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Disempowered, passive and isolated: how teenage mothers' postnatal inpatient experiences in the UK impact on the initiation and continuation of breastfeeding

Abstract

Teenage mothers in the UK and other developed, English-speaking nations are among those least likely to breastfeed. Evidence suggests more young mothers intend to breastfeed than actually start, indicating that their post-birth experiences militate against initiating breastfeeding. We aimed to explore how the inpatient experiences of a group of young women who gave birth as teenagers influenced their feeding decisions and experiences, and ascertain their ideals for breastfeeding support. Six focus groups or interviews were conducted with 15 women aged 16-20 who had intended to breastfeed or breastfed. Women were recruited from teenage parent groups in Oxfordshire, UK. Ethical approval was obtained from the relevant authorities. Data was analysed inductively using a thematic approach. Three overriding themes of 'postbirth experience on Labour Ward: disempowered and passive'; 'the postnatal ward: alien, alone and exposed'; and 'being there: a need for relational support' were identified. Sub-themes on Labour Ward were 'feelings at birth: 'so tired and so dazed'; 'deliver, stitch, dress' and 'initiating feeding'. Participants described care that followed set routines, discouraging their initiating breastfeeding by compounding feelings of dependance and encouraging a passive role as midwives took control, often deciding when and how babies should be fed. Sub-themes on the postnatal ward were 'an alien environment'; 'feeling exposed and judged' and 'miscommunications'. The young mothers' breastfeeding support requirements reflected those known to be desired by older women, but they particularly wanted guidance and esteem support to be provided by a health professional, while looking to their peers for emotional support.

Key words: breastfeeding initiation, breastfeeding support, teenage/adolescent mothers, postnatal care

Introduction

Young mothers in the UK and other developed nations are less likely to initiate breastfeeding than older women, and the number of young mothers breastfeeding declines more steeply over time (The NHS Information Centre 2012). The health benefits that breastfeeding confers could, however, have a greater impact in this disadvantaged group (Dyson et al. 2006). Increasing breastfeeding rates among young mothers and other disadvantaged groups is a health service priority in the UK (Department of Health 2012). An analysis of the effect of breastfeeding on conditions it is known to protect against, such as gastrointestinal and respiratory tract infections in infants and breast cancer in women, suggested that a modest increase in breastfeeding rates could save the UK National Health Service around £40 million a year (Renfrew et al. 2012). As part of a larger project which aimed to develop an intervention to improve inpatient care for young mothers intending to breastfeed (Hunter 2014), this small scale study explored the views of this group on their early postnatal inpatient experiences, in order to understand how these impacted on their infant feeding experiences and decisions. The participants' views of different breastfeeding support strategies were also explored, in order to ascertain appropriate and acceptable interventions for this client group.

Background

Questionnaire studies of pregnant and mothering teenagers in the US and UK have established that they know that breastfeeding is best for their babies' health and promotes bonding, and that more young mothers intend to breastfeed than actually start (Shaw et al. 2003, Wambach and Koehn 2004, Hunter 2008, Mossman et al. 2008). It is likely that young women's experiences in the early postnatal period impact on their feeding decisions. Literature from the UK, Canada and Australia suggests that young mothers feel uncomfortable in hospital and can have negative experiences of care, and that early, proactive breastfeeding support is crucial for this group (Benson 1996, Dykes et al. 2003, Nesbitt et al. 2012,

Noble-Carr and Bell 2012). Furthermore, psychological literature indicates that adolescents are in a liminal stage of development, caught between the worlds of childhood and adulthood (Frankel 1998). After birth, they are engaged in adopting the two new roles of adult and mother. This can make the early postnatal period a particularly vulnerable time for young women. It is suggested that emotional support and acceptance and validation of their new status is key if they are to negotiate this dual transition successfully (Frankel 1998). This study sought to add to current knowledge by further exploring the impact of inpatient experiences on young mothers' feeding decisions, incorporating their perceptions and feelings during this time, as well as their support needs.

Methods

A qualitative approach using constructivism was utilised to explore the reality that young women constructed in order to make sense of their inpatient experiences and explain their infant feeding decisions (Schwandt 2000). Focus groups were selected as an optimum vehicle for enabling the discussion and formation of views in a non-threatening environment (Kitzinger 1985). Open questions were used in a semi-structured format to promote discussion and gain data. This process is described in more detail elsewhere (Hunter & Magill-Cuerden 2014). Constructivism recognises that the findings of qualitative research can be influenced by the worldview of the researcher, who is intimately bound up in the process of data generation (Charmaz 2000). Reflexive strategies were therefore employed in the current study to ensure the young women's meanings were captured as accurately as possible. These included reflecting emerging concepts back to participants during the course of focus groups, using an inductive approach for data analysis, having a second researcher independently read the transcripts and identify themes, and validating findings with young mothers.

