (Preface). In Benner, P. (Ed), *Interpretive Phenomenology* (pp. vii-xi). Thousand Oaks, Ca: Sage Publications.
- Drewery, W., Bird, L. (2006). *Human development in Aotearoa: A journey through life* (2nd ed.). New Zealand: McGraw-Hill.
- Durie, M. (1998). *Whaiora: Maori Health Development*. Auckland: Oxford University Press.
- Eide, P., Kahn, D. (2008). Ethical issues in the qualitative researcher-participant relationship. *Nursing Ethics* 15(2), 199 – 207.
- Emmanuel, E., Creedy, D.K., St John, W., Gamble, J., Brown, C. (2008). Maternal role development following childbirth among Australian women. *Journal of Advanced Nursing*, 64(1), 18-26.
- Fegran, L., Fagermoen, M.S., Helseth, S. (2008a). Development of parent-nurse relationships in neonatal intensive care units – from closeness to detachment. *Journal of Advanced Nursing*, 64(4), 363-371.
- Fegran, L., Helseth, S., Fagermoen, M.S. (2008b). A comparison of mothers' and fathers' experiences of the attachment process in a neonatal intensive care unit. *Journal of Clinical Nursing*, 17, 810-816.
- Fenwick, J., Barclay, L., Schmied, V. (2001). 'Chatting': an important clinical tool in facilitating mothering in neonatal nurseries. *Journal of Advanced Nursing*, 33(5), 583-593.
- Figueiredo, B., Costa, R., Pacheco, A., Pais, A. (2009). Mother-to-infant emotional involvement at birth. *Maternal & Child Health Journal*, 13, 539-549.

- Hanna, B. (2001). Negotiating motherhood: the struggles of teenage mothers. *Journal of Advanced Nursing*, 34(4), 456-464.
- Harbaugh, B.L., Tomlinson, P.S., Kirschbaum, M. (2004). Parents' perceptions of nurses' caregiving behaviours in the paediatric intensive care unit. *Comprehensive Pediatric Nursing*, 27, 163-178.
- Harrison, H. (1993). The principles of family-centred neonatal care. *Pediatrics*, 92, 643-650.
- Health Research Council (2005). *Guidelines on Ethics in Health Research (Rev.ed.)*. Retrieved September 10, 2008, from <http://www.hrc.govt.nz>.
- Health Research Council (2008). Guidelines for Researchers on Health Research Involving Maori. Retrieved September 10, 2008, from <http://www.hrc.govt.nz>
- Heermann, J.A., Wilson, M.E., Wilhelm, P.A. (2005). Mothers in the NICU: outsider to partner. *Pediatric Nursing*, 31(3), 176-181.
- Heidegger, M. (1927). *Being and Time* (J. Stambaugh, Trans., 1996). Albany, N.Y.: State University of New York Press.
- Holditch-Davis D. Miles M.S. (2000). Mothers' stories about their experiences in the Neonatal Intensive Care Unit. *Neonatal Network*, 19(3), 13-21.
- Hughes, M. (2007). Parents' and nurses' attitudes to family-centred care: an Irish perspective. *Journal of Clinical Nursing* 16, 2341-2348.
- Hurst, I. (2001a). Mothers' strategies to meet their needs in the Newborn Intensive Care Nursery. *Journal of Perinatal and Neonatal Nursing*, 15(2), 65-82.
- Hurst, I. (2001b). Vigilant watching over: mothers' actions to safeguard their premature babies in the Newborn Intensive Care Nursery. *Journal of Perinatal and Neonatal Nursing*, 15(3), 39-57.
- Jackson, K., Temestedt, B-M., Schollin, J. (2003). From alienation to familiarity: experiences of mothers and fathers of preterm infants. *Journal of Advanced Nursing*, 43(2), 120 – 129.
- Johnson, S. (Ed.). 2004. *Health Care and the Law* (3rd ed.). Wellington: Brookers.
- Kaye, D.K. (2008). Negotiating the transition from adolescence to motherhood: coping with prenatal and parenting stress in teenage mothers in Mulago hospital, Uganda. *BMC Public Health*, 8(83). Retrieved October 4, 2011, from <http://www.biomedcentral.com/1471-2458/8/83>.

