

## A narrative analysis of the birth stories of early-age mothers

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**Abstract** The telling of birth stories (i.e. stories that describe women's experiences of giving birth) is a common and important social practice. Whereas most research on birth narratives reflects the stories of middle-class, 'adult' women, we examine how the birth stories told by early-age mothers interconnect with broader narratives regarding social stigma and childbearing at 'too early' an age. Drawing on narrative theory, we analyse in-depth interviews with 81 mothers (ages 15–24 years) conducted in Greater Vancouver and Prince George, Canada, in 2014–15. Their accounts of giving birth reveal the central importance of birth narratives in their identity formation as young mothers. Participants' narratives illuminated the complex interactions among identity formation, social expectations, and negotiations of social and physical spaces as they narrated their experiences of labour and birth. Through the use of narrative inquiry, we examine the ways in which re-telling the experience of giving birth serves to situate young mothers in relation to their past and future selves. These personal stories are also told in relation to a meta-narrative regarding social stigma faced by 'teenage' mothers, as well as the public's 'gaze' on motherhood in general – even within the labour and delivery room.

**Keywords:** birth, narrative, early-age motherhood, adolescent pregnancy

### Introduction

The historical and ongoing prevalence of stories about key life events reveals the centrality of narratives as a source of knowledge about social life. Stories are told (and re-told) in the form of ongoing and evolving sources of information, knowledge construction, and sense making (Larkin *et al.* 2009, Williams 1984), although the use of narratives as an organised version of reality and a legitimate form of 'knowing' has been problematised in various forms and for reasons of both ontological and epistemological origin (Meretoja 2014).

The telling of stories that describe women's experiences of giving birth is a common and important social practice in many cultures. These stories tend to feature descriptions of experiences with pregnancy and preparation for childbirth, the experience of labour, and the birth

itself. Birth stories are sometimes told as a culmination of other key events, such as conception or longer-term postpartum experiences (e.g. children's developmental milestones). And it is through narrated processes that birth stories and their intersections with other narratives help to situate mothers and others within the broader social, cultural, and indeed, medical worlds (Cook and Loomis 2012, Dillaway and Brubaker 2006, Larkin *et al.* 2009, Malacrida and Boulton 2014).

The peer-reviewed literature includes few birth stories from mothers under the age of 25 (i.e. early-age mothers), although strong, and often discriminatory, narratives about early motherhood serve to construct these mothers as social deviants (Brand *et al.* 2014, Dillaway and Brubaker 2006, Kelly 1996). By giving birth to their children before finishing high school, getting a job, or getting married, young mothers' life stories (especially those of young, single mothers) stand in stark contrast to authorised chronologies of normative modern Western motherhood (Barcelos 2014, Breheny and Stephens 2007). While much has been written about the power of stereotypes to stigmatise early-age mothers (Breheny and Stephens 2007), only a few studies have been published regarding early-age mothers' experiences of giving birth. The existing empirical research suggests that women's experiences with and feelings about child-birth may differ across age groups (Pillitteri 2009, Low *et al.* 2003, Nichols *et al.* 2014, Sauls 2010). For example, Low *et al.* (2003) suggest that early-age mothers are more likely than older mothers to perceive the responsibility of being a parent as being more 'painful' than the physical pain associated with labour and birth (whereas 'older' mothers are more likely to express concern about the physical pain of labour and birth). Other research has found that early-age mothers are less likely to describe being satisfied with their birth experiences than older women (Public Health Agency of Canada 2009), although the reasons for this remain unclear. Bissell (2000), however, suggests that other factors (e.g. ethnicity or social class identities of mothers) may explain differences in birth stories between early-age mothers and other mothers. In their examination of young mothers' birth narratives, Nichols *et al.* (2014) found associations between birth satisfaction and adolescent mothers' sense of agency and experiences of positive support. Together, these studies indicate a complex relationship among age, other socio-demographic factors, environment and personal agency – all of which may contribute to young mothers' birth experiences. Building on this nascent body of literature, we undertook the current analysis to contribute to enhanced understandings of how early-age mothers situate themselves and other people, such as their children, spouses/partners, as well as healthcare providers, in their stories about giving birth (Barcelos 2014, Nichols *et al.* 2014, Sisson 2012).

## Methods

We employed narrative analysis techniques (Cortazzi 2001, Mishler 1986) to analyse the birth stories presented to us during in-depth, individual interviews with 81 mothers (aged 15–24), seeking to understand how their telling of birth stories served to make meaning out of their experiences. Narrative inquiry concentrates on the stories that people tell; it positions those stories as having central roles in identity formation, and in contextualising and explaining the significance of key life events (Clandinin and Connelly 1998, Mattingly 1998), which we suggest is particularly relevant to studying birth stories (Erdmans and Black 2015). Narrative has been acknowledged as a means to recount and make sense of past events – and, as being reflective of who the teller was, is, and may become (Cortazzi 2001). We recognise that stories told within a research interview context may take on a particular form and content, and that such narratives might differ from stories one might tell peers (Ochs and Capps 2001).