A total of 15 young women attended the focus groups, with four groups ranging from two to five participants. When only one person attended the focus group, which happened twice, they were interviewed in order to

capture all relevant voices and data from these vulnerable young women (Marlowe 2008). However, in these interviews the young parent group leader was not present. These numbers are comparable to those in other studies involving young mothers, whose participation can be difficult to secure (Dykes et al, 2003, for example). The interviews and groups lasted approximately two hours.

Participants/setting

Although generally considered a prosperous area, Oxfordshire has significant areas of social deprivation, with its city ranked in the second quartile in the English Index of Multiple Deprivation 2010 (Oxford City Council online). The young parent groups from which the participants were drawn were in deprived areas in different rural and urban locations where there were pre-existing young parent groups. A visit was made by the researcher to the parent groups to explain and discuss the study fully and provide information leaflets. Potential participants were invited to attend a focus group on a subsequent date.

Young women were able to participate if they had a good command of spoken English, as this was the language in which the researcher was able to conduct the groups, and full interaction and exchange of ideas was a necessary part of the process. They were invited to consent to participate if they had considered breastfeeding, they were aged 16 or over and had given birth at age 19 or under. If the young parent group leader indicated that a teenager would be distressed by taking part they were not invited to participate.

Six focus groups were held. On attending the focus group a discussion was held with each participant prior to their giving consent, ensuring that confidentiality and anonymity were understood and that each participant was aware that withdrawing or withholding consent would not compromise their care (Matthews 2006). Participants were assured that pseudonyms would be used for data transcription. Demographic information and data

were locked in separate places. Ethical approval was obtained from the local NHS Research Ethics Committee and the researchers' university.

Data collection

The first author facilitated the focus groups in the presence of the young parent group leader, with the consent of the participants attending the groups. The teenagers indicated that they were used to the parent group leader's presence at meetings. As she was familiar with their needs and views she could act as an additional level of support. The data was not concerned with the role of community care or the young parent groups.

Data analysis

The data were recorded, transcribed verbatim, coded inductively and analysed thematically, as described elsewhere (Hunter & Magill-Cuerden 2014). To confirm the validity of the emerging codes and themes emerging transcripts were analysed by a third person (Lincoln & Guba 1985).

Six months following the data collection it was difficult to reconvene the original focus groups to confirm the data as the teenagers had progressed in their lives and left the young parent groups. As it was not possible to undertake retrospective member checking with the original groups the new members of a young parent group were asked to review the data analysis. They were able to confirm that the codes and themes resonated with their experiences in hospital.

Findings

Of the 15 participants, twelve were White British, two were of mixed White/Black African heritage, and one was Portuguese. Eleven stated that they had completed their education, and four planned to return to school or college. Three women resided in the city, one in a village and eleven in rural towns. The women were aged between 15 years 11 months and 19

years 9 months when they gave birth. Their babies were aged from two weeks to 21 months at the time of the focus group. Two of the participants were nearing the end of pregnancy when they first attended a focus group. The group in which these women took part (Focus Group 1) was reconvened after they had given birth, in order to capture their experiences of breastfeeding (these two groups are counted as one in the analysis as the same women attended on both occasions, and the second group was a continuation of the discussion commenced in the first). All but one of the participants was primiparous. The participants in each focus group knew one another socially. When they attended a focus group, three of the women were still breastfeeding, one had breastfed for over a month, two for 15 days to one month, another for 8 days to two weeks and another for 3-7 days. Seven had breast feed once, twice or not at all. Participant details are outlined in Table One below. In the findings, the focus groups are numbered 1-4. The two 'groups' with only one participant are designated Interview 1 and 2.