- Leiner, M., Villa, H., Singh, N., Medina, I., Shirsat, P. (2007). Pregnant teenagers and teenage mothers: how much they really know about the risks to children's health associated with smoking during and after pregnancy? (Letter to the Editor). *Journal of School Health* 77(3): 101 – 102.
- Lemermeyer, G. (2007). *Hearing the call of parents: Relational Ethics in the NICU*. Library and Archives Canada.
- Lowenthal, B., Lowenthal, R. (1997). Teenage parenting: challenges, interventions and programs. *Childhood Education*, 74(1), 29-32.
- Lupton, D., Fenwick, J. (2001). "They've forgotten that I'm the mum" – constructing and practicing motherhood in special care nurseries. *Social Science and Medicine*, 53, 1011-1021.
- Kai Tiaki (2011). Hawke's Bay Teenage Parenting Programme Awarded. *Kia Tiaki – Nursing New Zealand*, 17 (9), 11.
- Madjar, I., Walton, J.A. (Eds.). (1999). *Nursing and the experience of illness: Phenomenology in Practice*. London: Routledge.
- Magill, M.K., Wilcox, R. (2007). Adolescent Pregnancy and Associated Risks: Not Just a Result of Maternal Age. *American Family Physician* 75(9):1310-1311.
- Maggs-Rapport, F. (2001). 'Best research practice': in pursuit of methodological rigour. *Journal of Advanced Nursing*, 35(3), 373 – 383.
- Mapp, T. (2008). Understanding phenomenology: the lived experience. *British Journal of Midwifery*, 16(5), 29-31.
- Markovitz, B.P., Cook, R., Flick, L.H., Leet, T.L. 2005. Socioeconomic factors and adolescent pregnancy outcomes: distinctions between neonatal and postnatal deaths? *Child: Care, Health & Development* 31(6), 742-743.
- McAllister, M., Dionne, K. (2006). Partnering with parents: Establishing effective long-term relationships with parents in the NICU. *Neonatal Network* 25(5), 329-337.
- Maxwell, A., Proctor, J., Hammond, L. (2011). 'Me and my child' – parenting experiences of young mothers leaving care. *Adoption & Fostering*, 35(4), 29-40.
- Mercer, R.T. (2004). Becoming a mother versus maternal role attainment. *Journal of Clinical Scholarship*, 36(3), 226-232.

- Merenstein, G.B, Gardner, S.L. (2006). *Handbook of Neonatal Intensive Care* (6th ed.). St Louis: Mosby.
- Mertens, S.B, Anfara, V.A., Roney, K. (2009). *An international look at educating young adolescents*. USA: Information Age Publishing
- Miles, M.S. (Guest Editor) (2007). The impact of poverty in high-risk neonatal care. *Neonatal Network* 26(6), 355-356.
- Miles, M.S., Carlson, J., Funk, S.G. (1996). Sources of support reported by mothers and fathers of infants hospitalized in a Neonatal Intensive Care Unit. *Neonatal Network*, 15(3), 45 – 52.
- Moore, K.A.C., Coker, K., DuBuisson, A.B., Swett, B., Edwards, W.H. (2003). Implementing potentially better practices for improving family-centred care in Neonatal Intensive Care Units: Success and challenges. *Pediatrics*, 111(4), 450-460.
- New Zealand Nurses' Organisation (2010). *Code of Ethics*. Retrieved September 10, 2011, from <http://www.nzno.org.nz>
- Novak, G., Peláez, M. (2004). *Child and Adolescent Development – A Behavioral Systems Approach*. Thousand Oaks: Sage Publications.
- Nursing Council of New Zealand (2005). *Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice*. Retrieved June 5, 2009, from <http://www.nursingcouncil.org.nz>
- Nursing Council of New Zealand (2012). *Code of Conduct for Nurses*. Retrieved July 15, 2012, from <http://www.nursingcouncil.org.nz>
- O'Haire, S.E., Blackford, J.C. (2005). Nurses' moral agency in negotiating parental participation in care. *International Journal of Nursing Practice*, 11, 250 – 256.
- Papps, E., Ramsden, I. (1996). Cultural Safety in Nursing: the New Zealand Experience. *International Journal for Quality in Health Care* 8(5), pp 491 - 497.
- Papps,E. (2002). *Nursing in New Zealand – Critical issues Different Perspectives*. Auckland:Pearson Education.
- Pearson, J., Andersen, K. (2001). Evaluation of a program to promote positive parenting in the Neonatal Intensive Care Unit. *Neonatal Network* 20(4), 43-48.

