CONSTRUCTIONS OF ADOLESCENT MOTHERHOOD:

DISCOURSE ANALYSIS OF THE HEALTH PROFESSIONAL LITERATURE

AND HEALTH PROFESSIONALS' TALK ABOUT YOUNG MOTHERS

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MARY ROSE BREHENY

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ABSTRACT

Adolescent motherhood has been linked with disadvantage and has been framed as a social problem. Research has also drawn attention to individual and socioeconomic deficit to explain poor outcomes, and proposed individual interventions to address the problems of adolescent motherhood. This ignores the social context of adolescent motherhood. Health professionals are an important aspect of this social context, as they represent authoritative social voices in strong positions of warrant that powerfully shape the experience of mothering in adolescence. Social constructionism draws attention to the variable and constructed nature of health professionals' understandings of adolescent motherhood. Discourse analysis is based on the assumptions of social constructionism, and is used to identify 'discourses' which construct objects, and make available subject positions that have material effects on those constructed. Using discourse analysis, literature for health professionals and interviews with health professionals were analysed to describe the discourses available to construct adolescent motherhood. Four scientific discourses were identified in the professional literature: a 'Naturalist' discourse that constructs parenting as a biological matter and draws upon eugenic arguments; a 'Public Health' discourse which constructs adolescent motherhood as a disease requiring surveillance; an 'Economic' discourse which understands adolescent motherhood as a drain on society and a cost to the adolescent mothers; and an 'Ethnicity' discourse that separates people into categories to determine who will reflect or resist dominant social structures. These discourses were drawn upon to construct a 'cycle of disadvantage', in which adolescent motherhood is the result of individual choice or family deviance, which can be solved by intervening with disadvantaged individuals or families. In the interviews with health professionals, adolescent mothers were constructed primarily as 'adolescents' within a 'Developmental' discourse. This adolescent positioning precluded them from being positioned as a 'good' mother within a 'Motherhood' discourse. Health professionals also constructed adolescent mothers as having individual differences in mothering ability, but these constructions supported generalisations made about the category 'adolescent mother'. An 'Ethnicity' discourse was drawn upon primarily to construct Māori as the 'other', while mainstream European cultural practices and values remained unexamined. These discourses highlight the role of the individual, the family, and

social class in transmitting disadvantage, and were used to identify deviant individuals and families, rather than as a way to address the social context of disadvantage. The association of adolescent motherhood with deficiency and lack has implications for health care provision, as it is likely to impact negatively on adolescent mothers' experience of health care. In particular, advice for health professionals to be non-judgmental when providing care for adolescent mothers is unlikely to be effective, as this advice does not address the wider discursive location that produces these 'judgmental' attitudes.

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TABLE OF CONTENTS

CHAPTER I.
INTRODUCTION

Adolescent pregnancy in New Zealand is the second highest in the developed world (Dickson, Sporle, Rimene, & Paul, 2000). Seven percent of births in New Zealand are to adolescent mothers (Condon & Corkindale, 2002; Wilson, Clements, Bathgate, & Parkinson, 1996). Although the adolescent birth rate has declined over the last thirty years (Dickson et al., 2000), the number of adolescent mothers as primary caregivers has increased in New Zealand (Knightly, 1988), as very few adolescent mothers relinquish their children for adoption. These factors, combined with an increase in illegitimacy and welfare receipt, have fuelled public interest in adolescent motherhood (Coley & Chase-Lansdale, 1998). Rains, Davies, and McKinnon (1998) argue that adolescent mothers have become a popular issue for public and political concern because they concentrate public anxiety about youth, women, poverty, and race. Adolescent mothers also symbolise multiple meanings surrounding sexuality, adulthood, employment and the family (Kelly, 1996).

The Problem of Adolescent Motherhood

Adolescent motherhood has been a topic of consideration in social scientific research for decades, and has typically been framed as a social problem. The standard approach to researching adolescent motherhood has been to investigate simple associations between early parenting and a range of negative outcomes for mother and child. Adolescent mothers are often compared with older mothers on outcomes such as psychological functioning, parenting competence, and child neglect and abuse. In addition, adolescent mothers' socioeconomic status, ethnicity, and educational attainment have been the subject of research. The following sections will provide an overview of this research to illustrate the adolescent mother of the dominant paradigms of social science research.

Adolescent motherhood is typically associated with psychological dysfunction, including increased levels of depressive symptoms (Deal & Holt, 1998; Hudson, Elek, &

Campbell-Grossman, 2000), and suicidal ideation (Palmore & Millar, 1996). Adolescent mothers are more likely to have been diagnosed as aggressive, or aggressive and withdrawn during childhood, and such behaviour was associated with extreme patterns of sexual risk taking (Serbin, Peters, & Schwartzman, 1996). This draws attention to individual psychological pathology among adolescent mothers and is used as evidence for their unsuitability for motherhood. Abuse, neglect, and family dysfunction are also more pronounced among the families of pregnant and parenting adolescents than other adolescents (Anda et al., 2001; Garrett & Tidwell, 1999), suggesting that adolescent mothers are themselves the product of dysfunctional family systems.

In addition to increased rates of psychological dysfunction, adolescent mothers' adaptation to parenting has also been investigated. Payne (2001) reports that adolescent mothers are three times more likely to experience postnatal depression than older mothers. It has also been reported that adolescent mothers have poor maternal role development (Flanagan, McGrath, Meyer, & Garcia Coll, 1995) and high levels of parental stress (Secco & Moffatt, 2003). They are described as being ambivalent about pregnancy (Zabin, Astone, & Emerson, 1993), and as showing non-nurturing attitudes towards their children (Thompson, Powell, Patterson, & Ellerbee, 1995). Researchers have suggested that adolescent mothers have high levels of romanticism (Medora & von der Hellen, 1997) and relate their pregnancies to sentiments of love and aspirations for marriage with their baby's father (Scott, 1983). These sentiments of romanticism and love are characterised as naïve. Adolescent mothers' childcare practices are often described as examples of a childish need to role play an idealised happy family that is inconsistent with the reality of their lives. Musick (1993) describes the adolescents' reasons for wanting a baby and playing with their children as "just like a baby doll!" (p.124). Adolescent mothers are viewed as inappropriately using real babies to achieve the milestones of appropriate childhood development. This research presents adolescent mothers as psychologically and developmentally unprepared for parenting.

Adolescent mothers are also compared to older mothers on sociodemographic criteria. On average adolescent mothers have lower educational attainment, and are more likely to be unemployed and to be living in poverty than adolescents who are not mothers (Coley & Chase-Lansdale, 1998; Corcoran, 1998). Adolescent pregnancy rates are associated with poverty and income inequality (Gold, Kawachi, Kennedy, Lynch, &

Connell, 2001; Gold, Kennedy, Connell, & Kawachi, 2002; McLeod, 2001). This research is often drawn upon both to illustrate how motherhood among adolescents' leads to disadvantage and also how those adolescents who become mothers are already multiply disadvantaged. Studies have also found that adolescent mothers are more likely to be members of ethnic minorities (Black and Hispanic in U.S. studies (Koniak-Griffin & Turner-Pluta, 2001) and Māori and Pacific Islander in New Zealand studies (Dickson et al., 2000; Wilson et al., 1996)). This provides a focus on cultural explanations for adolescent motherhood.

The impact of adolescent motherhood on the children of adolescent mothers has also been investigated. The children of adolescent mothers are typically characterised as multiply disadvantaged. Research has found that they are at risk for intellectual and social-emotional problems, have lower IQ scores (Sommer et al., 2000) and higher levels of conduct disorder (Christ et al., 1990; Coley & Chase-Lansdale, 1998). They have been found to more commonly have attachment problems and to suffer higher rates of reported child abuse and neglect (Coley & Chase-Lansdale, 1998; Stevens-Simon, Nelligan, & Kelly, 2001). The children of adolescent mothers also have higher rates of unintentional injury than the children of older mothers (Murphy, Gilliland, & Griswold-Rhymer, 2001). Disadvantages in the children of adolescent mothers are found to become more pronounced with age (Brooks-Gunn & Furstenberg, 1986). Hardy et al., (1997) found maternal age at delivery to be related to the least favourable outcomes in children, and that these disadvantages persisted into adulthood. The children of adolescent mothers are also more likely to become parents at an early age themselves (Hardy et al., 1997; O'Connor, 1997). This research represents adolescent motherhood as a problem not only for the mothers, but also for their unsuspecting children, and constructs adolescent motherhood as propagating disadvantage.

Health Outcomes

One of the justifications for intervening in the lives of adolescent mothers and their children has been the negative health implication of early motherhood. The infants of adolescent mothers are often of lower birth weight (Corcoran, 1998; Gortzak-Uzan, Hallak, Press, Katz, & Shoham-Vardi, 2001; Koniak-Griffin & Turner-Pluta, 2001),

have increased rates of birth complications (Phipps-Yonas, 1980), and lower rates of immunisation than the infants of older mothers (Morrow et al., 1998). They are also less likely to attend newborn health visits (Specht & Bourguet, 1994). The children of adolescent mothers have increased rates of accidents and hospital admissions (Corcoran, 1998), and are more likely to die in the first year of life than the children of older mothers (Payne, 2001; Phipps, Sowers, & Demonner, 2002).

These relationships between adolescent motherhood and poor health outcomes are complicated by a number of other factors. Bai, Wong, and Stewart (1999) found that adverse neonatal outcomes among adolescents were not due to their young age, but to other factors such as maternal smoking, parity and unmarried status. Similarly, Cunnington (2001) reports that the increased risks associated with adolescent motherhood were predominantly caused by social, economic, and behavioural factors that predispose some young women to pregnancy. This review suggests that only in very young adolescents (maternal age of less than 16 years) was there any independent association of adolescence with poor pregnancy outcomes. Phipps and Sowers (2002) similarly advise that poor outcomes for adolescent mothers are only relevant for women giving birth at 15 years or younger. Within the New Zealand context, Trivedi (2000) reported that there was no evidence of any obstetric risk factors associated with early adolescent pregnancy (women aged 17 years and younger) even though there was no adjustment for sociodemographic influences, perhaps reflecting the lack of extreme poverty in New Zealand (Romans, Martin, & Morris, 1997).

This social scientific and health research on adolescent mothers provides a grim perspective on the outcomes for adolescent mothers and their children. These associations between adolescent motherhood and poor psychological, socioeconomic, and health outcomes suggest that adolescence is uniformly an inappropriate time for childbearing, and causes significant disadvantage for both mother and child. Findings of research such as that outlined above has reinforced the belief that adolescent parenting leads to individual and socioeconomic disadvantage.

CHAPTER II.
RE-CONSTRUCTING ADOLESCENT MOTHERHOOD

The social construction of adolescent motherhood is produced in part by research that describes and categorises adolescent mothers in particular ways. Authors of research represent authoritative social voices, in strong positions of warrant that participate in shaping dominant social attitudes towards adolescent motherhood. These research projects are used to develop policies, information, service provision, and practices that are major forces in shaping the experience of mothering in adolescence (Cherrington & Breheny, 2005). Much of the research on adolescent motherhood has constructed early motherhood as problematic for the mothers and their children. Alternative approaches propose new ways to view early motherhood that attempt to address the shortcomings of these simple associations between adolescent motherhood and disadvantage, but in doing so construct them in ways that also produce material effects on their lives.

The alternative approaches to researching adolescent motherhood presented below have attempted to overcome limitations such as those resulting from measuring simple associations between adolescent motherhood and poor outcomes. These alternative approaches have been categorised according to shared similarities in how they represent adolescent motherhood to show the different ways of constructing adolescent motherhood within social scientific research. Some of the articles draw upon more than one way of representing adolescent motherhood, and are included in more than one section. In addition, the boundaries between these categories are not clear. For example, the investigation into which factors make the difference for adolescent mothers' outcomes relies on an understanding of individual differences in mothering ability and circumstances. In spite of the blurring of these boundaries, the research discussed below is organised and discussed in four categories labelled: 'Individual differences'; 'Factors related to success'; 'Cause or consequence of disadvantage?'; and 'An outsider's view inside adolescent motherhood'. Research discussed within each category is often drawn from different areas of social science, with the 'Individual differences' and 'Factors related to success' categories typically drawn from

psychology, 'Cause or consequence of disadvantage?' from demography, and 'An outsider's view inside adolescent motherhood' from sociology and nursing.