Table One. Demographic details of participants

Focus group attended (and location)	Ethnic origin	Age at baby's birth (years,months)	Age of baby at time of focus group	Length of time breastfed	Still in education or planning to return	Age on leaving school
1 (city)	Mixed white British/ Black African	19,9	1 month	Still breastfeeding	Yes	N/A
1 (city)	White British	18,11	8 months	15 days- 1 month	No	15
1 (city)	Portuguese	19,2	1 month	Still breastfeeding	Yes	N/A
2 (town)	White British	15,11	21 months	Once, twice or not at all	No	16
2 (town)	Mixed white British/ Black African	18 or 19 (exact age not divulged)	18 months	Once, twice or not at all	No	Not divulged
3 (town)	White British	19,0	19 months	Once, twice or not at all	No	16
3 (town)	White British	16,6	11 months	Once, twice or not at all	Yes	N/A
3 (town)	White British	18,10	18 months	3-7 days	No	16
3 (town)	White British	19,1	2 weeks	Still	No	16

				breastfeeding		
3 (town)	White British	19,0	18 months	8 days – 2 weeks	No	16
4 (town)	White British	19,2	2 months	15 days – 1 month	Yes	N/A
4 (town)	White British	18,6	2 months	Once, twice or not at all	No	Not divulged
4 (town)	White British	18,0	17 months	Once, twice or not at all	No	Not divulged
Interview 1 (town)	White British	19,3	8 months	Once, twice or not at all	No	16
Interview 2 (village)	White British	18,5	4 months	Over a month	No	16

The findings presented below focus on inpatient care (personal and cultural influences on care, which were also discussed by the participants, are reported elsewhere – Hunter & Magill-Cuerden 2014). Experiences of care have been separated into time spent on Labour Ward and time on the postnatal ward. The participants' ideals for breastfeeding support are also outlined. In the direct quotations which follow, the convention of '...' is used to indicate words have been cut; '..' indicates a pause, and square brackets are used to add explanation where necessary.

Post birth experience on Labour Ward: disempowered and passive

The participants described post birth experiences on Labour Ward that affected their self-confidence and their relationships with their babies. This then affected what happened in relation to the newborns being fed. Three themes were identified: 'feelings at birth: 'so tired and so dazed', 'deliver, stitch, dress', and 'initiating feeding'.

Feelings at Birth: 'so tired, and so dazed'

Many of the young women felt incapacitated by tiredness and pain after giving birth. Although Vicky described feeling 'instant love' for her baby (Focus Group 3), the new mothers were more likely to use words like

'tired', 'dazed', 'scared', 'hungry' and 'overwhelmed' to describe how they felt after giving birth.

Pain featured strongly in the participants' recollections of this time, and appeared to prevent the new mothers from relating to their newborns:

Avril: ...'cos they was like 'do you want cuddles with her while you're having your stitches?' And I was like 'No!' 'Cos I didn't know if it was gonna hurt (Focus Group 1).

The young women also spoke of the shock of finding themselves immobile and helpless:

Tanya: I think that's horrible innit, when you can't move. ...I felt a bit like 'oh my God... like, I couldn't even go for a wee on me own – it was just awful..

Lauren: I know, I was exactly the same..

Tanya: I felt like a baby or an old lady..

Lauren: I didn't even dress him, or put a nappy on the first time (Focus Group 4).

At the very moment when they were embarking on their adult, mothering lives, the young women felt utterly incapacitated.

Deliver, stitch, dress

The young women's descriptions indicated that the focus of care was on completing tasks. The health professionals' first task after the birth was to check the baby. This resulted in some of the young women not being able to greet their newborns:

Becky: And I remember one of the midwives holding him up, like at the end of the bed – and of course I can't see that far [Becky is partially sighted]. And I couldn't see him, and then they took him away (Focus Group 1).

Once the baby had been declared healthy, the immediate postnatal period was then dominated by requirements to suture the mother and dress the baby:

Lottie: ...they passed her to me, like when they cut the cord and everything, but then I had to have stitches, so they like took her, dressed her, and then she was just in the cot (Focus Group 3).

After this, health professionals tended to leave the room, resulting in some of the new mothers feeling abandoned:

Lauren: I got left on my own, the minute I had him – they all went, when they knew he was OK (Focus Group 4).

These activities did nothing to address the helplessness felt by the young women, alleviate their discomfort and pain, or encourage and guide them in their new mothering roles.

Initiating feeding

Participants were aware of the importance of skin to skin contact for initiating breastfeeding, and had intended to initiate this after birth. However, their exhaustion and pain, combined with task-focused care, conspired against this happening for any meaningful length of time. The young women did not feel able to challenge this situation or make any demands of their carers however. One woman, Clare, didn't even feel able to ask for her baby to be passed to her for a cuddle after she was left alone in the delivery room, or to move the child herself without permission. Similarly, Katie did not feel able to ask for or initiate skin to skin contact:

Katie: Well I wanted to [have skin to skin] but they, they didn't, they wouldn't let me

Researcher: Why was that?