However, we suggest that all narrative accounts, including those gathered through research interviews, are partial and shift over time, context, and according to audience (Cortazzi 2001). Moreover, the potential schism between a teller's actual experience and their representation of that experience is of import within narrative inquiry – indeed, the way one tells a story helps to reveal its meanings (Cortazzi 2001, Good 1994).

### *Setting*

This analysis is based on data gathered during an ongoing longitudinal study of the lived experiences of young parents in two metropolitan regions of British Columbia (BC), Canada: Greater Vancouver (GV), pop. 2,313,328 (Statistics Canada 2011) and Prince George (PG), pop. 71,974 (Statistics Canada 2011). BC's largest metropolitan area is GV, while PG is the largest city in northern BC. PG is a regional hub for services designed to meet the needs of early-age mothers, including education and healthcare services. In Canada, the total fertility rate has decreased: this is attributed primarily to the decreasing number of births to women who are under the age of 30 (Statistics Canada 2013). In 2011, more than half of all live births in Canada occurred among women who are over the age of 30 (Statistics Canada 2013). BC's age-specific fertility rates (ASFR) are lower than the Canadian average for all age groups, except among women who are 45 years or older (Statistics Canada 2013). The ASFR for mothers under 20 in BC was 7.0/1000, and for women aged 20–24, the rate was 30.2/1000 (BC Statistics 2015). In PG, the ASFR for mothers under age 20 was 15.9/1000, and 64.0/1000 for mothers ages 20–24 (BC Statistics 2015). Comparatively, across GV, the ASFR for women ages 15–19 was between 0–2.8/1000, and between 3.7–13.9/1000 for women ages 20–24 (BC Statistics 2015). In contrast, the national ASFR for women aged 30–34 was 98.1/1000 (Statistics Canada 2013).

In BC, the cost of antenatal and birthing care is typically covered by the provincial health insurance plan, the Medical Services Plan (MSP). Through MSP, a pregnant woman may choose a family physician, an obstetrician, or a licensed midwife to act as the primary caregiver during pregnancy, labour, and during the post-natal period (Provincial Health Services Authority 2014). Guidelines for care of pregnant women in BC vary by professional group; however, all publicly funded services endorse a 'woman-centred' approach (British Columbia Perinatal Health Program 2010). This approach is described as relying 'on understanding women's preferences and needs with respect to care. It also involves engaging women and their families (as defined by the woman) as partners in the processes of planning, delivering and evaluating services' (British Columbia Perinatal Health Program 2010).

An appreciation of the sociocultural and historical impact of colonisation is also important to the current analysis. PG lies within the traditional territories of the Dakelh First Nations People, while GV exists on the traditional territories of the Coast Salish, Musqueam, and Tsleil-Waututh. Recently, the Truth and Reconciliation Commission of Canada (2015) released a report documenting the cultural genocide committed against Indigenous<sup>1</sup> peoples of Canada. The report highlights the impacts of the systematic removal of Indigenous children from their families and communities to so-called 'residential schools', with the singular objective of breaking children's links to their Indigenous cultures and identities. The report states '[i]n establishing residential schools, the Canadian government essentially declared [Indigenous] people to be unfit parents' (The Truth and Reconciliation Commission of Canada 2015: 4). The ramifications of these actions are only beginning to be acknowledged and addressed by Canadian society and are particularly important in helping to contextualise the narratives of mothers in our study who self-identify as Indigenous. According to the latest available Census, 4.8 per cent of the entire population in BC identify as Indigenous; while less than 2 per cent in GV and over 11 per cent in PG identify as Indigenous (Statistics Canada 2007).

### *Recruitment and data collection*

Participants in each city were recruited through three alternative school programmes as well as five community-based youth and parenting programmes using both passive and active recruitment methods. Recruitment posters were posted at each site. Research staff also visited each site multiple times, explaining the study to all programme participants and inviting them to participate. Some of the programmes also agreed to post recruitment information about our study on Facebook pages accessed exclusively by programme members. Women were eligible to participate in an interview if they were between the ages of 15–24, were pregnant or had a child/children, were fluent in English, and lived in one of the two study communities. Written informed consent was obtained from participants prior to each interview. Interviews were conducted in private spaces and the interviews were open-ended and conversational in style. Two research staff and one doctoral student conducted the interviews. One of three interviewers was a parent and all were female, white, and in their thirties or early forties. Questions from the semi-structured interview guide covered a range of topics, including: preparations for labour, experiences during labour and birth, and perceptions about others who figured in their stories about giving birth. Each interview took between 40 minutes and two hours to complete; all interviews were audio-recorded and transcribed verbatim. All participants were provided with a \$30 cash honorarium. Participants were offered the opportunity to review and revise their interview transcripts. This study was approved by the University of British Columbia's Behavioural Research Ethics Board (Certificate #: H13-00415), as well as by the school boards that operated each alternative education programme for young parents. Two school boards agreed that young parents under the age of majority should be considered emancipated minors and did not require us to obtain parental/guardian consent; a third school board required active consent from parents/guardians on behalf of young mothers who were classified as minors.