Individual Differences

One critique of the mainstream approach to adolescent motherhood is that difference in experience and outcome for adolescent mothers and their children should be the focus, rather than aggregating adolescent mothers and comparing them to adolescents who are not mothers or mothers who are not adolescents. Kelly (1995) documented this attention to the differences between adolescent mothers:

> Currently, a change in focus has occurred in the study of adolescent parenting from comparing them to older mothers on parenting measures, to attempting to identify differences within groups of adolescents that help explain varying levels of parenting ability (p.105).

This research draws attention to the previously overlooked 'successful' adolescent mothers who

> Handled the responsibilities of child rearing and managing their lives with surprising fortitude, determination, and resiliency. They exhibited a wealth of strengths and indicated some of the ways that parenthood had changed their lives for the better (Arenson, 1994, p.256).

Here the focus in on the heterogeneity of the adolescent mothers, rather than the success of adolescent mothers in general. The success of adolescent mothers is not viewed as the norm; it is "surprising" to encounter young mothers of "fortitude" and "resiliency". The category of adolescent mother is still portrayed negatively in spite of the existence of exceptions to the rule. This focus on comparison of successful with unsuccessful adolescent parents places a strong judgement on those who fail to rise to the challenge of adolescent parenting.

An understanding of adolescent mothers as differing in experience and outcome provides the possibility of a positive evaluation for some. However, this relies on assessing adolescent mothers' ability to parent in a way acceptable to mainstream social science and is likely to provide a positive evaluation for those few White, middle class, educated adolescent mothers who are already the least stigmatised. The 'Individual differences' approach does not refute the problems associated with adolescent motherhood, but positions some mothers as better than others. This emphasises that all adolescent mothers are not necessarily unfit for the role of mother. For example, Dalla and Gamble (2000) found that mothers in their study differed in their cognitive complexity. Those adolescent mothers who had a strong commitment to the maternal role demonstrated strong problem solving skills and an understanding of multiple causes and consequences of events (Dalla & Gamble, 2000). Flanagan et al. (1995) also found that maternal role development was related to the mothers' psychosocial and cognitive development. Both papers suggest that well developed cognitive abilities enable adolescent mothers to cope with the complex tasks and roles involved in motherhood. However, there is no evidence that those mothers who were unable to demonstrate commitment to the maternal role or complex problem solving skills would be able to do so if they were *older* mothers. Accordingly, the assessment of appropriate or inappropriate parenting is apparently only warranted by the age of the mothers. A focus on individual differences in parenting ability is used to separate out the cognitively capable from the incapable parents, but this tactic would not be tenable without the apparently unbiased use of age to justify the conclusions.

'Individual differences' resources were deployed to position some adolescent mothers as problematic subjects. Adolescent mothers may see pregnancy and parenthood as an opportunity to re-order their disordered lives and through doing so provide a better home for their own children than they experienced themselves (Davies, McKinnon, & Rains, 1999). However, aspects that 'Individual differences' research suggests make adolescents unable to cope with the challenges of motherhood (such as disrupted family background, substance abuse, and lack of maturity), are those aspects which adolescent mothers themselves suggest provide the impetus for change. Within this approach some adolescent mothers are positioned as problematic subjects who differ from more acceptable adolescent mothers who are able to perform the requirement of motherhood of mainstream psychology. These approaches ignore the social context of the behaviour

investigated. The construction of behaviours as 'individual' enables them to be separated from the context in which they are performed (Riggs, 2005). This deployment of 'Individual differences' resources encourages a self-management approach, and suggests that improved outcomes for the individual are the result of individual work. It also fails to acknowledge the contextualised meaning of motherhood as a potentially transforming life event.

The notion of inequality focuses intervention on individual change and improvement of deficient parenting skills. As Dalla and Gamble (2000) suggest: "directing services and formal assistance to young mothers, based on individual need, to facilitate optimal development" (p.235). The focus in on improving individual factors such as infant mother attachment, maternal depression, and maternal self esteem as a way to improve outcomes (Hubbs-Tait, Osofsky, Hann, & Culp, 1994). This individualistic approach to researching adolescent motherhood suggests a particular type of social action, that is, a focus on individual change to improve the parenting of specific adolescent mothers. Adolescent mothers are separated into those who respond appropriately to their children and those who respond inappropriately and behaviour adjustment is suggested to improve the psychological development of individual adolescent mothers. The focus on individual differences focuses on comparing individual worth so that individuals can be managed to "maximise their social utility and minimise their social danger" (Rose, 1999, p.144). This constructs differences in young mothers as able to be recognised, assessed and adapted.

The separation of capable and incapable adolescent parents places the blame on individuals and focuses attention on the development of individual interventions to maximise parenting potential. This approach relies on placing some adolescent mothers above others, and judging adolescent mothers by these criteria. Mothers themselves also use this approach to explain their own mothering in the face of the highly negative stereotype of adolescent mothers. As Higginson (1998) states

> Teen mothers contrasted themselves to other mothers in an effort to make themselves look good, rather than fighting the stigma of all teen mothers in the form of identity politics where they might seek to change societal conceptions of teenage mothers (p.145).

Thus, the possibility of adolescent mothers positioning themselves positively comes at a cost. This approach considers that there is a right way to parent, and assesses the ability of adolescent mothers to attain this standard. Within this research, although positive positions for adolescent mothers are made available, there remains an adolescent mother to condemn and assist. Adolescent mothers are positioned by their age, by their success according to certain criteria, and as individually responsible for that success.

Factors Related to Success

Another approach to adolescent motherhood suggests that individual differences may be further dissected to determine which differences in situation, personality, and parenting make the difference in child outcomes. Adolescent mothers are viewed as having a set of characteristics that predict success or failure in themselves or their children. This approach critiques the aggregation of adolescent parents, and also seeks to uncover those specific differences between adolescent mothers that make the difference in outcomes. This research often uses a quantitative design to test the predictors of 'successful' outcomes and seeks to define those group differences that can be used to divide adolescent mothers into the 'successful' and 'unsuccessful'.

A wide variety of predictors have been considered including depression (Luster, 1998), locus of control, and social support (Kelly, 1995), maternal self esteem (Dubow & Luster, 1990; Luster, Bates, Fitzgerald, Vandenbelt, & Key, 2000), intelligence (Barratt, 1991), maternal child rearing beliefs (Luster, 1998; Luster & Rhoades, 1989), parental expectations (Stoiber & Houghton, 1993), and home environment (Barratt, 1991; Luster et al., 2000; Luster & Rhoades, 1989; Spieker & Bensley, 1994). Dubow and Luster (1990) undertook a comprehensive study of the influence of a variety of risk and protective factors on children's academic and behavioural adjustment. The risk factors included psychological functioning such as maternal self esteem; family factors such as number of children in the home and single parent family; and socioeconomic indicators such as poverty, urban residence, and level of maternal education. Protective factors included the child's verbal intelligence score, child's self-esteem, and a measurement of the quality of home environment provided for the child. They found that different risk

and protective factors combined to produce different outcomes for the child and suggested that further research is required to determine which specific risk and protective factors produce which outcomes. This research emphasises the development of an increasingly specific focus on predictors, in which differences between individuals are reduced to factors that are more amenable to intervention.

It is important to consider which predictors of successful outcomes are considered and how they are defined within this research. For example, Barratt (1991) provided the following description of the Reading and Enrichment measure in their study:

> Credit was given for the child having 10 or more books, the mother reading stories to the child at least three times a week, subscribing to a newspaper, having a musical instrument in the home, encouraging the child to do hobbies, arranging lessons or activities for the child, taking the child to a museum, taking the child to a musical or theatrical performance, and discussing TV programs with the child (p.444).

The list includes items that reflect the values and culture of the middle classes, and therefore privileges these activities over other cultural values and activities. Many of the activities described in this list would be available only to the children of affluent families, and as such are unlikely to do more than separate out the more advantaged adolescent parents from the less advantaged. Luster et al. (2000) use more accessible measures of educational environments by evaluating whether adolescent mothers play learning games and point things out to their children. The factors identified by this research are unlikely to be equally valued and accessible to all adolescent parents, nor reflect values that are shared by all.

It is also important to consider how 'success' and 'successful outcomes' are defined within this research. Luster et al. (2000) investigated the factors that were related to cognitive ability in preschool children of adolescent mothers by comparing the highest and lowest quartile scorers on factors such as measures of home environment, mother's school success and psychological well-being, and family factors. However, comparing the most and least cognitively able children may not be a meaningful way to evaluate successful outcomes if children already have different inherent abilities. Barratt (1991)

states specifically that "the end point of intervention efforts is not parenting itself, but rather optimal outcomes for children" (p.443). In this study, optimal outcomes were determined by tests of math achievement, reading achievement and vocabulary. Although optimal outcomes for children appear to be an appropriate aim, the sole focus on educational outcomes, rather than a focus on family values, cultural integration or social competence indicates the particular concerns of the researchers in evaluating these adolescent mothers. Barratt also blurs this distinction by referring to the results of these outcome measures as "optimal parenting" (Barratt, 1991, p.444). What is being measured here is not optimal parenting, but improved educational attainment, and it is damaging to conceptually conflate these aspects of children's lives in this context. Such observations are unlikely to help adolescent mothers, may encourage condemnation of less educationally advantaged adolescents, and draw attention to the reproduction of inability that is already used to categorise many adolescent mothers as unsuitable parents. Researchers have noted that it is the less educationally successful, less stable adolescents who choose to continue their pregnancies, while the more able are more likely to choose abortion (Combs-Orme, 1990). These comparisons encourage a view of adolescent mothers as unfit to be parents. As these arguments are considered inappropriate when applied to older mothers and minority groups, their use should also be questioned when applied to adolescent mothers.

Identification of specific differences is used to advocate the development of empirically based intervention programs for adolescent mothers (Barratt, 1991; Luster & Rhoades, 1989; Sadler, Anderson, & Sabatelli, 2001; Shapiro & Mangelsdorf, 1994). This approach can be seen as a set of 'how to' guidelines for moving adolescent mothers from failure to success. For example, Dalla and Gamble (2000) advocate the development of a measure of maternal role commitment to identify those adolescent mothers most at risk of ineffective or neglectful parenting. Similarly, Sadler, et al. (2001) investigated the determinants of adolescent mothers' parenting competence and found that this was related to their own mother's self esteem. They suggested that grandmothers who are less capable should be identified and provided with formal support such as support groups, community meetings or home visitation. Thus, this approach assumes a recipe format of appropriate adolescent parenting. The task is to determine what must be included for a successful outcome and what can be left out of the recipe without causing the result (mother and child) to fail. This reflects a way of

viewing parenting that suggests that there are things that can permanently damage children and things that are irrelevant in the goal of raising healthy children. Parenting competence is not represented as an ongoing process of discovery and development, but as something that can be 'got right or wrong'. The recipe for adolescent parenting suggests that things such as marriage can be merely added to the social environment of the mother to improve the outcome of the child. For example, Barratt (1991) suggests that interventions can "perhaps encourage marriage and father involvement" (p.446). This author more specifically suggested welfare reform to encourage marriage and aggressive efforts to determine paternity without any apparent consideration that it may not be marriage per se that result in positive outcomes for the children of adolescent mothers, but the quality of the relationship experience for both parents. Enforcing marriage and paternity seems unlikely to produce positive outcomes when divorced from the individual's own desire to marry or to participate in their child's care. Qualitative research has suggested that family members often believe that encouraging adolescent marriage will exacerbate existing child-rearing difficulties (Dalla & Gamble, 2000). As described in this example, intervening to encourage the factors related to successful outcomes in isolation from the social context is unlikely to improve outcomes for adolescent mothers or their children.