Katie: Well they didn't say I can't do it, they just didn't say anything to me to do it' (Focus Group 3).

The notion that if something wasn't offered then it must be forbidden was a common thread in the data.

When skin to skin did happen, mothers were usually able to enjoy an unremarkable, successful first breastfeed:

Avril: ...and then we had skin to skin and then she ate a bit (Focus Group 1).

For most mothers though, the first breastfeed was generally initiated by midwives, either during or just after the mother was sutured, or just before the new family was moved from the delivery room to the postnatal ward. Nearly all the new mothers described the first breastfeed as something that was done to them, rather than something they were helped to do themselves. Many described being man-handled, and found the midwives' manner very abrupt:

Clare: I was just left, and then when I was gonna like be moved up onto the ward the nurse come and she just like sort of grabbed [baby] and tried to like ram her on to my breast and that (Focus Group 3).

Participants in 3 groups (Focus Groups 2, 4, Interview 1) had intended to breastfeed but were not given any feeding support at all, as staff assumed they would want to bottle feed. Rachel had written about skin to skin contact and breastfeeding in her birth plan, but was not offered either:

'I dunno I just didn't get round to – after I had him – they didn't present it as an option really, they just thought I was bottle feeding' (Interview 1).

Lauren related that she was asked about her feeding intentions over the intercom:

‘And they just buzzed through and they went ‘do you want – are you bottle feeding or breastfeeding?’ So I went ‘yea’. ‘What milk?’ ‘Cow and Gate’. That was it, then. [Pause]. I had no support there (Focus Group 4).

Overall, the participants’ accounts indicate that they felt exhausted and disempowered after giving birth. Task-based, routinised care, during which the young women were treated as objects rather than self-determining individuals, reinforced their perceived helplessness and encouraged a passive acceptance of hospital routines and rituals that discouraged a positive start to breastfeeding. These feelings were exacerbated on the postnatal ward.

The postnatal ward: alien, alone and exposed

Three themes were identified relating to experiences on the postnatal ward: ‘an alien environment’, ‘feeling exposed and judged’, and ‘miscommunications’.

An alien environment

The young mothers clearly saw themselves as outsiders on the postnatal ward, viewing it as an alien environment in which they didn’t always feel comfortable or understand what was expected of them. Even those like Lucy (Focus Group 2), who liked being on the ward because ‘it was nice. It was always clean’, initially found the set up quite strange:

‘it was really weird...you see all these women walking around!... I’ve never seen so many babies in my life’ (Focus Group 2).

The unfamiliarity of the ward is particularly brought into focus when the young women’s families go home:

Tanya: ...and then like my Mum went home and it was just like 'oh my God I'm here on my own... It was just really, like, creepy – I think of hospitals as where you go to.. die' (Focus Group 4).

The strangeness of the ward was compounded by routines and rules that appeared nonsensical to the young mothers, such as a requirement to transport babies in cots, rather than carrying them in their arms. Together with some ward routines, these regulations further disempowered the young women, putting the midwives firmly in charge:

Sarah: ...she [the midwife]'d come and open my curtains at like six o'clock in the morning, and I was next to the window, and I'd only just sort of got to go to sleep (Interview 2).

Such experiences did nothing to address the young women's feelings of discomfort and alienation, or encourage them to relate to and breastfeed their babies.

Feeling exposed and judged

Alone on the ward, the young women also felt exposed, watched and judged by both midwives and other mothers:

Tanya: I think they [midwives] do talk down to you (Focus Group 4).

In some instances, this was mitigated by young women being given a single room:

Jemma: ...being in a room where no one can really look at you or anything like that – that's what made me feel a bit more – um, like myself, ...it wouldn't feel like anyone was peeking round looking at me (Focus Group 3).

This sense of exposure, together with a perceived lack of privacy on the ward, led to young mothers feeling unable to perform intimate mothering tasks such as holding their babies skin to skin, or expressing breastmilk:

Lottie [re skin to skin]: I think that when you're downstairs [on Labour Ward] it's better 'cos you're like on your own, but when you go upstairs there's like other people, and I wouldn't wanna do it (Focus Group 3).