### *Data analysis*

We drew on techniques associated with narrative inquiry (Clandinin and Connelly 2000, Mishler 1986) to illuminate the meanings that these young mothers ascribe to giving birth and to examine the meanings of the key experiences described within their birth stories. To guide our approach to analysing and interpreting the birth stories as told to us, we employed techniques described by Cortazzi (2001), examining the elements of each story in an effort to identify the meaning that the events hold for the storytellers. These dimensions commonly included a description of the events (e.g. who, what, when and where); the experiences that the narrator ascribes to those events (e.g. feelings, reactions and meanings); the form of the narrative (e.g. oral or visual); as well as moral and aesthetic evaluations of the events (Cortazzi 2001). We also identified other characteristics in the stories such as voice, verb tense, points that are emphasised or downplayed, and aspects that may appear contradictory to one another (Cortazzi 2001). We searched across stories for central patterns or themes, which we refer to hereafter as narratives. In our analysis, we treated the mothers' birth stories as representations of their individual and relational constructions of key events. We recognise that their storytelling and our analysis of their stories involved choices by them and by us – choices about what aspects of stories to tell or omit and which pieces to emphasise or to downplay. The interviews also involved interpretations during the acts of telling and listening (e.g. mothers' reactions to the interviewer's verbal and non-verbal cues; mothers' own somatic and emotive manifestations involved in telling and having their stories listened to) (Bamberg 2012, Cortazzi 1993).

After being stripped of all identifying information, accuracy checked, and member checked (81% of participants opted to review their own transcript), interview transcripts were uploaded into NVivo 10 (QSR International, Brisbane). Transcripts were then read and reread to inform initial conceptual coding efforts. Utilising thematic content analysis, we identified individual-

level concepts in the interviews, and then discussed, revisited, and compared those concepts with data from additional interviews. Six research team members participated in the initial coding and data analysis. Findings were discussed and analyses revised at team meetings. We used this process to begin to identify nascent themes across the interviews. Participants' transcripts and our accompanying fieldnotes were frequently re-read throughout the analysis to ensure that we understood the chronology presented within the narratives as well as to help the analysis stay as close as possible to the described experiences and contextual factors that mothers featured in their stories (e.g. social position and intimate or familial relations) (Cor-tazzi 2001, Erdmans and Black 2015). As new interviews were completed, we continued to use this comparative approach to both identify and test emergent themes.

## Findings

We interviewed 81 mothers (ages 16–24) across both study sites. Most identified as White and/or Indigenous, were completing their high school education, and had one child. Most participants ( $n = 51$ ) told stories of their first childbirth experiences, although some told stories that included events from the birth of previous children. Three major themes emerged in our analysis of these young mothers' birth stories: (a) the role of the birth in participants' identity formation processes; (b) 'bearing up' under pain and desire for 'natural' childbirth; and (c) managing the complex social spaces in which these births took place (Table 1).

Forming an identity as a capable, competent, and mature person emerged as a central theme across the interviews. Constituting oneself as mother and managing the life transitions that accompany that experience were discussed in great detail. Mothers concentrated primarily on establishing themselves as a person 'fit' to be a mother. Stories that emphasised previous experience in caring for children featured strongly. For example, one participant explained that she had raised her younger siblings before she herself became a mother, using this aspect of her story to position herself as capable and competent to provide care for her own child:

I was the 'mom' in the house and . . . yeah. I pretty much, like . . . raised them for a long period of time and . . . you know, they would always ask me if they were allowed to do things. Like, they would never ask my mom. So they would ask me if they're allowed to go outside or 'What time's dinner? When are we having dinner?' (009-PG, age: 19, Indigenous)

Demonstrating insight into what attributes constitute socially accepted competencies and qualities of good mothers (e.g. prepared; loving; attached to baby; selfless) was also an important feature of these narratives. Representations of maternal instincts were presented as being central to forming an identity as a mother. The interviews also included many examples of mothers 'learning' to trust their own instincts, as well as their deliberate acts of 'learning motherhood'. For example, when asked how she determined what kinds of foods she should eat during her pregnancy, one mother explained:

Definitely from the doctor and my mom. But also just what I felt was right to do, so . . . that was a big part in what I felt was right. (017-GV, age: 21, White)

Narratives that included descriptions of deliberate and learned acts of preparation (e.g. attending antenatal classes) revealed the value placed on knowledge about giving birth and parenting