- Perinatal and Maternal Mortality Review Committee (2011). Fifth Annual Report - Perinatal and Maternal Mortality in New Zealand 2009. Wellington: Heath Quality & Safety Commission, NZ Government.
- Polit, D.F., Beck, C.T. (2006). *Essentials of nursing research: methods, appraisal, and utilization*. (6th ed.) Philadelphia: Lippincott Williams & Wilkins.
- Price, A.L. (1965). *The Art, Science and Spirit of Nursing*. London: W.B. Saunders.
- Rawiri, C. (2007). *Adolescent Maori mothers' experiences with social support during pregnancy, birth and motherhood and their participation in education*. Unpublished thesis, Waikato University, Hamilton, N.Z.
- Rolfe, G. (2006). Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing*, 53(3), 304 – 310.
- Sachdev, P.S. (1990). Whakama: culturally determined behaviour in the New Zealand Maori. *Psychol Med* 20(2), 433-44.
- Santrock J.W. (2007). *Adolescence* (11th ed). New York: McGraw-Hill.
- Sauls, D.J., Grassley, J. (2011). Development of the Adolescent Support Model. *Journal of Theory Construction & Testing*, 15(1), 24-28.
- Scherf, R.F., Reid, K.W. (2006). Going home: what NICU nurses need to know about home care. *Neonatal Network*, 25(6), 421-425.
- Schneider, Z., Elliott, D., LoBiondo-Wood, G., & Haber, J. (2003). *Nursing Research: Methods, Critical Appraisal and Utilisation*. Sydney: Mosby.
- Seamark, C.J., Lings, P. (2004). Positive experiences of teenage motherhood: a qualitative study. *British Journal of General Practice*, 54, 813-818.
- Secco, M.L., Profit, S., Kennedy, E., Walsh, A., Letourneau, N., Stewart, M. (2007). Factors affecting postpartum depressive symptoms of adolescent mothers. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 36(1), 47-54.
- Shields-Poë, D., Pinelli, J. (1997). Variables associated with parental stress in neonatal intensive care units. *Neonatal Network*, 16(1), 29 – 37.
- Shin, H., White-Traut, R. (2007). The conceptual structure of transition to motherhood in the neonatal intensive care unit. *Journal of Advanced Nursing* 56(1), 90-98.
- SmithBattle, L. (1994). Beyond Normalizing: the role of narrative in understanding teenage mothers' transition to motherhood. In P. Benner