Focusing on the impact of individual factors is based on the understanding that: "it is difficult to alter broad socioeconomic or educational factors" (Raeff, 1994, p.217). Economic and political factors associated with poor outcomes for adolescent mothers and their children are considered as constraints, however, psychological variables are considered as more likely to be affected by intervention programmes (Dalla & Gamble, 2000). Although many of the factors associated with poor outcomes for adolescent mothers and their children cannot be changed (for example, age of mother at birth, IQ of mother, education of maternal grandmother) the *impact* of these factors on outcomes for adolescents and their children is still amenable to change. Expanding adolescent capacity for reproductive choice and reducing the disadvantage that some choices entail may be a more appropriate goal (Lawlor & Shaw, 2002b; Lawson and Rhode, 1993). However, within the 'Factors related to success' approach, the focus is on encouraging approved choices, rather than addressing the disadvantage associated with alternative choices. These approaches attempt to determine a successful outcome by investigating individual aspects while holding constant such insoluble issues as poverty and

disadvantage. Consequently, interventions to change maternal behaviour and attitudes are suggested, which focus attention on the responsibility of the adolescent mothers for outcomes. The use of cross-sectional research encourages an understanding of these factors occurring in isolation from each other and from their social context.

Research which focuses on determining which factors predict successful outcomes for adolescent mothers and their children understands parenting in a formulaic manner that suggests that success and failure can be achieved by ensuring that the necessary elements are present rather than attending to the wider context. Within the research on adolescent motherhood these differences in predictors and outcomes are used to divide adolescent mothers into the successful and the unsuccessful, and to ensure the careful management of the unsuccessful.

Cause or Consequence of Disadvantage?

The central argument of much of the research on adolescent motherhood is that adolescent childbearing *causes* long term disadvantage for mothers and their children. This argument suggests that pregnancy initiates a series of negative events such as school leaving, welfare acceptance, and lack of training for employment, that preclude adolescents from future life success. In response to this, research has been undertaken that questions the direction of causality. Rather than adolescent childbearing leading to disadvantage, the association between these variables may be due to pre-existing differences between adolescents who later become mothers and those who do not (Geronimus, 1991, 1992a, 1992b). These differences include structural issues such as adolescent mothers being members of economically disadvantaged groups, being minority group members, and living in either densely populated inner city areas or isolated rural areas, all of which are medically and educationally under-served. Within these disadvantaged communities, adolescent mothers are less academically successful prior to pregnancy than other adolescents. Given all these disadvantages, recent critiques suggest that there would be little difference in outcome for these women and their children if they were to postpone childbearing beyond adolescence (Geronimus, 1991, 1992a, 1992b; Geronimus & Korenman, 1993a; Lawlor & Shaw, 2002a). The argument for prevention of adolescent pregnancy and parenting is considerably

weakened if the direction of the association of early parenthood and disadvantage is called into question.

A range of research methods have been used to untangle the causal relationship between adolescent pregnancy and disadvantage. These methods have included comparing sisters, one of whom gave birth during adolescence with another who gave birth in her twenties (Geronimus, Korenman, & Hillemeier, 1994); comparing the outcomes for adolescents who chose to raise their children, to outcomes for those who relinquished them for adoption (McLaughlin, Manninen, & Winges, 1988); and comparing the outcomes for adolescents who miscarried to those who gave birth (Hotz, McElroy, & Sanders, 1997, cited in Hoffman, 1998). An innovative study also compared the outcome for adolescent mothers who gave birth to a single infant with those who gave birth to twins on the assumption that the difference in outcome can be approximately compared to that of an adolescent with no children versus an adolescent with one child (Grogger & Bronars, 1993). These studies generally find fewer disadvantages associated with adolescent childbearing than found with standard control of measurable variables such as education and family circumstances. For example, there is less difference in outcome for sisters who differed in age at first birth than for unrelated women of matched socioeconomic status and education. This indicates that there are familial characteristics of early child-bearers that will influence their outcomes irrespective of their age at first birth. The results of these studies suggest that the role of adolescent pregnancy and parenthood in causing disadvantage have been overstated. Geronimus (1991, 1992b, 2003) further argues that becoming a parent early in life can be seen as a culturally rational act given the poor health outcomes and limited life span of many poor urban minority group members. Geronimus (1997, 2003) reports evidence suggesting that early childbearing is associated with better outcomes for poor Black women than childbearing in their twenties.

Although these studies generally find fewer disadvantages associated with adolescent childbearing than with delaying parenting beyond adolescence, the level of remaining association between adolescent childbearing and disadvantage remains a topic of contention. Some authors suggest that prevention of adolescent pregnancy is still a worthwhile goal:

> Reduction of early parenthood will not eliminate the powerful effects of growing up in poverty. But it represents a potentially productive strategy for widening the pathways out of poverty or, at the very least, not compounding the handicaps imposed by social disadvantage (Hoffman, Foster, & Furstenberg, 1993, p.11).

Other authors suggest that postponing childbearing beyond adolescence will have little influence on outcomes as "women of any age may be victims of environmentally induced risk factors for poor childbearing prognoses" (Geronimus, 1986, p.1416). These authors position the adolescent woman as a victim of circumstance, handicapped by the powerful effects of her social situation. Rather than seeing these women as individual victims, this research implicates group membership in poor outcomes. This constructs adolescent motherhood as existing in particular social milieu and reinforces the notion of an underclass.

This focus on adolescents as the victims of poverty is the point at which these two responses to the cause or consequence of early parenthood diverge. Although both approaches acknowledge the role of structural poverty in producing disadvantage, the pathways out of poverty are viewed differently. Suggesting that prevention of adolescent pregnancy is a worthwhile aim promotes the role of the individual in producing disadvantage. Individual acts of reproductive choice are viewed as a pathway out of poverty. In contrast, those authors who suggest that prevention of pregnancy will not impact on levels of disadvantage, view poverty as a structural problem that cannot be remedied with an individual solution. Determining whether adolescent motherhood is the cause or the consequence of disadvantage is a dialogue about blame and responsibility for early motherhood.

Geronimus (1991) highlights this dialogue when she states that a cultural rationale for adolescent childbearing among the poor is not to be confused with a conscious, individual choice to become a mother. Geronimus states that youth are members of larger social and cultural systems that generate social expectations, sanctions, and norms that influence fertility behaviour. However, for those who subscribe to the view that individual choice can make a difference in reducing the effects of poverty, the individualised nature of choice is seen to reside outside of any understanding of culture. In rebuttal of Geronimus' (1991) description of cultural rationality, Furstenberg (1992)

replies that some adolescents choose to become parents due to immediate advantages to them such as "attention from family and peers, access to special services, and encouragement from prospective fathers" (p.240). Culture is made invisible, taken for granted, and any choice made must then be the result of individual motivations and rewards. The understanding of cultural rationale has been transformed into individual choice, as within this understanding of rationality, a decision is the result of an individually rational personal choice.

Geronimus' (1991, 1992b) suggestion that adolescent pregnancy is a culturally rational solution to the problem of poor health and limited life span among minority group members can be seen as a response to the previous research on individual differences in experience and outcome for adolescent mothers. Those who question the causes versus the consequences of disadvantage, question the widely held view that adolescent motherhood is not the rational economic response to the situation of adolescent pregnancy. Both approaches continue to promote the rational economic actor as the appropriate child bearer for society, however. In contrast, Hays (1996) suggests that treating other people in a purely instrumental fashion is at odds with current societal views of appropriate motherhood.

These studies of the socioeconomic correlates of adolescent motherhood highlight the incompatibility of structural and individual explanations for poverty and disadvantage. If the cause of disadvantage lies outside the individual then the responsibility for disadvantage lies with social structures and systems. Although this allows adolescent mothers to escape blame, the suggestions of researchers that poverty and its effects will need to be ameliorated to deal with the situation provides little agency for the adolescent mothers. They are seen as vulnerable to constraining social structures over which they have little or no influence (Kelly, 1996). Representations such as these, which remove responsibility for outcomes, also remove ability for adolescent mothers to address these outcomes. Just as the 'Factors related to success' research considers the social structures as beyond intervention, the sociological critique considers that changes to the social structures must come from outside the adolescent mothers. In contrast, much of the reply to this focus on structural approaches to poverty understands the individual as able to escape the constraint of poverty through individual action. This denies that social structures are genuinely constraining and places the blame on the individual for

continuing to live in poverty through making poor reproductive choices. The impact of social structure is often reinterpreted to mean individual decision making within a social context. The dialogue over the causes and consequences of adolescent motherhood attempts to reconcile the role of the individual within highly constraining social environments.

An Outsider's View Inside Adolescent Motherhood

Much of the qualitative research on adolescent motherhood has sought to understand the experiences of pregnancy and motherhood from the adolescent mothers' perspective (Davies et al., 1999; Lerman, 1997). This 'insider' view of mothering in adolescence is contrasted with the view of 'outsiders' such as social scientists and policy makers. This identifies adolescent mothers as a group with specific values and needs which may differ from the needs of older mothers, but may also have similarities with those of other marginalised groups such as welfare mothers and single mothers (Rains et al., 1998).

Research on the insider perspective has investigated adolescent mothers' notions of responsibility, and how this impacts on their acceptance of help from social agencies and baby-fathers. This research focused on the ability of adolescent mothers to change and control their social world, rather than merely being subject to the whims of their baby's father, welfare agencies and family relationships (Davies et al., 1999). Kirkman, Harrison, Hillier, and Pyett (2001) and Lerman (1997) have studied the way adolescent mothers made sense of their own lives. They found that adolescent mothers were aware of the prevailing negative stereotype of adolescent motherhood, but described themselves as 'good' mothers who saw motherhood as providing opportunities for growth. The research on adolescent mothers' own understanding of aspects of their lives suggests that these young women have considerable ability to manage their own complex lives with skill and maturity.

This research also acknowledges adolescent mothers' abilities, such as being able to make decisions regarding their own and their children's lives based on their own values. As Davies et al. (1999) suggest, adolescent mothers' decisions regarding employment,

welfare receipt and relationships are not arbitrary or the outcome of their shiftless characters, as often represented in the media, but are carefully considered decisions based on the complexity of these issues in their lives. These authors also suggest that an understanding of these insider views should impact on the prevailing views of adolescent mothers presented by outsiders such as policy makers and social scientists (Lerman, 1997; Rains et al., 1998). Merrick (2001) additionally suggests that research on the world of Black adolescent mothers can contribute to a varying understanding of the many ways that adolescent development can be achieved.

One rationale for understanding the insider view of adolescent motherhood is to provide programmes that serve the actual needs of adolescent mothers rather than provide what social scientists believe adolescent mothers require. Rains et al. (1998) used their findings to suggest that adolescent mothers may benefit from concrete assistance such as collective kitchens and furniture exchanges. Although this research intends to "help them [adolescent mothers] hear their own voices in regard to the development of their goals and the discernment of their needs" (Clifford & Brykczynski, 1999, p.14) the role of the researcher in determining what help is necessary and appropriate is still paramount. The provision of these services may improve aspects of the lives of adolescent mothers, but they still potentially set adolescent mothers apart from older mothers. These distinctions between adolescent mothers and older, usually self-supporting, mothers continue to reinforce the position of adolescent mothers as objects of deficiency based on their age. This research, undertaken to provide these young women with a voice, supports and validates the category 'adolescent mother' as having a meaning that is different from older mothers. This difference then supports the comparison of adolescent and older mothers, and encourages differential surveillance and treatment of adolescent mothers. Even when research provides adolescent mothers the 'voice' that much social scientific research has denied them, adolescence continues to be the focus. This research acknowledges the role of poverty and disadvantage in the lives of adolescent mothers and sees the role of researchers as helping adolescent mothers to escape poverty by their own efforts, in concert with the researchers. However, by researching adolescent mothers themselves, the researchers assume that there is something about adolescent mothers that is a cause for concern. This focus is not a necessary requirement, as adolescent mothers need not be separated out from other

mothers in common areas of research such as parenting competence, health-care utilisation and psychological functioning.