Table 1 *Socio-demographic characteristics of study sample*

	<i>Greater Vancouver n = 41</i>	<i>Prince George n = 40</i>	<i>Total n = 81*</i>
<b>Age</b>			
Median (range)	18 (16–23)	19 (17–24)	19 (16–24)
16–17	18 (43.9)	3 (7.5)	21 (25.9)
18–19	11 (26.8)	14 (35)	25 (30.9)
20–21	8 (19.5)	8 (20)	16 (19.8)
22–23	4 (9.8)	11 (27.5)	15 (18.5)
24	0 (0)	4 (10)	4 (4.9)
<b>Ethnicity</b>			
Indigenous	4 (9.7)	27 (67.5)	31 (38.3)
Black	1 (2.4)	1 (2.5)	2 (2.5)
Asian	6 (14.6)	0 (0)	6 (7.4)
Latin American	3 (7.3)	0 (0)	3 (3.7)
White	18 (44)	10 (25)	28 (34.6)
Indigenous & White	4 (9.7)	2 (5)	6 (7.4)
Indigenous & Latin American	1 (2.4)	0 (0)	1 (1.2)
Indigenous & Chinese & South East Asian	1 (2.4)	0 (0)	1 (1.2)
White & Latin American	2 (4.8)	0 (0)	2 (2.4)
White & Chinese	1 (2.4)	0 (0)	1 (1.2)
<b>Education</b>			
Some High School	5 (12.2)	11 (27.5)	16 (19.8)
Currently in High School	26 (63.4)	19 (47.5)	45 (55.6)
Graduated High School	3 (7.3)	7 (17.5)	10 (12.3)
Enrolled in Post-Secondary	5 (12.2)	3 (7.5)	8 (9.9)
Completed Post-Secondary	2 (4.9)	0 (0)	2 (2.5)
<b>Number of Children<sup>§</sup></b>			
Expecting 1 <sup>st</sup> Child	8 (19.5)	3 (7.5)	11 (13.6)
1 child	29 (70.7)	23 (57.5)	52 (64.2)
2 children	4 (9.8)	12 (30)	16 (19.8)
3 + children	0 (0)	2 (5)	2 (2.5)

Notes: \*Data are reported as n (%) unless otherwise specified.

<sup>§</sup>Number of children at the time of first interview. Birth stories from women expecting their first child were gathered during follow-up interviews.

Identity formation: capable, competent and mature

that is learned from health professionals. These stories offered an important opportunity for mothers to describe their understanding of the social significance of actively preparing to be a good mother, and appear to have a bolstering effect on establishing oneself as capable, competent, and mature. The mothers told stories about seeking out specific training (e.g. the 'right' antenatal class) and expertise (e.g. doula; midwife; nutritionist) in order to help prepare themselves for the birth process and becoming a mother. Some mothers also emphasised their ability to navigate the bureaucratic aspects of preparing for the birth of a child (e.g. applying for maternity leave from her employment). Stories that demonstrate maturity and competency were particularly important to mothers who were under the surveillance of the State (e.g. they reported to social workers). Expressing the ways in which they resist the stigmatising effects



of being under State surveillance provides much cherished opportunities to exercise agency and demonstrate competencies as a mother and an adult, as the following quote illustrates:

I knew if you have any like questions about the government [services] kind of thing, [the social worker] was supposed to take care of it. I was gonna ask her about my maternity leave, but I already figured it out ... 'cause I researched it online. (001-GV, age: 17, Latina)

*Bearing up under pain and desires for 'natural' childbirth*

While previous empirical research (Low *et al.* 2003) suggests that 'teenage' mothers may not be greatly concerned with the physical pain of labour and birth, pain was central to the stories told by almost all mothers in the current study. Their stories of pain tended to be told as stories of stoicism or humour, where pain features as a marker of 'natural' childbirth and a precursor to the reward of producing a healthy child. As one mother's story emphasised, bearing up under pain while giving birth also was highlighted as a valorised achievement:

[I]t's the hardest thing in the world, going through labour. I tell you, like, there's a lot of scary things but there's nothing like being in labour. (009-PG, age: 19, Indigenous)

A strong feature of the pain thematic drew upon mothers' descriptions of an idealised version of how a mother should behave during childbirth, reflecting internalised notions of how women in childbirth 'ought to' behave. This included descriptions of stoicism, calmness, and rationality in the face of severe pain or health emergencies (for themselves or the baby). Having one's pain and stoicism witnessed and acknowledged by those present at the birth was highly valued by mothers and served as external confirmation that their efforts to endure or bear up were valorised as a social norm. One mother's narrative describes how her baby remained in occiput posterior (face-up) position until her final push, and the stoicism with which she had endured that pain:

So I felt bad 'cause it hurt and then, yeah. My dad said, 'She only cried one tear ... at the end'. I was, like, yeah, 'cause the last push, it – that one was the one that *really* hurt. (019-PG, age: 22, Indigenous)

This mother's narrative utilises her father's voice (as well as her own) to highlight her stoicism, strength, and endurance during her labour. This story, like similar stories of stoicism presented by other participants, was told with a sense of pride, revealing an understanding of the social importance of enduring pain as gracefully and heroically as possible.