- (Ed.), *Interpretive Phenomenology* (pp.141-166). Thousand Oaks, Ca: Sage Publications.
- SmithBattle, L. (1995). Teenage mother's narratives of self: an examination of risking the future. *Advances in Nursing Science*, 17(4), 22-36.
- SmithBattle, L. (2000). The Vulnerabilities of Teenage Mothers: Challenging Prevailing Assumptions. *Advances in Nursing Science* 23(1), 29 – 40.
- SmithBattle, L. (2003). Displacing the “Rule Book” in caring for teen mothers. *Public Health Nursing*, 20(5), 369-376.
- SmithBattle, L. (2005). Teenage mothers at age 30. *Western Journal of Nursing Research*, 27(7), 831-850.
- Statistics New Zealand (2006). *2006 Census*. Retrieved September 19, 2008 from www.stats.govt.nz/census-outputs
- Stevens, C.A. (2006). Being healthy: voices of adolescent women who are parenting. *Journal for Specialists in Pediatric Nursing*, 11(1), 28-40.
- Streubert Speziale, H.J., Carpenter, D.R. (2007). *Qualitative Research in Nursing – Advancing the Humanistic Imperative* (4th ed). Philadelphia: Lippincott.
- Taranaki District Health Board, (2008). *Neonatal Unit Quality Plan*. Retrieved October 17, 2008, from <http://www.tdhb.org.nz/neonatal/qualitymanagement>
- Te Puni Kokiri – Ministry of Maori Development (2010). *Report on the Benefits of Education for Maori*.
- Thomas, L.M. (2008). The changing role of parents in neonatal care: a historical review. *Neonatal Network* 27(2), 91 – 100.
- Thomas, S.P. (2005). Through the lens of Merleau-Ponty: advancing the phenomenological approach to nursing research. *Nursing Philosophy*, 6, 63-76.
- Thomson, S. (2010). Complexities of supporting teenagers in pregnancy. *British Journal of School Nursing*, 5(8), 388-392.
- Tillett, J. (2005). Adolescents and informed consent. *Journal of Perinatal & Neonatal Nursing* 19(2), 112 – 121.
- Titchen, A., McGinley, M. (2004). Blending self-knowledge and professional knowledge in person-centred care. In J. Higgs, B. Richardson & M.A. Dahlgren (Eds.), *Developing practice knowledge for health professionals* (pp.107 – 126). London: Butterworth-Heinemann.

- Tolich, M. (Ed.) (2001). *Research Ethics in Aotearoa New Zealand*. Auckland: Pearson Education.
- Tran, C., Medhurst, A., O'Connell, B. (2009). Support needs of parents of sick and/or preterm infants admitted to a neonatal unit. *Neonatal, Paediatric and Child Health Nursing*, 12(2), 12-17.
- Tschudin, V. (2003). *Ethics in Nursing – The Caring Relationship* (3rd. ed). London: Butterworth-Heinemann.
- VandenBerg, K.A. (2000). Supporting parents in the NICU: guidelines for promoting parent confidence and competence. *Neonatal Network*, 19(8), 63-64.
- Van der Zalm, J.E., Bergum, V. (2000). Hermeneutic-phenomenology: providing living knowledge for nursing practice. *Journal of Advanced Nursing*, 31(1), 211-218.
- van Manen, M. (1997). *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy* (2nd ed.). London, Ontario: The Althouse Press.
- van Manen, M. (2002a). *Writing in the dark: Phenomenological studies in interpretive inquiry*. London, Ontario: The Althouse Press.
- van Manen, M. (2002b). *Phenomenological Inquiry*. Retrieved September 10, 2008, from <http://www.phenomenologyonline.com>
- Wahn, E.H., Nissen, E., Ahlberg, B.M. (2005). Becoming and being a teenage mother: how teenage girls in South Western Sweden view their situation. *Health Care for Women International*, 26, 591-603.
- Walker, W. (2007). Ethical considerations in phenomenological research. *Nurse Researcher* 14(3), 36 – 45.
- Watson, J. (1985). *Nursing: Human Science and Human Care – A Theory of Nursing*. Norwalk: Appleton-Century-Crofts.
- Watt, D. (2007). On becoming a qualitative researcher: The value of reflexivity. *The Qualitative Report*, 12(1), 82 – 101.
- Wereszczak, J., Miles, M.S., Holditch-Davis, D. (1997). Maternal recall of the neonatal intensive care unit. *Neonatal Network*, 16(4), 33 – 40.
- Whiting, L.S. (2008). Semi-structured interviews; guidance for novice researchers. *Nursing Standard*, 22(23), 35 – 40.

- Wigert, H., Johansson, R., Berg, M., Hellström, A.L. (2006). Mothers' experiences of having their newborn child in a neonatal intensive care unit. *Scandinavian Journal of Caring Science*, 20, 35-41.
- Wilkinson, T.M. (2001). The core ideas of research ethics. In M. Tolich, (Ed.). *Research Ethics in Aotearoa New Zealand* (pp. 13 – 24). Auckland: Pearson Education.
- Wilson, H., Huntington, A. (2006). Deviant (M)others: the construction of teenage motherhood in contemporary discourse. *Journal of Social Policy*, 35, 59-76.