Tension is created when adolescent mothers' voice has been provided by the researchers, who have imposed order upon their world through the analysis of transcripts and summarising of themes. Clifford and Brykczynski (1999) highlight this tension when they describe their method of clarifying the meaning of the text by using a number of informed sources:

> Interpretations were consensually validated by both authors, as well as a pediatric health educator, a maternal-child nursing faculty, a school health administrator, a school nurse colleague, a graduate student in psychology, and a clinical psychologist (p.6).

This level of validation by experts is comprehensive, however, is quite separate from the world of the adolescent mothers whose "lived experience" (p.4) these authors are intending to capture. This is particularly relevant when considering the gap between the world of adolescent mothers and of health and social service professionals. SmithBattle (2000a) acknowledges the difficulty of researchers imagining a social world radically different from their own. However, the assumption made is that the forms of knowledge supported by qualitative research will provide this voice for adolescent mothers, in contrast to the positivist forms of knowledge that deny adolescent mothers their own forms of knowing. In practice, however, there often appears to be little difference in the development of categories imposed on adolescent mothers by positivist and non-positivist research. Merrick (2001) illustrates this tension as she provides themes that underlie the lived experience of Black adolescent childbearing, but then attempts to evaluate the logic of the participants' suggestions:

> These participants hoped to make up or correct the mothering they were given through raising their own children. This seems like a hopeful move, though how successful they will be is questionable (p.60).

Providing Black adolescent mothers with a voice has culminated in determining their lived experience as naive and romanticised in much the same way that mainstream

research has characterised adolescent mothers (see Medora & von der Hellen, 1997; Scott, 1983).

The difference between insider research and traditional research on adolescent motherhood appears to lie in the attempt by qualitative research to perceive adolescent mothers as positive on the researchers' terms, rather than encouraging them to see themselves as positive without the support of expert researchers. SmithBattle (2000a) states that

> After listening to teenage mothers for more than 8 years, I have been impressed with how deeply young mothers want to become good mothers and how they attempt to do so by extending, modifying, or rejecting the caregiving traditions of their families of origin (p.86).

As shown by this quote, researchers have investigated adolescent mothers and determined that they are deserving of praise and support. This approval of a faction of social scientists is not the same thing as deciding to provide the young women with a voice, as this voice is dependent on their continuing to deserve this support.

The importance of this becomes clear when the ethnocentric values of researchers interact with the different social world of adolescent mothers. Hanna's (2000, 2001) ethnographic research addresses this issue and acknowledges the difficult role of the researcher. She questions the researchers' right to "intrude on them [the adolescent mothers] by bringing my middle class values into their lives" (Hanna, 2000, p.6). Hanna also states that much of the lives of these adolescent mothers were a huge shock to her. However, this acknowledgment of the different worldview of the researchers and adolescent mothers is rare. As Davies et al. (1999) explain, there are differences between middle class mothers and working class mothers (who tend to be younger). For example, middle class mothers believe that they must achieve maturity before having children, whereas working class mothers experience themselves as achieving maturity through motherhood.

Despite the importance in this research of understanding the lives of adolescent mothers within a particular context, there is still the underlying desire to mould the lives of

adolescent mothers to the mainstream. This is particularly apparent with Lerman's (1997) discussion of how the transforming effect of early motherhood identified by adolescent mothers should be harnessed earlier to prevent pregnancy. Clearly, the ideal is to prevent adolescent pregnancy, but the positive outcomes of early pregnancy; the impetus for improving their lives and improvement in employment prospects should be retained. This sees the direction provided by motherhood as occurring in isolation rather than as a result of the prevailing understandings of adolescence as a time of experimentation and irresponsibility, in contrast to motherhood as a time of responsibility and stability. The notion that the desirable aspects of responsibility and stability could be induced without the state of motherhood ignores the social context in which these occur.

'Insider' research attempts to view adolescent mothers positively in contrast to much of the previous social scientific research on adolescent motherhood. In practice, because this research is conducted by social scientists whose lives are often very different from the young mothers, the research often draws upon similar explanations and understandings of adolescent motherhood that are reproduced in mainstream research. Researchers' empathy for adolescent mothers does not provide an understanding of the mothers' lived experience, but the researchers' sympathetic reading of their lives.

Conclusion

Although mainstream research on adolescent mothers tends to equate adolescent motherhood with a number of negative outcomes, recent research has not focussed exclusively on the 'problem' of adolescent motherhood. Alternatives to negative constructions of adolescent motherhood have also been presented. The 'Individual differences' approach reconsiders the aggregation of all adolescent mothers and suggests that differences in outcome for adolescent mothers are paramount. This approach moves the deficiency of adolescent mothering from the entire group, to those within the group who are not coping well. Research on the 'Factors related to success' moves the focus ever inward by considering the intra-individual factors that predict success or failure in adolescent motherhood. This approach assumes that these factors can be divorced from their social context and subjected to improvement in isolation,

without consideration of the cultural factors and social structures that constrain adolescent mothers. The dialogue over the 'Cause or consequence of disadvantage?' attempts to reconcile the role of the individual within highly constraining social environments. An understanding of social constraint is often reinterpreted to mean individual decision making within a social context. This blames adolescent mothers for their situation. The 'Insider' perspective changes the focus again by considering adolescent mothers on their own terms. This attempts to provide adolescent mothers with a voice within social scientific research, but pays minimal attention to aspects of the social world that impact on adolescent mothers, including the unexamined assumptions of the researchers themselves.

This review of the research describes the variety of ways that adolescent mothers have been researched. Each of these has a particular focus, and each has particular implications for those mothering in adolescence. It is essential to acknowledge that research conducted on adolescent mothers does much more than just describe adolescent mothers; it categorises, constructs and positions them in particular ways. Within much of the social scientific research, adolescent mothers are positioned as individually responsible social actors. Although recent research has drawn attention to the importance of the wider social world in mediating access to health care and perpetuating social disadvantage (Yardley, 1999) attention to social constraint, and how that might be conceptualised in social scientific research is still equivocal (Cherrington & Breheny, 2005). Within social scientific research, social constraint is often transformed to mean individual decision making within a particular social environment. This particularly highlights individual prevention programmes as realistic forms of social change versus changes to broader social structures, which cannot be realistically attempted. As such, adolescent mothers are positioned as individually problematic and requiring intervention, or as capable of avoiding disadvantage through appropriate individual action. Ultimately research returns to a construction of adolescent mothers as the problem rather than examining social contexts and their processes.

The ways that adolescent mothers have been researched has contributed to the social world for these young women and their children. It has been argued that the negative health statistics on adolescent mothers and their children reflect the effect of social and economic exclusion (Lawlor, Shaw, & Johns, 2001). Future research needs to address

this exclusion with strategies that attend to the multiple issues, both societal and individual, that surround adolescent motherhood and consider the impact of these issues on social and economic participation and health.

CHAPTER III.
ROLE OF THE HEALTH PROFESSIONAL

Motherhood

An important part of the social context is the health professional. Motherhood involves increased contact with the health care system. In the New Zealand context, most children are born in hospital, and midwives typically visit mothers daily for a week following discharge from hospital. Regular visiting continues until the midwife 'discharges' the baby to the care of the 'Well Child' health care provider. From this time, the baby is monitored using a standard schedule of visits until beginning school and moving to the care of the school nurse. This approach to child care sets the boundaries of the relationship between the mother and health professional; the mother provides daily care, but is monitored by the experts in child raising, the health professionals. The increasing focus on the 'correct' method of childcare (Kedgley, 1996) or the professionalisation of motherhood, (Woollett & Phoenix, 1991) encourages mothers to consult these experts in health care. Although it is the baby that is measured and checked, the mother becomes the focus of the health care system as she performs the mundane daily care of the child under expert guidance. The clinic becomes the arbiter of child health and development (Burman, 1994). Consequently, within the New Zealand context, health professionals have considerable influence over mothers.

As the role of motherhood is seen as a primary one for women, the achievement of 'good' motherhood through appropriate health and development of the baby is an important aspect of their social world. For a mother, being able to view herself as a 'good' mother is integral to viewing herself as a good person (Musick, 1993). As Parker (2002) states, a discourse addresses us in a particular way, and it is not possible to avoid the perceptions of ourselves that the discourse invites. The discourse of motherhood positions women in ways that it is not possible to avoid and the achievement of 'good' motherhood becomes the lens through which women see themselves. The health professionals hold considerable power over mothers in determining the quality of their mothering. As health professionals are viewed as the

experts in baby care and development, they contribute to defining what it means to be a 'good' mother.

However, correct motherhood is fraught with difficulty as the normal child is evidence for 'good' motherhood and "the mundane tasks of mothering came to be rewritten as emanations of a natural and essential state of love" (Rose, 1999, p.161). The evidence for 'good' motherhood is written on the child. The child becomes the object of scientific gaze and by assessing the normality of the child the mother can be assessed. As such, there is an increasing power of the expert to determine the quality of physical and emotional mothering through surveillance of the child. This increases the attention on to the mother and on to the minutiae of daily relations between the mother and the child (Rose, 1999). The quality of the mothering is linked to wider social behaviour and intellectual qualities of the child, justifying this attention (Burman, 1994).

What it is to be a 'good' mother is particularly problematic for young working class women. Doctors, nurses, and midwives in New Zealand are drawn mainly from the privileged classes. Their backgrounds and life experiences may prevent them from understanding the social world of members of the other classes (Chamberlain, 1997). This different approach to motherhood between health professionals and adolescent mothers may be class related rather than directly age related (Kirkman et al., 2001). Motherhood is enacted through culture, ethnicity and class. Research suggests that working class mothers approach parenting as a route to maturity (Davies et al., 1999). Young mothers also tend to support a more spontaneous and intuitive approach to childrearing as opposed to older mothers anxiety about 'correct' mothering (Abel, Park, Tipene-Leach, Finau, & Lennan, 2001). This provides an important area of potential conflict between mothers and health professionals. Hays (1996) states "whatever is defined as good parenting is defined by the middle class as the opposite of working class parenting" (p.203). The professionals' judgment of adolescent mothers' parenting and attempts to encourage them to parent the 'right' way is likely to alienate younger mothers who parent in a way that makes sense for their own situation and social class. Research has suggested that differences in health-relevant behaviours are developed in the context of daily living and as such depend upon the wider experience of health care and social class (Chamberlain, 1997). Consequently, imposing middle class practices

on other classes is unlikely to be successful, as their experience of daily living may be very different.

Power and Voice

Health professionals are an important starting point for this work as they have a powerful warrant for their construction of adolescent motherhood to be given a wide audience. They have access to the media and a strong network of professional communication through professional journals and conferences to engage in debate and consolidation of research ideas and discourses (Kelly, 1996). In contrast, adolescent mothers are in a particularly weak position to counter the professional construction of adolescent motherhood (Wong, 1997). Partly because they lack access to such institutional support, and also as the health professionals are seen as the experts on health and motherhood, they have a warrant not only in the eyes of the public, but also in the eyes of the adolescent mothers themselves.

The power and warrant of health professionals to regulate individuals is legitimated by psycho-medical expertise (Rose, 1999). Scientific research has a strong claim to true knowledge and effective practices that legitimate their power through various surveillance and intervention strategies. In the context of adolescent motherhood, scientific research produces knowledge of adolescents as inadequate mothers compared to the 'good' mother of science (MacLeod, 2001). Privacy is also used to separate the public and private lives of individuals to suggest that what occurs outside public view is outside the scope of public powers. This is the case for motherhood, which is viewed as the arena in which women have power, but motherhood is subject to regulation through child-care manuals, magazines, and advice from health professionals. All these forms of advice regulate how 'good' motherhood can be performed within this apparently private sphere. Those mothers who do not undertake motherhood in the ways sanctioned by health professionals are marginal mothers who legitimate the need for professional intervention in the lives of women and their children (MacLeod, 2001). In addition, individuals are constructed as free to choose on the basis of personal motives and aspirations rather than through the exercise of public power. In the context of motherhood, women are encouraged to manage their behaviour towards their children in

terms of achieving 'good' motherhood, freely choosing to be the best mother they can be with the knowledge of science. In these ways, the power of the medical profession is enacted as the institution claims to know the truth, but individuals are viewed as free to choose their actions and live much of their lives in the private sphere that is beyond the apparent possibility of public control.