The young mothers' intense discomfort did result, in some cases, from genuine discrimination:

Sarah: she [midwife] kept going round to all the other women like 'oh she's gorgeous! What's her name?' And then she'd come to me and she just wouldn't ask me a thing (Interview 2).

However, most of the participants reflected that their perceptions of midwives' and other mothers' unfriendliness may not have been entirely fair, as pregnancy and new motherhood were emotionally stressful times when they were more likely to feel slighted and take offence where perhaps none was intended:

Tanya: Well I took everything to heart actually, so most probably it wasn't her [midwife], it was probably just – just the way I was at the time (Focus Group 4).

The young women's discomfort on the ward was also due in part to their being exposed to different cultures and practices during their hospital stay. It was evident that many of the participants had never been away from home before, and had very little experience of life outside their own communities.

Miscommunications

The young women's accounts revealed instances of a basic inability of some health professionals and adolescents to understand and communicate with one another. This appeared to stem at least in part from the young mothers not trusting their carers:

Tanya: ...she [midwife] was really nice but I didn't know if she was just being nice to be nice, or if she was genuinely nice (Focus Group 4).

In particular, the young women often failed to communicate their needs to the health professionals on the ward. Despite their awareness that the ward was a very busy place and that staff were overstretched, they tended to wait for help to be offered rather than asking for assistance. This meant that breastfeeding opportunities were missed, particularly since it was evident that even if they had given their baby a bottle on labour ward, the mothers would still have liked to initiate breastfeeding. Lucy (Focus Group 2), who bottle fed her baby after birth, eventually felt able to ask for help with breastfeeding on day three of her postnatal stay, only to have her request dismissed:

'I said to them 'I wanna try and breastfeed at night time'. They said 'oh, it's going to take a while to get used to breastfeeding', and I said 'OK then'. And I just thought 'oh, we'll try it'. But we never did'.

Other participants did receive breastfeeding support when they asked for it, but were unable to communicate their wish to be shown what to do, and not simply to have their baby latched on for them:

Lottie: ...when they helped me they just like put her on, but they didn't actually help me to do it myself... that's why I couldn't really do it myself or anything (Focus Group 3).

A general discomfort with asking for help led some participants to adopt more devious tactics to attract the midwives' attention:

Sarah: Sometimes I used to press the buzzer, sort of put it back, and they'd come and I'd say 'oh, oh, I must have leant on it!' And then I'd say 'oh, while you're here..', because I just felt like I was being such a nuisance (Interview 2).

Other mothers would close down interactions and not communicate their needs when help was perceived as unsympathetic:

Jemma: she came in and she said 'what do you want? We're busy'. Sort of, like that! And I was thinking 'alright, don't bother then! I'll try and do it [latch baby on] myself'. And I just said 'don't worry about it' (Focus Group 3).

As a result of experiences such as those described above, most of the new mothers felt that they had worked out how to breastfeed on their own:

Shannon: ...luckily we [Shannon and baby] worked it out together (Focus Group 1).

Being there: a need for relational support

Participants were asked what breastfeeding support they would have liked in hospital. Their views were also sought on a number of different informational, instructional, emotional, esteem and network interventions provided by health professionals or peers and dispensed face to face, via text or online. Support from health professionals was seen as fundamental:

Jemma: I wouldn't really wanna talk to anyone else about it [breastfeeding] except like a midwife or a nurse or something (Focus Group 3).

Breastfeeding support should, in the views of the young women, be given in the context of an open and honest relationship and give young mothers a realistic idea of what to expect, warn them that difficulties are normal and give strategies for overcoming them:

Becky: 'cos if you get a problem then, you know, if you don't know what it is or why it's happened you're gonna freak out about it. Whereas if you've got some sort of idea of why it's happening, it's not gonna be quite so scary (Focus Group 1).

Sarah: No one ever says to you... it's like normal to not be able to do it...I just felt like a complete failure, because no one .. had explained to me .. that I weren't the only one (Interview 2).

Praise and proactive support were also considered essential. Participants appreciated midwives spending time with them, working alongside them without putting them under pressure or taking control, and reassuring them that they were doing well. Even if young mothers were not having problems with breastfeeding, the midwife's presence was incredibly reassuring:

Avril: It's like that support, kind of comfort, it's like kind of protecting you, just knowing that you're doing the right thing (Focus Group 1).