Enduring pain and its importance in conforming to 'natural' labour and birth also emerged strongly across participants' birth stories. The desire to measure up to a predetermined ideal of 'natural' childbirth emerged as an important marker by which the young mothers in this study self-evaluated their own performance of childbirth. For many participants, this ideal was characterised as a vaginal birth with minimal medical intervention, two notions that appear frequently within dominant narratives about 'natural' childbirth. For example, one mother described feeling proud that her experience conformed to an ideal version of how she understood labour and birth ought to progress, naturally:

[T]here's 10 centimetres of dilation. You're supposed to dilate one centimetre an hour. So that's pretty much what happened. [Laughs] I, like, had the, like, textbook-perfect birth and

I didn't have to, like, get an epidural or anything, which I was happy about 'cause I didn't want to use very much medication. (029-GV, age: 19, White)

While her narrative includes descriptions of having been in pain during her labour, the chosen emphasis within the narrative rests instead on the ways in which her labour conformed to an idealised process of giving birth. In this way, markers of 'natural' birth (e.g. dilation of 1 cm/hour; minimal use of drugs; vaginal birth) also emerge as markers of the normalcy of their birth stories, which in some cases appear to reflect a desire to align their stories with those told by mothers who do not face ageism, classism, and racism to the same degree faced by most of the mothers in the current study.

Stories about 'natural' births also were told so as to emphasise a mother's innate, almost biologically-determined ability to create a healthy birth experience and, ultimately, to produce a healthy child. In fact, stories that downplayed the pain experienced during labour frequently segued into narratives that focused on the ultimate result – the birth of a healthy child. In all the interviews, the pain of childbirth was characterised as having been 'worth it', as an excerpt from this mother's birth story illustrates:

The reality was that I would most definitely love to go through labour again . . . yeah. I would love to. I was scared, obviously. I knew it was gonna hurt, but I was extremely, extremely excited, uhm, to finally have my son – and the labour was hard. But I barely even remember the pain because . . . it ends. It happens so quickly . . . even though it lasted 26 hours. It comes on so quickly and then when it ends, it's done. Like, when it's done it's done and you have your son or your daughter. (021-GV, age: 20, White)

A number of participants suggested that their young age was, in fact, a benefit in terms of feeling more physically resilient and better able to easily give birth. Birth stories where mothers characterise their experience of giving birth as a natural, easy process, also were frequently recounted with a degree of aplomb:

It was good. It was easy. I ended up all natural. No drugs. Popped that sucker out! (015-PG, age: 20, White)

Similarly, another mother spoke about how easily and quickly she gave birth to each of her two children, inferring that labour and giving birth is something that she is capable of doing well and with confidence:

With [my older son] I was only . . . in labour for eight hours and I – he came out within, like, five minutes. And then [my younger son] . . . I was in labour and he was out of me within two hours. So super fast. [Laughs] . . . So labour is not a problem for me. I'm not afraid of labour. (023-GV, age: 22, White)

There also is a bravado inherent in the telling of this story that demarcates her birth experience as an achievement that speaks not only to her value as a mother, but also to her standing as a person who can accomplish something important with minimal trouble. Given the degree to which many of the mothers in the current study have experienced marginalisation, stories told with such confidence and with respect to personal competence register a challenge to prevailing and stigmatising narratives regarding early-age mothers.

These kinds of 'natural' birth stories stand in stark contrast with those where an experience of giving birth was described as 'unnatural' (e.g. a C-section was performed). Those stories,



instead, were used to convey a sense of not having 'done' birth the proper way. In one mother's story, she used the word 'easy' to describe her emergency C-section, following 26 hours of labour:

It wasn't as bad as I thought it would be. What I think would have been the worst part was when I had to push. But I didn't. I think I got it the *easy* way, having the emergency C-section. (028-GV, age: 17, Indigenous)

Within this mother's description, the pain she felt during 26 hours of labour (longer than many other participants' entire labour and birth experiences) was downplayed in comparison to the anticipated 'natural' vaginal childbirth. This quote illustrates the broadly held sentiment expressed by almost all mothers in the study (regardless of their ethnic identity or city of residence) – having a C-section is widely perceived as a failure because it is perceived as a most 'unnatural' form of childbirth.

Situating oneself as the protagonist in a story about naturally and easily birthing a healthy child also offers important social and personal currency. These stories are told to friends and family; and in some cases, also are told to people in positions of authority (e.g. social workers; nurses) – including those with the legal powers to remove children from the custody of their mothers. In fact, being able to describe oneself as a 'natural' mother (e.g. through stories that feature the natural, easy birth of a perfectly healthy child) was sometimes presented as a form of evidence to counteract concerns about a mother's competence. One mother, for instance, had lived in foster care for part of her childhood and said her family had a bad 'reputation' with social services. She was very concerned that her baby might be apprehended at birth, a fear more commonly voiced by the Indigenous mothers in the study. She chose not to take any painkillers during her labour, in part, because she was afraid that it might demonstrate to child protection workers that she was not a suitable mother:

Like for the birthing ... they were asking me what [drugs] I wanted to take ... And, I just wasn't too sure, 'cause you never know with medication. And actually I had a friend that took something for the birth and it showed [in a subsequent drug test] that she did drugs, when she's not that kind of person. And, they instantly took that baby ... So, I didn't take anything [during labour]. It was pretty crazy. I was scared. (004-PG, age: 19, Indigenous)

Stories where apprehension concerns feature strongly, particularly among Indigenous participants, tended to position the mother and her family history as a co-produced protagonist facing unreasonable thresholds in terms of the production of a healthy child, revealing the combined impacts of ageism, racialisation, and overall high child apprehension rates. Birth stories about the production of a healthy child also included details about the mothers' exemplary antenatal behaviour (e.g. many took antenatal vitamins; quit smoking; avoided certain foods; and/or completed antenatal education classes).