The power and warrant of health professionals can be viewed in different ways. A functionalist approach suggests that the power of the health professional reflects the legitimate authority of doctors and nurses over patients. The patient has the power to choose to have their health care needs met by an alternative provider of health services (Lupton, 2003). Improvements in the relationship between health professionals and patients in this paradigm focus on the need to convey information more clearly and less judgmentally to ensure patient compliance. Much of the research on the interaction between adolescent mothers and health professionals draws upon this understanding of the power imbalance between health professionals and adolescent mothers.

An alternative approach suggests that power imbalances are due to the professional status of health professionals and their control over medical knowledge. Medical understandings of health and illness also divert attention from social and political determinants of ill health by representing ill health as an individual state (Lupton, 2003). Because health professionals are disproportionately powerful in society as well as in the medical encounter, they are able to represent problems as medical rather than social issues. This approach suggests that the power imbalance should be addressed through increased access to medical knowledge. In addition, patients should be encouraged to describe the wider context of their lives to address the impact of social issues on ill health. In contrast, a Foucauldian perspective suggests that an invitation for patients to discuss their lives and symptoms in the context of daily living provides a greater opportunity for the medical gaze to increase surveillance and social control into broader areas of patients lives that may impact on health care practices (Lupton, 2003).

These approaches take for granted the power imbalance between health professionals and patients. Scientific knowledge and the links between science and wider forms of societal power place patients in a weak position to counter medical knowledge. Resistance is possible, however, and is often enacted by members of the lower classes

in medical encounters by becoming uncooperative, non-compliant, helpless, or by small acts of defiance (Lupton, 2003). These acts of resistance can be understood as a reaction against the perceived power imbalance, but are often viewed within mainstream health professional literature as a need to explain more simply and manage compliance more closely, resulting in further acts of defiance.

Health Professionals and Adolescent Mothers

There is considerable research on the health of adolescent mothers and ways to improve health outcomes. This research draws upon wider understandings of what it means to be an adolescent mother. Adolescent mothers are viewed within the health professional literature as presenting "unique challenges" (Davis, Burke & Braunstein, 2001, p.478; see also Robinson, 1992). They are assumed to lack parenting skills, be unable to provide accurate observations of the infant, and require cautious handling as they are often intimidated by health professionals (Davis et al., 2001). In addition, adolescent mothers are often characterised as insensitive and impatient towards their children and as having inferior mothering skills compared to older mothers (Ruff, 1990; Secco, Ateah, Woodgate, & Moffatt, 2002). These pervasive understandings of adolescent motherhood are also shown by Powell, Griffore, Kallen and Popovich's (1991) survey of physicians' preferences for adoption, abortion or keeping a child among adolescents, which found that becoming a mother in adolescence is the least preferred option for pregnancy resolution among physicians. Much of the health professional literature draws attention to the need to 'manage' adolescent pregnancy (James, 2000) and 'assess' adolescent mothers (Roye, 1995). Consequently, the daily care that is provided by the adolescent mother is suspect and called into question by health professionals.

One outcome of this is that adolescent mothers report feeling under surveillance when dealing with health professionals, which may prove to be a barrier to accessing care. de Jonge (2001) retrospectively studied the support that mothers received as adolescent mothers and found they reported feeling that they were being watched, and a fear that their baby may be taken away if they were not seen to be coping well. In addition, Melhuish and Phoenix (1987-8) state that an awareness of being stigmatised may make adolescent mothers distrustful of professionals, which they view as making negative and

inaccurate judgments about them. Adolescent mothers experience health professionals as patronising (Kirkman et al., 2001; Rozette, Houghton-Clemmey, & Sullivan, 2000), expect to be treated in a condescending manner (de Jonge, 2001) and are relieved and grateful when treated well (Folkes-Skinner & Meredith, 1997). Fear of surveillance is viewed as a problem within this research, but it is produced by an attention to adolescent mothers as different from older mothers and requiring supervision to avert their suspect parenting. Reduction of surveillance cannot be reasonably achieved in the social context of adolescent mothers as dubious parents. There is a need to address the health professionals' apparent need to monitor adolescent mothers, rather than the adolescents' perception of this surveillance.

In response to this problem of surveillance, there is a theme in the health professional literature that suggests that adolescent mothers require non-judgmental care, free from the negative views of health professionals (see Better Health Services, 1998; Clark, 2001; Hawksley, 1996; James, 2000; Michels, 2000; SmithBattle, 2000b). Judgmental attitudes and behaviours are viewed as residing within the individual health professional and impacting on individual adolescent mothers. Salladay (1997) reflects this when she describes the prejudice against out of the mainstream adolescent mothers as "involves stereotyping and thrives on ignorance" (p.28). However, these 'prejudicial' attitudes can usefully be understood as occurring within wider social understandings of appropriate behaviour. Within this framework, 'attitudes' towards adolescent mothers do not reflect individual prejudice or mistaken stereotypes, but how it is possible to view adolescent motherhood given the understandings of developmental psychology, family structure, and motherhood that adolescent mothers challenge.

Most previous research on the health of adolescent mothers and their children begins with the premise that it is the adolescent mother who should be the subject of research and intervention. There has been little attention paid to the health professionals. The health care provider is constructed as a neutral participant in the health interaction. This approach overlooks the role of the health professional in constructing the interaction. Similarly, research on factors related to seeking or delaying prenatal care in pregnant adolescents identified factors related to the adolescents' health during pregnancy, and relationship with their own mother as important in differentiating early and late attenders for prenatal care (Lee & Grubbs, 1995; Simms & Smith, 1984). These studies

did not investigate any influence of health provider characteristics on attending for prenatal care. Lee & Grubbs (1995) did report that those young mothers who sought early care were more likely to agree to be interviewed than those who received late prenatal care, suggesting that those who delay prenatal health visits may not trust nurses or the health care system. Ray (1997) suggests that health care providers contribute to utilization of well-child care. SmithBattle (2000b) suggests that the relationship between adolescent mothers and health professionals have the capacity to empower or diminish adolescent mothers, and Lawlor and Shaw (2002a) state that adolescent mothers experience of health care may reflect prevailing values of health professionals. Focusing on this relationship deflects attention from adolescent mothers as deficient and addresses the social context of the health of adolescent mothers and their children. This focus on the relationship provides the impetus for this research on the constructions of adolescent mothers among health professionals.

Conclusion

Health professionals have an important place in the social world of adolescent mothers. They are regular visitors into their lives, monitoring the health and development of their children. They have the power to define adolescent mothers as 'good' or 'bad' mothers, an area of major importance in the lives of young mothers. As the arbiters of 'good' motherhood, health professionals' views of adolescent mothers receive wide circulation through professional literature and contribute to the construction of adolescent mothers as separate and different from older mothers. This study examines health professionals' constructions of adolescent motherhood and understands these constructions as an important aspect of the social lives of adolescent mothers. Social constructionism is an appropriate perspective to investigate the construction of adolescent motherhood by health professionals.

CHAPTER IV.
METHODOLOGY

Social Constructionism

Social constructionism is an epistemological position, which maintains that knowledge is unstable, constructed and intimately entwined with social process and social structure. Crotty (1998) defines social constructionism as "the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context." (p.42). Traditional psychology looks for explanations of social phenomena by investigating intra-psychic events such as emotions, attitudes and motivations, and sociology focuses on the wider social structures such as economic systems, marriage, and the family as the source of social phenomena (Burr, 1995). Social constructionism, however, suggests that social phenomena should be investigated not by investigating these stable intra-psychic or social structures, but by looking at the social processes people are engaged in (Burr, 1995). Gergen (1985) states that social constructionism is "principally concerned with explicating the processes by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live." (p.266). Social constructionism has radical implications for the way that we consider the individual, knowledge, and claims to truth. Accordingly, social constructionism has implications for undertaking research in the construction of adolescent motherhood by health professionals. This epistemological position is founded on a skeptical approach to taken for granted knowledge, an acknowledgement of the cultural and historical specificity of knowledge, the belief that knowledge is sustained by social processes, and an assertion that knowledge and social action are related practices.

The first of these criteria is a critical approach to taken for granted knowledge (Burr, 1995). What exists is not necessarily what we perceive to exist. Gergen (1985) states that what we know of the world is not a map of the world, but a reflection of the categories that we have to construct the world. Therefore investigation of the world

tells us about these categories, not about any external structures that these categories purport to describe. This challenges the objective nature of conventional knowledge (Gergen, 1985). Research into particular phenomena creates and reinforces these taken for granted categorisations of the world rather than revealing the reality of the categories. This invites a critical evaluation of categorisations and an acknowledgment that these categorisations are not arbitrary, but are shaped by power relationships (Cromby & Nightingale, 1999).

Social constructionism particularly draws attention to the role of language in providing the categories we use to construct the world. Health professionals' construction of adolescent mothers in the professional literature and in interviews can be considered as discursive practices, which involve claims that categorise adolescent mothers in certain ways. The social function of these categories is to separate adolescent motherhood from later motherhood so that the claims for reducing adolescent motherhood are justified. Without this categorisation of adolescent and non-adolescent mothers, there is no basis on which to treat adolescent mothers and their children as different to older mothers and their children. These discursive practices of separation and categorisation involve comparing adolescent mothers to older mothers on medical statistics, on marriage and welfare receipt, and by drawing on understandings of appropriate adolescent development to justify separation.

Accordingly, the present research begins by taking a critical perspective on adolescent motherhood and the constructions of this category by health professionals. This critical approach encourages a sceptical approach to research that finds differences between adolescent and older mothers by accepting these age demarcations as valid, and sees the body of literature on adolescent motherhood as constructing adolescent motherhood rather than describing it. The categorisation of mothers into adolescent and non-adolescent does not reflect a reality inherent in these individuals, but reflects the ways that we have of categorising persons into particular types. Research findings that uncover differences in depression or maternal role attainment, for example, do not reveal the nature of adolescent motherhood, but reflect how it is possible to construct adolescent motherhood and how the intersecting categories of age, maternity and psychology frame these constructions. In addition, the categorisation of adolescent pregnancy and parenting is dependent on many other categories. Because of this, it is

also important to consider the implications of these other categorisations and how they impact on the construction of adolescent motherhood.

Although a critical approach to the 'taken for granted' is a basis of social constructionism, it is also important to consider the limitations in providing a critique of particular categorisations. Fish (1980) states that

> The mental operations we can perform are limited by the institutions in which we are *already* embedded. These institutions precede us, and it is only by inhabiting them, or being inhabited by them, that we have access to the public and conventional senses they make (pp.331-2).

Given this, our participation in these institutions provide us with the framework to comprehend the world, and as they structure the world that is apparent to us, also limits the extent to which we can step outside this structure and become critical of what we have taken for granted. Crotty (1998) describes social constructionist research as "an invitation to reinterpretation" (p.51). However, it is necessary to see this reinterpretation as constrained by the inevitability of our position as embedded within the institutions whilst simultaneously attempting to facilitate their critique. As Foucault suggests

> What we have, think, know and understand today was not inevitable but, because of the way in which our episteme is ordered, we have very little chance of either understanding that things could have been different, or of speaking differently about them (Danaher, Schirato, & Webb, 2000, p.21).

Consequently, it is important to see any deconstruction of categories as framed by the current ways we have of constructing alternatives. We cannot account for what is repressed and consequently impossible to think (Danaher et al., 2000).