Mothers who had been shown how to feed and care for their newborns were noticeably more satisfied with their postnatal care:

Lucy:...so they helped me while I changed him, and they helped me dress him and showed me how to do it... And then he had a bath – they showed me how to bath him... So it was alright. It was alright (Focus Group 2).

If this nurturing aspect of support was missing, however, offers of help or advice could be perceived as putting unwelcome pressure on the new mothers. This was likely to backfire, as Sarah's response when she is asked if she will breastfeed her next baby shows:

'I dunno whether I'd just wanna say ' do you know what – no, I don't wanna do it'...just to get them off my case a little bit'
(Interview 2).

Perhaps in view of their difficulties obtaining breastfeeding support on the postnatal ward, participants suggested that a specialist breastfeeding supporter should offer proactive guidance at this time. Some felt that new mothers should not be allowed home until such support had been given.

Peer relationships and support

While participants would prefer to receive breastfeeding information, guidance and esteem support from a midwife, they looked to their peers for emotional support and encouragement:

Shannon: I think I'd rather hear I'm doing well from somebody that done it. Quite recently as well...than...say a midwife that's never had children (Focus Group 1).

They could only relate to the idea of peer support, however, if the peers were their own age and going through similar experiences:

Clare: or even if that person was maybe like pregnant as well, the same way as you. Then when you like give birth you can both talk about like the experience and everything, and what you both find helpful and how they've done it and stuff like that (Focus Group 3).

The ability to access peers in a similar situation, even online, is considered an important part of coping with motherhood:

Shannon: They [new mothers] can just sit there [by a computer], and they've got their baby and they've got their advice

Becky: Yea

Shannon: And other young Mums that are there – not necessarily in the same room, but they're still there to help (Focus Group 1).

The young women were wary, however, about accepting breastfeeding support from 'strangers', either online or face to face. The idea that help might be provided by text or in person by volunteer visitors to the ward was felt to be unacceptable because such people were not professionals and were not known to the young women.

Discussion

The findings from this study suggest that young women often feel disempowered and vulnerable immediately after birth, and adopt a relatively passive role, rarely challenging established practices. Care at this time is dominated by routines that discourage breastfeeding initiation by putting health professionals firmly in control, compounding the helplessness felt by the young women. On the postnatal ward young mothers felt uncomfortable and judged by other mothers and staff. They had difficulties procuring the help and support they required. Young women considered relational breastfeeding support from health professionals such as praise, proactive assistance and the discussion of coping strategies, to be most effective. Ongoing proactive offers of help emerged as particularly important as some young women still intended to breastfeed even if they had given their baby formula milk on Labour Ward. Peer friendships emerged as an important source of emotional support for young breastfeeding mothers.

Previous research focussing on general inpatient experiences as well as specifically on breastfeeding has also indicated that young mothers feel isolated and judged in hospital, are reluctant to ask for help and feel infantilised by the medical nature of intrapartum care (Dykes et al. 2003, Bailey et al. 2004, Peterson et al. 2007). The assumption of some UK midwives that young mothers will want to formula milk feed is also noted elsewhere (Brown et al. 2011, Condon et al. 2012). This study shows how the treatment of young mothers postnatally impacts on their behaviour and feeding decisions by reinforcing feelings of incapacity and helplessness. Although these emotions are also felt by some older women (Schmied et al. 2009), as women in the liminal states of both adolescence and new motherhood, young mothers are particularly vulnerable and require additional support and validation in order to build identities as confident and capable breastfeeding mothers. The current findings show that when such support is not forthcoming young women adopt more passive and child-like roles and feel unable take control or act on their own initiatives: some do not even feel able to hold their own babies without permission. The young women's sense of vulnerability further manifests itself in a mistrust of the motivations of those caring for them and a propensity to take offence at any perceived slight. Even aspects of care such as leaving a mother and baby alone after birth, often seen by caregivers as providing the new family with space to get to know each other in private, may be interpreted as abandonment.

The breastfeeding support requirements outlined by the young women in this study are similar to those desired by older mothers (Schmied et al. 2009). Specifically, building confidence and self-esteem by involving young women in their care and the care of their babies appears to validate them as the responsible, capable adults they are anxious to become. This has also been noted by a Canadian study (Peterson et al. 2007). Providing young people with coping strategies has been identified as a key tactic in enabling them to take control of and cope with adult life (Frydenberg 1997). Furthermore, the current findings support and

strengthen the observation that, for young mothers, relational support is fundamental to the acceptability of other interventions (Dykes et al. 2003).