In general, there is a form of competency demonstrated in the telling of a 'natural' childbirth story – and, these stories were frequently told as representations of a performance of strength and grace, culminating in achievement, as this mother described:

And I was, like, this went by, like, so fast, these, like, however many months [...] It flew by and, like, she came out so perfectly and she was healthy. And there's 'absolutely nothing wrong with her!' So I was really proud that I was so young, but I did what I could. (017-PG, age: 20, Indigenous)

Recounting natural birthing experiences helps to underscore the teller's readiness to be a skillful mother – a powerful bolster to one's efforts to formulate a socially-acceptable maternal identity in the face of broader stigma that pathologises early-age motherhood and their children.

Humour was frequently used as a rhetorical device to describe dramatic or traumatic moments within these birth stories, and provided a socially acceptable means of telling others about the pain of labour and giving birth. The use of humour allowed mothers to position themselves as both the teller of the joke and the subject of the joke; and, in this way, humour provided a means to re-claim their centrality and control in their birth narrative. For example, one mother used humour to reframe her experience of having had severe tearing of her perineum as well as voiding her bowels during labour as a 'positive' in the overall experience of giving birth. Her use of humour was used to at once recount and discount an extremely painful experience (multiple tears to her perineum):

I ripped; yeah, I got a second-degree tear. I ripped to the side and I ripped up – I actually crapped the whole time I gave birth ... And, you know, most women ... always are, like, 'Oh, my god! I don't want to crap!' ... 'Oh, my god, it's the worst thing ever'. And, I'm, like, holy shit, you 'definitely' want to crap [during labour] because I had stitches and I didn't have to poo for the next three days 'cause I was completely empty. [Laughs] And it was a blessing. (015-PG, age: 20, White)

Being able to provide an 'entertaining' narration to their experience was also used to describe the mother's centrality to the birth experience and as a means by which we learn about the mother's interactions with other people who attended the birth (e.g. doctors; family members). In this way, the birth narratives presented by mothers in this study reflect experiences that included the interviewer, as well as providing a means by which we heard about the reactions of other, broader audiences, as the following example illustrates:

It wasn't my [regular] doctor, but it was this British doctor and ... at the end of my birth, um ... he comes in, shakes my hand and he's, like, 'You were one of the funniest clients and women I've ever experienced going into labour and having a child'. He's, like, 'Next time you have a kid make sure you come back to me'. (017-PG, age: 20, Indigenous)

This story was told with a sense of pride, positioning the young Indigenous mother as the central, powerful and positive character in her narrative, and sets up a future story where a medical professional is waiting to receive her.

#### *The labour and delivery room – a complex social space*

Participants' stories of giving birth were told in relation to the seemingly ubiquitous public 'gaze' on motherhood in general. Becoming a mother has been described as an act that puts one in the public gaze (Good 1994) – even during intimate moments such as labour and delivery, where mothers are the central characters and manage the complex social relations that arise amongst the various actors in this setting. Participants in the current study also told their stories in relation to widespread social stigma faced by early-age mothers within the Canadian context. These two broader phenomena were reflected in key aspects of the mothers' stories about the labour and delivery room – who gets to be in the room, what they do, and how those actions are (re)constructed by mothers as they re-tell the experience.

For some participants, stories about those people who were present in the labour and delivery room reflected the culmination of a long planning process (e.g. invitations to attend the birth had been issued well in advance of the due date). Other mothers described the

spontaneous, sometimes unwanted, presence of other people at the birth. For example, one study participant described how her partner's mother tried to 'scare' her own adolescent daughter by forcing her to watch the birth at close proximity:

His mum made his little sister watch the entire thing. I think she was like trying to scare her into not getting pregnant. . . . Uh, she was, like, 13 or something, but she made her stand at, like, the foot of the bed. (010-PG, age: 20, Indigenous)

In recounting this story, this mother was upset by the notion that a young girl was forced to watch a birth as a means to frighten her into chastity, but she went on to explain her reaction at the time she was giving birth:

I was more in just so much pain, I just didn't care who was there or anything. I just didn't care. (010-PG, age: 20, Indigenous)

Many other mothers, however, positioned their actions as assertively managing or even determining, who else was inside (or outside) the labour and delivery room. One mother, for example, recounted with a sense of pride and achievement how she had been the person who ultimately decided which family members would be present in the delivery room. When her boyfriend's grandmother (who had raised her boyfriend) showed up uninvited, she asked her boyfriend's grandmother to wait outside:

Well . . . [my boyfriend's grandmother] wanted to be there when [our son] was born, like, in the room. And I wasn't quite comfortable with that because . . . I didn't really know her all that well. And I'm, like, 'I don't think I want you in there. I mean, I know it's your family, but, like, I'm not comfortable with that'. I mean, it's my body. . . . She just showed up at the hospital and she came into the room while I was having him. And I'm, like, 'Um, no! Like, no, I don't want you in here, sorry'. So then my boyfriend told her, like, 'Can you just wait out in the hallway? We'll call you as soon as he's born'. . . . So then she was quite pissed off. She, like, walks out and is, like, 'Well, fine then'. *Slams the door* and I'm, like, really? Like, you're just making this worse. (024-PG, age: 18, Indigenous)

Some narratives that we initially coded as powerful, managerial-like birth experiences, were revealed as we re-read the transcripts to concomitantly reflect vulnerability and strength, as the following excerpt from this mother's story illustrates:

And then I kicked everybody out of my delivery room. I just did it by myself because I just – I don't know, I'm kind of a do-it-myself person. Never really – I don't really trust – well, it's not that I don't trust, it's just that I don't like having help. Like, I'm quite capable of doing it on my own. (017-PG, age: 20, Indigenous)

This participant later revealed that she had been victimised by family members during her childhood and had kept this fact hidden in order to prevent herself and her siblings from being placed in foster care. Years later, at the time of giving birth to her own child, she was simultaneously struggling to establish clear boundaries with her family while acknowledging that strong familial connections are integral to her identity as a good mother. This is an example of a story that carries within it other stories – a frequent occurrence, as not surprisingly, the narratives told to us during our interviews also needed to accommodate previous narratives (e.g. the value of secret keeping) that have been established previously in a mother's life.

The sub-narrative about managing the room also is a story of things that cannot be managed – even by the most capable mother. For example, there were numerous stories that described the disappointment and frustration of not having a birth attended by the healthcare provider with whom participants had established a relationship with throughout their pregnancy (e.g. their family doctor). These stories frequently featured distressing examples of mothers in the midst of labour and delivery needing to explain important aspects of birth plans to healthcare providers who were unaware of those particulars. In some instances, mothers described how they resorted to confrontational tactics in order to re-assert their original birth plan, as one mother's story illustrates:

[The nurse] kept asking me, 'Now do you want an epidural? Do you want an epidural now? Do you want an epidural now?' I was, like, 'I want a natural birth. Stop asking me. I don't want to have drugs . . . That's manipulating my body, you know? . . . The final straw for me was [my partner] was, like, 'You heard her. She said she doesn't want it and you're asking her right in the middle of a contraction. We have talked about this for months. She does not want it'. And she [the nurse] was, like, 'You have no idea what she's going through,' . . . 'you have no right to tell her what she can and cannot do'. And it's, like, 'You have no right [to speak to him that way]. He is my partner. We have done birthing classes together. We have talked about this for hours. We have written it down. We have talked to our midwife. We have done everything! And you . . . you have no right to tell me what I want'. (008-PG, age: 18, White)

On occasion, mothers described the perception that their centrality to labour and within the delivery room was being disregarded altogether, or described a feeling that they had been pushed to the fringes of the birthing experience. One mother spoke about how a physician decided on an operative vaginal delivery without consulting her:

The staff there don't treat you like a human being. It doesn't matter if you're 15, you're still, you know, you should still be treated equally. They just did forceps on [my baby] without even discussing with me. There was so much going on that I didn't even realise how bad they were treating me. (006-GV, age: 20, White/Chinese)

This experience remained as a very painful and emotionally wrought memory for this mother four years later when she described it to us.

While these stories denote distinctly negative descriptions of the interpersonal experience with a 'professional authority' (e.g. a nurse or doctor), other young mothers' stories described how having a 'professional authority' in the room was helpful. Professionals who 'stood by' the young mothers (e.g. doulas who reinforced their perception that it was their right to be treated well within and beyond the labour and delivery room) were characterised as bolstering forces within the mothers' stories. Those professional authorities that contributed (deliberately or inadvertently) to the mothers' sense of resilience during labour and delivery were also frequently credited with helping to build mothers' confidence in their own capabilities – during labour and delivery, and beyond.

## Discussion

This paper presents an opportunity to examine young mothers' stories of labour and delivery – perspectives and experiences that to-date, have remained under-examined in the literature. Using narrative inquiry, we were able to examine the ways in which re-telling the experience of giving

birth serves to situate young mothers, both in relation to their past and future selves, as well as in relation to broader social and cultural forces. Participants illuminated the complex interactions among identity formation, social expectations, and negotiations of social and physical spaces as they narrated their experiences of labour and birth. For many participants, their story of being a mother began long before they gave birth to their own children, as many had acted as a caregiver for younger siblings. Participants' birth stories provide many illustrations of the notions of capability, competence, and maturity. The use of rationality, stoicism, and humour also emerged as important aspects of their birth stories. Many of the descriptions appear to reflect and employ internalised notions of how women in childbirth 'ought to' behave (e.g. idealised versions of stoicism; use of humour) and how birth itself 'ought to' be experienced (e.g. a vaginal birth with minimal medical intervention). The interviews contained many examples that were at once instantiated as expressions of resistance to dominant narratives about young mothers (e.g. resistance to stigmatising narratives that characterise young mothers as incapable), while also reflecting internalised notions of broader, valorising narratives related to childbirth. In interpreting these stories, it is important to understand that cultural narrative plays an important role in shaping the individual narrative. That the mothers' constructions of counter-narratives of resistance also include aspects of existing cultural narratives (e.g. those that valorise natural childbirth) reveals the interplay between cultural and individual narrative.