The second aspect of a social constructionist position is the acknowledgement of the historical and cultural specificity of knowledge and social practice. What counts as knowledge depends upon a variety of social and economic arrangements that may differ substantially across cultures and periods of time (Burr, 1995). We are born into a world

that is already structured and made meaningful by our historical and cultural position. Our culture tells us how to see and whether to see certain objects (Crotty, 1998). It is also important to consider history and culture at many levels. History and culture are not confined to large time spans or very different cultural groups; they also include the micro historical and cultural effects that determine how knowledge is constructed. Historical and cultural specificity is not merely different cultures having different practices. In addition, it means that what counts as knowledge and how we go about determining what is knowledge, is constructed differently across time and culture. This shifting of knowledge means that there are many knowledges, rather than one definitive knowledge of the world (Foucault, 1997). This does not reflect progress from the unenlightened to the enlightened, but the different practices that are used to structure knowledge in another time and place. These differences mean that in other times and places, people may have made sense of the world in ways that we could not imagine (Danaher et al., 2000).

Knowledge rises and falls, and the knowledge surrounding adolescent motherhood is particularly susceptible to these shifting patterns of practice over time and culture as responses to both adolescence and motherhood have changed dramatically over the last one hundred years (Combs-Orme, 1990). Acknowledging the importance of these historical and cultural differences and their variation across different social and economic arrangements encourages an understanding of adolescent motherhood as changing and constructed rather than as solved for all time by a particular approach to adolescence or motherhood. The history of adolescent motherhood in our society in recent times can be traced through the use of adolescent pregnancy as indicative of a social problem. Wong and Checkland (1999) state that prior to the 1970s, illegitimacy was the dominant term and seen as the major problem. Following this, adolescent pregnancy, and then adolescent parenting, became the terms and problems as more and more young women chose what was once the rarest option of pregnancy resolution, keeping their children without the sanction of marriage. Adolescent pregnancy and parenting can be seen as the new moral terms that have replaced illegitimacy and unwed motherhood (Wong, 1997). These morals reflect and reproduce what we know about appropriate motherhood and appropriate adolescent development. These terms sanction young women who reject middle class expectations of appropriate development for the 'normal' young woman.

In addition, the cultural prescription for what counts as knowledge also impacts on adolescent motherhood. At this point in history, research endeavour is directed at determining the 'true' effect of adolescent motherhood in isolation from poverty, ethnicity, and class (see Furstenberg, 1991; Geronimus & Korenman, 1993a, 1993b; Grogger & Bronars, 1993; Hoffman, Foster, & Furstenberg, 1993). Adolescent motherhood is intimately entwined with race, poverty, social class, and individual achievement in ways that make finding the unified and stable effect of adolescent motherhood in isolation a complex and arguably pointless task. From a social constructionist perspective, these attempts to reify adolescent motherhood reflect just one sort of knowledge that can be heard regarding adolescent motherhood, and serve one set of interests. Other knowledge regarding adolescent motherhood can be constructed based upon different sets of assumptions concerning the nature of knowledge that reflect a different set of interests. For example, it is possible to see adolescent motherhood as only able to be understood within the wider context in which it occurs. Adolescent mothers are positioned in many ways determined by the intersection of their class, race, socioeconomic status, and personal attributes and to 'remove' these is to fail to see adolescent motherhood in context.

A third aspect of social constructionism is the acknowledgment that social processes sustain knowledge. Knowledge is not determined by an external reality, but reality is a function of the way it is possible to construct categories and meaning through available linguistic resources. Gergen (1985) states that knowledge is not something that resides in peoples' heads, but is something that people do together; it is performative. This does not mean, 'anything goes', however. A constructed truth is still stable and secure as it is situated within a specific atmosphere of historical and sociopolitical circumstances (Hook, 2001). Therefore, knowledge is created and sustained by the minute daily interactions between people. The ways of understanding the world that are currently accepted are a product of the many social interactions in which people are constantly engaged (Burr, 1995), rather than a reflection of a singular truth. Crotty (1998) argues that "what constructionism drives home unambiguously is that there is no true or valid interpretation" (p.47), however, one version may operate as truth. Given a certain set of conditions, some statements can be seen to be true (Foucault, 1997; Hook, 2001).

The role of social process in sustaining knowledge and supporting one version of the truth means that there is no once and for all time description of adolescent motherhood. This knowledge is constantly being managed and maintained through the mundane daily interactions between people. What it means to be an adolescent mother is constantly created and recreated by the social processes that people are engaged in. Given that the ways of understanding adolescent motherhood are constructed between people in social interactions, it is important to understand the linguistic resources that health professionals bring to their interactions with adolescent mothers.

Finally, social constructionism asserts that knowledge and social action are related practices. Language is a form of social action. A variety of constructions are possible, and each construction consequently invites particular actions. Traditional approaches to knowledge posit that knowledge determines social processes. Within this paradigm, knowledge is discovered, and this knowledge is used to suggest a particular approach to practice. However, within social constructionism it is possible that social processes are seen as the initial step and knowledge seen as produced to serve a particular social process. Rather than 'discovering' the inadequate mothering of adolescents, and using this 'knowledge' to prevent motherhood or improve the mothering of adolescents, the social action of support for adolescent motherhood could be the starting point for the development of particular 'knowledges' to promote this outcome. This approach recognises the reciprocal nature of knowledge and social action. In addition, current constructions of adolescent motherhood as inappropriate and related to a range of economic, health, social, and educational disadvantages for both the mother and child, promote particular social actions, primarily a focus on 'prevention' of adolescent motherhood. However, constructing adolescent mothers as striving to assert their independence and responsibility (see Davies et al., 1999) would make other actions regarding adolescent mothering appropriate. The production of one sort of reality limits the exploration of others, as investigation follows one path at the expense of others (Rose, 1999). The construction of adolescent motherhood in particular ways has material effects on the world.

Discourse and Material 'Reality'

Social constructionism does not bring with it a position on the nature or existence of reality. As Gergen (1994) states, "constructionism is ontologically mute" (p.72). However, it does bring with it a debate on the nature of reality. Social constructionism itself is subject to a number of varying constructions. The extent to which the material world can be excluded from a consideration of the discursive is a subject of ongoing debate within this area. Gergen (1985) suggests that there is not a necessary relationship between the material and the discursive. He suggests, rather, that "the rules for 'what counts as what' are inherently ambiguous, continuously evolving, and free to vary with the predilections of those who use them." (p.268). Crotty's definition differs from that of Gergen and many other social constructionist researchers (see Edwards, Ashmore, & Potter, 1995; Edwards & Potter, 1992) as he argues that "subject and object emerge as partners in the generation of meaning." (p.9). Crotty argues that the material world (objects) have characteristics that influence their possible construction, and these objects can be see as building blocks out of which the world can be flexibly constructed. Constructions involve much more than reflecting these characteristics, as the subject contributes to the construction. As Crotty (1998) argues "meaning making is always an 'ongoing accomplishment'" (p.47) which involves both the subject and object of the discourse. Similarly, Cromby and Nightingale (1999) argue that material objects, although reproduced through discourse, cannot be reduced to discourse. They argue that materiality creates possibilities for discourse, and places constraints on what can be constructed. The relationship between the material and discursive does not have a line that delineates the real from the not real. It is a two way process where the material and discursive are constantly in dialogue.

The nature of reality and its relationship to adolescent motherhood has particular implications for this project. Gergen's (1985) argument would suggest that adolescent motherhood could be constructed in any way that health professionals see fit to construct this category. He argues that the actual characteristics of any and all individual adolescent mothers provide no constraint on the description of that state by others. However, according to others (Cromby and Nightingale, 1999; Crotty, 1998), at some level there is a materiality of circumstance that impacts on that construction. That materiality is mediated through discourse. The categorisations produced are the result

of much more than the material circumstances, but they do impact on how it is possible to construct the world. It is impossible to pinpoint the moment when material aspects of phenomena become constructed. Adolescent motherhood is constructed and changing. There is nothing that can be said to be 'really' adolescent motherhood, or motherhood at all. Categorisation influences what can be seen, and the dominant discourses of motherhood, care, and nurturing are invoked in health professionals' constructions of adolescent motherhood. But there are better and worse ways to be mothered, in discourse and in the material aspects of care. To deny this is to suggest that all mothering is equally valid and inherently appropriate. However, these evaluations of motherhood are not stable, but vary according to different historical, cultural, and moral contingencies.

A social constructionist position, therefore, considers how mothering by adolescents is constructed through discourse. Parker (1990b) states that things can be endowed with three types of existence: ontological, epistemological, and moral/political. Things with ontological status exist independently of thought processes and language. Adolescents' pregnancies and mothering practices have ontological existence, and investigating the discursive construction of adolescent motherhood does not deny the material problems that many adolescents face as mothers. However, this approach sees the discursive as implicated in these material difficulties. Epistemological existence refers to those things that have been given meaning by discourse (Burr, 1995). In this case, it is concerned with what can be known about adolescent motherhood. The construction of motherhood among adolescents as a health problem gives meaning to the mothering practices of an adolescent as separate from the practice of motherhood in other age groups, and as requiring different social actions. The third category is moral/political existence. Things that exist in the moral/political realm are those that are constructed through discourse and through this construction are attributed with reality. Burr (1995) states that there is a danger that an object with moral/political existence is treated as if it had the same kind of reality as an object with ontological status. The existence of adolescent motherhood as a social problem is constructed as a reality as concrete as that of the pregnancy of a young woman. This construction of adolescent motherhood as a social problem means that alternative ways of viewing the object are suppressed in favour of the apparent truth of the social problem. The way that adolescent motherhood is constructed in much biomedical and social scientific literature indicates that its reality

as a moral and political issue exists in the same way that the pregnancy of a young woman exists. As Parker (1990b) states, once objects are circumscribed through discourse and constructed in this way, it is difficult not to refer to them as if they were real. It is difficult not to see adolescent motherhood as real, but the categorisation and delineation of adolescent motherhood is not natural, or existing without the construction of adolescent motherhood as an epistemological and moral/political reality.

The meanings ascribed to particular categorisations such as 'adolescent mother' have implications for social practice. These meanings and categorisations are not "just talk"; they have material effects on people's lives and reproduce or resist established power relations and institutions (Gavey, 1989; Willig, 2001). The discourses used to construct adolescent motherhood have implications for how adolescent mothers are positioned in health settings and as subjects with rights to access material and non-material support that influences their health and health care utilisation. These include material aspects such as access to the best qualified and experienced health professionals, and well resourced health centres, as well as non-material aspects such as respect, patience, and admiration.

Subjectivity

Generally, subjectivity within psychology is seen as a result of the conscious, self-governing individual making choices and taking control of outcomes. This individual's subjectivity can be enhanced through self-inspection and self-improvement (Rose, 1999). Within social constructionism, subjectivity is seen as situated within discursive possibilities, and institutional practices (Danaher et al., 2000). People do not make meaning, but social structures speak through people. Individual identity is "the product of discourses, ideologies and institutional practices" (Danaher et al., 2000, p.xv), which are constraining, though not wholly determining. Rather, there is a tension between the extent to which individuals have their lives scripted by the powerful interplay of institutions, discourses, and practices and their ability to negotiate their identity. Consequently, our subjectivity is not private, but governed by the wider social structures in which we are embedded.

Foucault (1982) refers to the three modes of objectification that transform human beings into subjects. The first is the scientific mode of inquiry that objectifies the subject through the analytic framework of any form of scientific thought. The second mode is the use of dividing practices to separate the subject from others or from aspects within themselves. This includes separating the sick from the healthy, the sane from the mad, and the poor from the wealthy. The third mode reflects how the person turns him or herself into a subject. Foucault refers to this as the 'cultivation of the self', as it is viewed as the responsibility of the individual to care for and manage themselves in accordance with societal values (Foucault, 1988).