By specifically asking young mothers for their views on support interventions, this study has highlighted the perceived importance of health professionals in giving breastfeeding information and support in the early postnatal period. It was to their peers, however, that young mothers looked to for emotional support whilst breastfeeding. Looking to a peer group for support and validation is a defining feature of adolescence (Frankel 1998). Support from peers has been identified in the US and UK as increasing confidence and self-esteem as young mothers build new lives and identities (Clemmens 2003, Formby et al. 2010). Attending a breastfeeding support group has been correlated with increased breastfeeding duration in another UK study (Brown et al. 2011). There is perhaps an argument for fostering informal peer friendships antenatally and in hospital, however, rather than investing in training teenagers to become formal peer supporters - an approach that has been found to be fraught with difficulties (Di Meglio et al. 2010). Even if peers were trained successfully, their impact may be limited if they were viewed as outsiders or 'strangers' by those they tried to help.

Although other researchers have found young mothers to be ambivalent about skin to skin contact (Stapleton 2010), participants in the current study had intended to initiate this. The success of uninterrupted skin to skin contact for those mothers who were able to have this indicates that this intervention may go some way to addressing the distress experienced by new mothers, as well as helping their babies initiate breastfeeding.

Limitations

The study was limited to one geographical area of the United Kingdom though the research gained a view of teenage parents from differing deprived locations. The findings in this study may not be transferable to a wider population of teenage mothers as the number of participants was

small and self-selecting from young parent groups, though the data offer a glimpse of the perspectives of young teenage women who experience postnatal care in hospital. Whilst the transcripts were reviewed by a third person to agree coding and development of the themes, the focus groups and data collection with initial coding were undertaken by one researcher. This could cause bias of the internal validity of the study. However, confirmability of the data was audited through member checking and the findings, whilst offering some new insights, demonstrated similarities to other research in USA and UK suggesting that the views given here could be those of other young mothers who wish to breastfeed.

Conclusion

Young mothers can find giving birth an overwhelming and disempowering experience, and feel uncomfortable and out of place in a hospital environment where care is focused on tasks. These experiences, combined with the absence of uninterrupted skin to skin contact, militate against initiating and continuing to breastfeed. Young mothers particularly require relational and esteem support and validation, but lack the confidence and social skills necessary to access such assistance. Proactive support is therefore a crucial ingredient of breastfeeding success. The participants in this study particularly appreciated a professional working alongside them, offering encouragement and a realistic appraisal of the challenges ahead. Additionally, emotional support from other known young mothers who are going through, or have recently gone through, a similar experience is considered immensely helpful as young mothers overcome challenges and acclimatise to their new roles.

Key messages

Task-focused care compounds young mothers' feelings of helplessness and dependence after giving birth and discourages the initiation of breastfeeding.

Young mothers will wait for and value proactive offers of breastfeeding support on the postnatal ward, even if they have given a formula milk feed.

Health professionals are the preferred providers of breastfeeding support and guidance, but young women look to their peers for emotional support.

References

Bailey N., Brown G., DiMarco H., Letherby L., Wilson C. (2004) Teenage pregnancy: medical encounters. *British Journal of Midwifery* **12:11**, 680-85.

Benson S. (1996) Adolescent mothers' experience of parenting and breastfeeding – a descriptive study. *Breastfeeding Review* **4:1**, 19-26.

Brown A., Raynor P., Lee M. (2011) Young mothers who choose to breastfeed: the importance of being part of a supportive breast-feeding community. *Midwifery* **27**, 53-9.

Charmaz K. (2000) Grounded Theory: objectivist and constructivist methods. In *Handbook of Qualitative Research. 2nd Edition* (eds Denzin N and Lincoln Y), pp. 509-36. Sage: London.

Clemmens D. (2003) Adolescent motherhood – a meta-synthesis of qualitative studies. *Maternal and Child Nutrition* **28:2**, 93-9.

Condon L., Rhodes C., Warren S., Withall J., Tapp A. (2012) But is it a normal thing? Teenage mothers' experiences of breastfeeding promotion and support. *Health Education Journal* **72:2**, 156-62.

DH (2012) *Public Health Outcomes Framework for England 2013-2016*. DH: London.

Di Meglio G., McDermott M., Klein J. (2010) A randomised controlled trial of telephone peer support's influence on breastfeeding duration in adolescent mothers. *Breastfeeding Medicine* **5:1**, 41-7.