Further to this point, it is also important to recognise historical and proximate influences on the stories told by many of the Indigenous mothers in the study. For example, many Indigenous mothers had parents or grandparents who as children had been forcibly detained in residential schools. As well, many of the mothers in the current study had personal experiences with social workers and the foster care system. Recent data confirms that over 50 per cent of youth in foster care in BC are Indigenous (Turpel-Lafond and Kendall 2015). These realities affect both the content (e.g. what was included or excluded from the telling) and the rhetorical techniques used in telling their birth stories (e.g. utilising stoicism, humour). Research indicates that there are disparities in the obstetric care received by first time mothers who identify as Indigenous (as compared to non-Indigenous) in BC, including both fewer antenatal check-ups and decreased use of obstetric interventions (Riddell *et al.* 2015). Combined with increased rates of stillbirth and perinatal mortality among Indigenous populations in BC (Luo *et al.* 2004) and across Canada (Smylie *et al.* 2010), further qualitative inquiry utilising a lens of decolonisation and self-determination has been called for in order to better understand the reasons behind these disparities in obstetric care and outcomes.

While incorporating narratives of the past self, birth stories also contribute to future selves, which simultaneously serve to break down and rebuild the self. In this way, by narrating their birth stories, participants provide glimpses into the complexities associated with becoming a mother while navigating overlapping stigmas and, concomitantly asserting their own version of motherhood. The early-age mothers in the current study 'frame up' their stories against widespread, stigmatised depictions of 'teen moms' (as distinct from, and somehow 'less than' their older counterparts). Stories with a central meaning of constituting self as mother continue to be told as a form of resistance or at least told in juxtaposition to broader, punishing social stigma and material circumstances. Drawing on Nichols *et al.*'s (2014) findings, we suggest that the narratives in our current study reflect mothers' desires to demonstrate that they are performing birth and motherhood according to normative expectations.

The birth stories gathered through the current study also highlight the ways in which other people impose moralising judgments on young mothers (based on ageism, racism, or classism), even during one of life's most significant moments. Early-age mothers in Canada report lower satisfaction with their birthing experiences than older-age mothers (Provincial Health Services Authority 2009). Previous research suggests that clinicians ought to partake in specialised

education in order to better meet the needs of early-age mothers in the delivery room (Low *et al.* 2003, Nichols *et al.* 2014). While there are numerous programmes that have been developed specifically to assist young mothers during the antenatal and post-natal periods (e.g. antenatal classes, post-natal support groups), we found few examples of research on effective specialised training for healthcare providers who assist early-age mothers as they labour and give birth. However, the Society of Obstetricians and Gynecologists of Canada's recent publication of adolescent-specific pregnancy guidelines (Fleming *et al.* 2015) for clinicians is an encouraging development. As healthcare planners consider techniques for improving clinical practice, our findings point towards the need for fully realising interventions that are designed to take a woman-centred approach to birthing (regardless of maternal age) and that address social phenomena across contexts (e.g. racism; ageism) (Shoveller *et al.* 2015).

### *Strengths and limitations*

Our study methods included purposive sampling and our results are not meant to be representative of all young mothers. However, the rich narratives shared here provide vital insights into the perspectives of a relatively large and heterogeneous group of young mothers from two cities in BC, Canada, including young women who are racialised and further marginalised by socioeconomic factors. Because stories are concomitantly shaped both by storytellers and listeners, we acknowledge that our data are a product of this process. For example, some participants might have emphasised details they assumed that the interviewers wanted to hear and left out other details they were concerned might give us a negative impression (e.g. fear of pain). Moreover, as relative 'unknowns' in the interviewee's lives, telling their stories to us (i.e. researchers) might reflect a distinct experience from the birth stories that they may tell others, such as their friends or family members. Finally, although an important focus for our future empirical work, our analysis does not include young fathers' narratives.

## **Conclusion**

The telling of birth narratives by early-age mothers provides a means to constitute the self and others within the complex social, cultural, and medical worlds. The stories told here emphasise the various ways that young mothers are competent, capable, and informed. Documenting these stories offers a way to break open a more dominant and negative narrative about early-age mothers in favour of their own presentations of themselves as characters whose intentions and behaviour run counter to pervasive stereotypes and stigmatised representations. In the absence of these stories, opportunities may be missed that would help us to understand and appreciate the strength and vulnerability of early-age mothers in the face of society's broader narrative representations of them.

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## Note

1 The term 'Indigenous' refers to the First Nations, Inuit and Métis peoples of Canada.

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