Danaher et al. (2000) uses the example of school children to illustrate how the structure and discourses of school life attempt to produce compliance and obedience, but these practices are often far from successful. As these authors state, those that the system is designed to subdue, often rebel and the attempts to produce docility are often abortive. These same ideas can be transferred to the production of adolescence and motherhood. Discourses and institutional practices work to subdue the sexuality of adolescents and contain it in ways that make adolescent sexuality co-exist with discourses of appropriate development of the educated and income producing worker. The sexuality of adolescents is appropriate, but only if non-procreative. A number of reproductive technologies are implicated in this. With the use of contraceptives and abortion, adolescent sexuality can be produced as developmentally appropriate, without disturbing the life course progression in which adolescence is a step towards development that is inconsistent with motherhood. Contraceptive technologies increase individual control over fertility, but may reduce reproductive freedom (Paul, 2002). Freely available contraception and abortion are used to coerce women to control their fertility under the guise of what is best for them, but what is best for them is also what makes them most useful to the state.

However, these institutional practices and discourses that attempt to script adolescent behaviour are not always successful, as people are active in negotiating their identity within the available discursive resources. Those that it generally fails to subdue are those for whom these norms of education and employment are least relevant. When the rewards of docility are seen as unavailable, the negotiation of an alternative subjectivity

is viewed as more enticing. Institutional practices that produce an educated income producing worker are just as likely to produce unemployed welfare dependent adolescent mothers. At each turning point where the discursive alternatives to take up the approved position exist, there is also an opportunity to resist these and take up an alternative subjectivity that provides different rewards and disciplines from the mainstream. Those adolescents who rebel from the appropriate use of such technologies of the self are disciplined and set out as outside the bounds of normal adolescent development. Foucault contributes to an understanding of contextualised experience and an analysis of the role of ideological power in understanding subjectivity.

Foucault's (1979, 1981) description of the medicalisation and objectivisation of 'marginal groups' in the seventeenth century are relevant to the construction of adolescents who mother as both medically and sexually beyond the bounds of the appropriately disciplined body. Foucault argued that human beings came to be interpreted as knowing subjects and at the same time as objects of their own knowledge (Foucault, 1981). With the development of epidemiology, statistical techniques for aggregating social data, and the application of science to the social world, bodies could be transformed into objects. Foucault's description of the extent to which bodies are 'inscribed in discursive practice' provides a framework to understand how prevention of adolescent motherhood as legitimated in public health campaigns problematises the female body. The adolescent female body requires careful management through reproductive technology and by medical and public health institutions through the medical gaze (Foucault, 1973).

Power

A social constructionist position also promotes an investigation of the power relationships that are supported by the current constructions of adolescent mothers by health professionals. "Power relations are rooted in the whole network of the social" (Foucault, 1982, p.224). Social constructionism provides a way of challenging dominant social constructions and calling into question their consequent social practices. Foucault argues that there is more to power than merely how things are constructed: "power is not reducible to the discursive because it also takes the form of

social relations or institutionalised practices in which discourses are lodged." (Burkitt, 1999, p.70). Foucault describes three distinct types of power. Sovereign power refers to the complete physical authority of the sovereign over those who are subject to this authority. Disciplinary power refers to the internalized form of surveillance whose goal it is to produce a docile person (Dreyfus & Rabinow, 1982). Pastoral power employs the goal of individual salvation. Leaders provide guidance to encourage followers' obedience and renunciation of the self as a way to achieve moral correctness (Foucault, 1982). Although Foucault describes the workings of power as developing through history, aspects of these mechanisms of power can be identified.

The power relationships between adolescent mothers and health professionals are supported by a range of social structures such as the primacy of medical or professional knowledge above cultural or lay knowledge, the economic division of individuals and the determining of status by economic means, and the understanding of age as a relevant marker of development and maturity. These systematic power relationships are produced both by individuals in interaction and wider social structures in interaction with individuals and groups. These power relationships are not merely to be found in wider social structures, but are reproduced in everyday social interactions. Burkitt (1999) states, "the norms we use in everyday life are connected to power relations and the hegemony of social groups." (p.73). The ways that we have of constructing the world provide advantages for some and disadvantages for others (Banister, Burman, Parker, Taylor, & Tindall, 1994). These are not arbitrary distinctions, and material and social power is implicated in these categorisations and their relative positions.

The way people understand the world, how they behave, and their values and aspirations are fashioned out of the structures of power. It is tempting to think that the regimes of power work to oppress only the powerless, however, power does not just act upon the dominated but on the dominant as well (Foucault, 1997). The effect of institutional contexts, ideas and discourse impact on everyone (Danaher et al., 2000). Although we are all constrained and enabled by these institutional practices, they provide more advantages for the dominant and more disadvantages for the subordinate. As a result, it is work to resist the effects of these institutional practices. Power is not held by individuals or groups, but is rather a set of relations between groups and areas of society. In addition, power is not viewed as a negative force enacted to repress or

control people; it is also highly productive. Power produces what we are and what we can do, how we see ourselves and the world (Foucault, 1997). Power also determines what practices are seen as normal and what are seen as not normal. Power can be viewed as the impact of the discursive on the individual and the unequal distribution of resources.

Adolescent motherhood does not just exist, it is produced by policies and laws that determine who may reproduce and who is normal and moral. These policies are based on the knowledge produced by disciplines and institutions. The disciplines and institutions of medicine, psychology and sociology produce what it is to be a normal healthy mother and this is used to regulate and normalise individuals.

Crotty (1998) argues that

> There are useful interpretations, to be sure, and these stand over against interpretations that appear to serve no useful purpose. There are liberating forms of interpretation too; they contrast sharply with interpretations that prove oppressive. There are even interpretations that may be judged fulfilling and rewarding – in contradistinction to interpretations that impoverish human existence and stunt human growth. 'Useful', 'liberating', 'fulfilling', 'rewarding' interpretations, yes. 'True' or 'valid' interpretations, no (p.47-8).

This appears unsustainable however. If there are no criteria to judge what is true or valid, then how can there be any criteria to judge those apparently more 'subjective' criteria of useful, rewarding or liberating. Surely these are constructed and situated within a particular framework that at any time can be called into question. In addition, what is constructed as useful or liberating reflects the values and framework of who is determining what liberates or oppresses others. Liberation and oppression are not inherent in these practices, but come about from determining the implications of these practices for particular groups and individuals. This may reflect a desire to redistribute power, but reflects power nonetheless.

Using a social constructionist epistemological foundation for research on adolescent motherhood acknowledges that the practice of research is socially mediated. Secondly,

it does not focus on adolescent mothers as an individual or social problem, but is concerned with the discursive resources that are used to construct them as a problem. Finally, it acknowledges the constructive nature of health care, and the interaction between the material and discursive world (Yardley, 1999). If discourses are social products with material origins and implications, then it is important to investigate the discursive resources available to construct adolescent motherhood.

Discourse Analysis

Discourse analysis is based on the assumptions of social constructionism and "approaches language as both reflecting and perpetuating power structures and dominant ideologies in society" (Lupton, 1992, p.147). Discourse analysis involves identifying 'discourses' that language is organised around. A discourse is a set of meanings, images and statements that are used to construct an object, or a class of persons in a particular way (Burr, 1995). 'Discourse' refers to the language associated with particular institutions. The language used within institutions reflects the ideas and values of the institution. Within the context of psychological research, discourses construct the objects and subjects that they claim to explain (Willig, 2001). These constructions do not merely *describe* phenomena, they enable some ways of being in and seeing the world and constrain other ways. Consequently, discourses make possible different subject positions (Korobov, 2001); these include related rights and obligations for the subject, and a location for a person within this set of rights. A useful example of positioning within discourse is illustrated by the use of a medical discourse. Within a medical discourse, constructing an experience as a disease provides a number of subject positions, one of which is that of a patient. Being constructed as a patient positions the individual as a passive recipient of expert medical care (Willig, 2001). This construction and positioning constrains the person constructed as a patient from active management of their care and health. This construction can be contrasted to that of health care as an economic encounter with the 'patient' constructed as a health care consumer. Within this economic metaphor, the dominant position is that of the consumer, and the needs and desires of the consumer determine the quality of the interaction. The phrase 'the customer is always right' underscores the power of the consumer to determine the way in which their needs will be met. The comparison

between a patient and a consumer of health services illustrates how talk can be seen to have material effects on health and health care.

Two main approaches to discourse analysis as it is currently practiced in psychology can be identified; one identified with Potter and Wetherell (1987) and the other with Parker (1990a). Wetherell and Edley (1999) describe these two types of discourse analysis as the fine-grained form of discursive psychology influenced by conversation analysis and ethnomethodology and the more global form of analysis derived from poststructuralism. The fine grained form of discourse analysis is often characterised as attending to the functional nature of language such as blaming, justifying, or promoting a positive presentation of the speaker. This form confines its interest in power to the role of language in the discursive production of power and inequality (Burkitt, 1999). The global version of discourse analysis "sees discourse as embedded in relations of power that form systems of constraint which regulate social actions" (Burkitt, 1999, p.69). Parker's (1990a) approach to analysis concentrates on social change and how current power relations are reproduced through discourse. This approach to discourse analysis acknowledges the role of the discursive in constructing inequality, but further suggests that power can not be reduced to the discursive, as it also functions through the social relations and institutionalised practices in which the discourses are embedded. Based on the writings of Foucault, Parker's discourse analysis attends to issues of power and knowledge and how they are created and maintained through language. Discursive resources make available subject positions that provide differing access to material resources and understandings of the self.

Parker's (1990a) approach to discourse analysis has been used as this research focuses on how health professionals construct adolescent motherhood and how these constructions serve to reinforce existing power relations and institutional practices. The focus in this research is on how these power relations can be analysed and deconstructed to achieve social change. Parker (1990a, 2002) defines a discourse as "a system of statements which construct an object" (1990a, p.191). This definition, he argues, is supported by a set of seven criteria for identifying discourses. These criteria will be used to investigate the discourses present in the analysis of health professional literature and in the transcripts of interviews with health professionals.

(1) A discourse is a coherent system of meanings

The first of Parker's criteria is that a discourse should be identified as a coherent system of meanings. These meanings can be identified through the use of metaphors, analogies and descriptions of an object that together bring a certain sort of reality into being. Parker (1990a) states that "The statements in a discourse can be grouped, and given a certain coherence, insofar as they refer to the same topic" (p.192). In terms of this criterion, the statements grouped together as a discourse are coherent in as much as they are a similar set of metaphors and analogies that seem to relate to each other and draw institutional and discursive support from each other. This coherence does not reside in the text, however. To achieve this coherence, the researcher must bring their own understanding of the topic to the text. The analysis of discourse is not possible without importing knowledge from outside of the analysis. This outside knowledge is not private and individual, but reflects culturally available ways of constructing the object. Parker (1992) argues that these coherent systems of statements map a particular picture of the world. He also argues that it is important to consider how a text employing this discourse would manage objections to this terminology.

Discourse analysis involves organising statements that construct adolescent motherhood in a coherent and meaningful way. This also involves identifying the inconsistent ways that the object, adolescent motherhood, was constructed, and identifying these as alternative discourses that may be utilised separately or in combination with each other. MacLeod (2001) provides an example of a discourse of motherhood as a skill. An alternative way of speaking of motherhood is that of motherhood as a natural ability. These are examples of separate 'discourses' of motherhood and have implications for the construction of adolescent motherhood. They provide different resources for constructing the 'good' mother and provide different possibilities for constructing adolescent mothers.

(2) A discourse is realized in texts

Parker describes discourses as found at work in texts. These texts can be seen as "delimited tissues of meaning reproduced in any form that can be given an interpretive gloss" (Parker, 1990a, p.193). Parker provides a broad definition of a text, and includes speech, writing, advertisements, architecture and fashion. These all reflect the practices

and possibilities that are made available by particular discursive constructions. The second step in this approach to discourse analysis is to explore the "connotations, allusion, [and] implications which the texts evoke" (Parker, 1990a, p.193). Doing so requires moving beyond a consideration of the individual intentions of the author, to how the discourse is formulated. Parker also states that there is no need to attend to an author behind the text, as the discourse can be seen not as derived from individual intentions, but as socially available ways of constructing the object.