Dykes F., Hall Moran V., Burt S., Edwards J. (2003) Adolescent Mothers and Breastfeeding: Experiences and Support Needs – An Exploratory Study. *Journal of Human Lactation* **19:4**, 391-401.

Dyson L., Renfrew M., McFaddon A., McCormick F., Herbert G., Thomas J. (2006) *Promotion of Breastfeeding initiation and duration. Evidence into practice briefing*. National Institute for Health and Clinical Excellence: London.

Formby E., Hirst J., Owen J. (2010) Pathways to adulthood: reflections from 3 generations of young mothers and fathers. In *Teenage Parenthood: what's the problem?* (eds Duncan S., Edwards R. Alexander C.), pp. 85-110. Tufnell Press: London.

Frydenberg E. (1997) *Adolescent Coping – theoretical and research perspectives*. Routledge: London.

Hunter L. (2008) Teenagers' experiences of postnatal care and breastfeeding. *British Journal of Midwifery* **16:12**, 785-90.

Hunter L. (2014) *Supporting teenage mothers to initiate breastfeeding and developing a support intervention to increase breastfeeding rates in a vulnerable group*. Unpublished PhD thesis. University of West London: London.

Hunter L., Magill-Cuerden J. (2014) Young mothers' decisions to initiate and continue breastfeeding in the UK: tensions inherent in the paradox between being, but not being able to be seen to be, a good mother. *Evidence Based Midwifery* **12:2**, 46-51.

Kitzinger J. (1995) Introducing Focus Groups. *British Medical Journal* **311**, 299 – 302.

Lincoln Y., Guba E. (1985) *Naturalistic Inquiry*. Sage Publications Inc.: Beverley Hills, California.

Matthews J. (2006) *Introduction to Randomised Controlled Trials. Second Edition*. Chapman and Hall: Florida, USA.

Mossman M., Heaman M., Dennis C., Morris M. (2008) The Influence of Adolescent Mothers' Breastfeeding Confidence and Attitudes on Breastfeeding Initiation and Duration. *Journal of Human Lactation* **24:3**, 268-77.

Nesbitt S., Campbell K., Jack S., Robinson H., Piehl K., Bogdan J. (2012) Canadian adolescent mothers' perceptions of influences on breastfeeding decisions: a qualitative descriptive study [online]. *BMC Pregnancy and Childbirth*. Available at <http://www.biomedcentral.com/1471-2392/12/149>. [Accessed on 15.01.2013].

The NHS Information Centre (2012) Infant Feeding Survey 2010. Available at <http://www.ic.nhs.uk/pubs/infantfeeding10final> [Accessed 03.12.12].

Noble-Carr D., Bell C. (2012) Exposed: younger mothers and breastfeeding. *Breastfeeding Review* **20:3**, 27-38.

Oxford City Council (online) *Poverty and deprivation statistics*. Available at http://www.oxford.gov.uk/PageRender/decC/Poverty_and_deprivation_statistics_occw.htm. [Accessed 21.01.2014].

Peterson W., Sword W., Charles C., DiCenso A. (2007) Adolescents' perceptions of inpatient postpartum nursing care. *Qualitative Health Research* **17:2**, 201-12.

Renfrew M., Pokhrel S., Quigley M., McCormick F., Fox-Rushby J., Dodds R., Duffy S., Trueman P., Williams A. (2012) *Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK*. UNICEF UK: London.

Schmied V., Beake S., Sheehan A., McCourt C., Dykes F. (2009) A meta-synthesis of women's perceptions and experiences of breastfeeding support. *JBIM Library of Systematic Reviews* **7:14**, 583-614.

Schwandt T (2000). Three epistemological stances for qualitative inquiry: interpretivism, hermeneutics and social constructivism. In *Handbook of Qualitative Research. 2nd Edition* (eds Denzin N and Lincoln Y), pp. 189-214. Sage: London.

Shaw R., Wallace L., Bansal M. (2003) Is breast best? Perceptions of infant feeding. *Community Practitioner* **76:8**, 299-303.

Silverman D. (2006) *Interpreting qualitative data. 3rd Edition*. Sage: London.

Stapleton H. (2010) *Surviving teenage motherhood: myths and realities*. Palgrave: London.

Wambach K., Koehn M. (2004) Experiences of infant-feeding decision-making among urban economically disadvantaged pregnant adolescents. *Journal of Advanced Nursing* **48:4**, 361-70.