This research was concerned with the construction of adolescent motherhood by the health profession, both in professional journal articles and by health professionals in interviews. These were utilised as texts and through these texts discourses of adolescent motherhood were identified. However, adolescent motherhood is constructed and produced in many other ways, including policies which prevent unmarried mothers under 18 years of age collecting welfare independently of their parents and by encouraging pregnant adolescents to leave school or attend separate schools for pregnant and parenting adolescents. These are also texts, and construct adolescent motherhood in particular ways. These texts construct adolescent mothers as financially unreliable and a risk to other adolescents. Texts can be seen as including more than the discursive, and the discursive has implications for wider practices.

(3) A discourse reflects on its own way of speaking

The third criterion is that a discourse can be identified by the way in which it reflects upon itself. Within a discourse, there is evidence of how the discourse deals with apparent contradictions. These apparent contradictions are indicated in a number of ways where the terms chosen to describe the object are reflected upon. Parker (1990a) argues that these aspects of the discourse enable the analyst to reflect on the terminology being used within the discourse, to focus on the discourse itself as an object, and to encourage reflections on the terms used to describe the discourse.

Brooks-Gunn and Furstenberg (1986) in their review of the physical, academic, and psychological outcomes of adolescent motherhood provide an example of this. This review considers the individual psychological impacts of early childbearing and the authors acknowledge that parenthood has been influenced by changes in social

structural variables. However, these social structural variables are transformed into individual choices as adolescent mothers are

> More likely to be unmarried, to have children out of wedlock, and to head a single parent household than are older childbearers (...) thus their children are more likely to be living in poverty than are children born to older mothers (Brooks-Gunn & Furstenberg, 1986, p.233).

Living in poverty is viewed as the result of individual decisions made by the adolescent mothers. The apparent contradiction between a focus on individual influence on outcomes and an acknowledgment of social structural issues is dealt with by constructing social structural issues as a set of faulty individual decisions by the adolescent.

(4) A discourse refers to other discourses

The next related point identifies how a discourse refers to other discourses. The contradictions within the discourse introduce questions about what other discourses are also being constructed. Parker (1990a) states "Discourses embed, entail and presuppose other discourses to the extent that the contradictions *within* a discourse open up questions about what other discourses are at work." (p.195). This criterion focuses on identifying the apparent contradictions between the different ways of describing the object under study. These contradictions are necessary to understand the interrelationship between different discourses in an analysis.

Danaher et al. (2000) provide an example of the co-articulation of two discourses, a biological discourse referring to the fitness or unfitness of individuals, and an economic discourse which states that such people are unfit because they represent a cost to others:

> American capitalists explained that they were destined to, and deserving of, power and wealth because they were, in Darwinian terms, 'the fittest', while the poor were biologically unfit to compete with them (p.10).

Although discourses are often separated and reified, they can be co-articulated in complementary ways to present a coherent construction of the object which draws upon

discursive resources from many discourses. How discourses refer to other discourses are often made more obvious when the discourses do not work together in a complementary way. These examples show how apparently contradictory discursive resources can be drawn upon to construct a single object.

(5) A discourse is about objects

Parker's fifth criterion is that discourse is about objects, and discourse analysis is about discourses as objects. This refers to the two levels of reality that are considered with discourse analysis. The first level of reality is that which the discourse refers to, the second is the reality of the set of statements about the object. Parker (1992) argues that this leads us to ask what objects are referred to in the text and then to talk about the text as if it were an object, that is, a discourse. This objectification of discourse is plausible because discourses have material effects on the lives of people.

The first level of reality is the identification of what is referred to in the text. In this research, adolescent motherhood is the object that is described in the text. Adolescent motherhood is an object that is constructed by health professionals. This is the central object within these analyses, however, this object does not exist in isolation. Many other objects are constructed that influence this analysis.

(6) A discourse contains subjects

The sixth criterion is that a discourse has subjects, and within a discourse it is not possible to avoid the perceptions of ourselves that the discourse invites. "A discourse makes available a space, and it addresses us in a particular way" (Parker, 2002, p.152). This refers to the positioning of subjects within the discourse and their rights to speak within that discourse. Parker (1992) separates this out into two steps, firstly to determine what types of person are talked about in each discourse and what rights to speak and ways of speaking are available in the discourse.

For example, a discourse that constructs adolescent motherhood as a disease provides a subject position for the adolescent mother as a patient, the recipient of expert medical attention. There are also subject positions within this discourse for health professionals, as the experts capable of providing this medical attention. The subject positions

provided by these discourses constrain and enable what adolescent mothers and others positioned within this discourse, can do and say. The discourses used to construct adolescent motherhood are not singular and fixed, however. They are constructed by many discourses and consequently the subjectivity provided by the positions available within these discourses is fluid and plural.

(7) A discourse is historically located

The final criterion is the acknowledgement that discourses are historically located. Discourses are not static and unchanging; they incorporate past references to the object. This enables the discourse analyst to consider what the present allusions to the discourse refer to and how they emerged. Rose (1999) suggests we question the present, what we know and who we are by confronting the present with history.

The importance of historical development is particularly the case at the intersection of two discourses (e.g. motherhood and adolescence) which both have a history that has emerged through changing economic and cultural circumstances (MacLeod, 2003). Adolescent pregnancy as a conceptual term has a short history connected to the larger history of social sanctions towards childbearing outside of marriage (Carabine, 2001). Initially, constructions of unwed mothers were solely as immoral subjects (1830s) but over time these ideas shifted towards mental deficiency or psychological lack, and latterly to health concerns, although also re-attached now to a concern for social stability (Carabine, 2001; Lawlor & Shaw, 2002a). It was only in around the 1970s the concept of the unwed mother came to be replaced by that of adolescent pregnancy (Arney & Bergen, 1984; Carabine, 2001; Wong, 1997). These altering definitions reflected ongoing cultural shifts in political, material, and educational systems, and social and family structures (Lawlor & Shaw, 2002a). The shift from a representation as a moral problem to being a psychological or health problem has strongly legitimised pregnancy as an issue for science (Gordon, 1997; Wong, 1997). A detailed analysis of the historical construction of adolescent motherhood has not been covered here, however, a history of the ways that adolescent motherhood has been viewed can be found elsewhere (see Gordon, 1997; Luker, 1996).

Parker (1990a) supplements this list of criteria with three auxiliary criteria of discourses. These criteria explicate how discourses work, rather than their identification. These criteria refer to the ability of discourses to support institutions, reproduce power relations, and have ideological effects. An understanding of these criteria is important for the interpretation of discourses once they have been identified.

(1) Discourses support institutions

A number of discourses can be used to construct any given object. These include discourses supporting the status quo, discourses offering possibilities of resistance and discourses co-opting resistance into an adapted status quo (Foucault, 1972; Parker 1992). Truth claims are dependent on institutional and discursive practices. These practices determine the rules by which truth can be judged.

This research on the construction of adolescent motherhood involves the institutions of medicine, science, and the family. A medical discourse supports the wider institutions of medicine and science, which are reproduced in specific sites such as hospitals and medical colleges. A medical discourse also determines what qualifies as medical knowledge and what is excluded from this validation of medical truth, such as homoeopathic remedies and faith healing. Medical institutions determine the boundaries of what is genuine medicine. These institutions are the arbiters of what is considered physical illness and the appropriate treatment of these illnesses. The medical discourse also produces texts that support these classifications (Danaher et al., 2000). Institutions are supported or challenged by particular discursive construction of adolescent motherhood.

(2) Discourses reproduce power relations

Power relations are reproduced though the use of particular discourses and are challenged by the use of other discourses. Certain people benefit from these power relations and others are subjugated. These discourses are not necessarily utilised deliberately to subjugate, but reflect and reproduce the power relations at work in wider social structures that serve some interests rather than others.

(3) Discourses have ideological effects

Discursive explanations create effects in other areas and maintain certain forms of knowledge over other possible ways of knowing. Ideological effects come in the form of supporting certain regimes of truth that establish certain moral and political truths simultaneously. For example discursive constructions of adolescent motherhood relate to politics as they provide useful scapegoats for explaining rising poverty and welfare acceptance.

Within each research project, Parker's approach to undertaking a discourse analysis can be flexibly managed. Some of the criteria are discussed outside of the analysis section. For example the attention to the social scientific development of adolescent motherhood is considered in the introductory sections.

Reflexivity

Reflexivity refers to accounting for the researcher's contribution in the construction of meaning. The structure of the research, the interviews conducted and the analysis are all inherently related to the researcher. As such, they represent one possible way of orienting to the research and to the data collected. In addition, the interviews are bound up with identity and power. The data are generated within both the dynamics of the interview and the wider discourses that frame such conversations (Cooper & Burnett, 2006). Interview participants attend to the social context of the interview, and also to the imagined audience of the encounter (Bevan & Bevan, 1999). The research presented here should be considered in the context of this situated relationship, rather than viewed as the definitive construction of adolescent motherhood in the health professional literature and by health professionals.

Discourse Analytic Data

Foucault understands discourse as specifically writing in an area of technical knowledge. These technical fields of knowledge have profoundly shaped the structure of society and as such deserve particular attention (Fillingham, 1993). This focus on technical discourse invites an analysis of the formal language that informs the health professional and the professional journal. The authors of professional literature represent authoritative social voices, in strong positions of warrant that participate in

shaping dominant social attitudes towards adolescent pregnancy. Consequently, this research takes literature such as medical and nursing journals as the starting point for investigating how health professionals construct adolescent motherhood. These sources have high status and a strong warrant of veracity. Therefore, it is likely that the constructions of adolescent mothers they present are taken to be truth and reflected in the discourses used by health professionals in their practice.

Although social constructionist approaches to language suggest that the situation and participants within the social interaction determine language use, there are two factors that suggest that the language used in professional journals will provide important understandings regarding how adolescent mothers are constructed by health professionals. Firstly, the constructions of adolescent motherhood contained within the professional literature include assumptions regarding the nature of the category of 'adolescent mother' which underlie both the research itself and conclusions that health professionals make about adolescent mothers based on this literature. There is reciprocity between the research that is conducted on adolescent mothers and the conclusions that are drawn about adolescent mothers based on this research. Secondly, we draw upon a limited number of available discourses when making sense of the world. It is likely that health professionals in contact with adolescent mothers will be drawing upon many of the same discourses both in professional journals and in their interactions with adolescent mothers.

The second stage of this research involves interviewing health professionals to explore the discourses of adolescent motherhood they draw upon. Burr (1995) states "a piece of text may be thought of as a manifestation of prevailing discourses, and we should not be tempted to look inside the heads of particular individuals for their origins" (p.171). Consequently, we should not be tempted to think that the discourses present in both literature and talk about adolescent motherhood reflect the attitudes of individual health professionals. They reflect how it is possible to talk about adolescent motherhood within the prevailing culture of health. Different discourses are likely to be identified in the interviews from those identified in the health professional literature as health professionals have other socially available resources to construct adolescent mothers.

This research on the construction of adolescent mothers seeks to examine the constructions of adolescent mothers produced by health professionals. What is intended is a re-evaluation of the category of 'adolescent mother'. Given that this category is validated by the research that is conducted on the health of adolescent mothers and their children, it is important to consider this category in its own right.

Conclusion

Social constructionism provides a framework for re-evaluating existing research on the health of adolescent mothers and their children. It also promotes a critical approach and using this approach suggests that research on their health need not be confined to directly researching adolescent mothers. Acknowledging the relationship between health professionals and adolescent mothers and researching this relationship is the first step in understanding the importance of the social world in mediating the health care of adolescent mothers and their children. The analysis of discourse acknowledges that the mothering by adolescents does not occur in a separate world from how it is discussed in professional journals and by health professionals.

Consequently, the questions addressed in the present research are:

Study 1: What discursive resources are available in the literature for health professionals?

Study 2: What discourses do health professionals use to talk about adolescent mothers?

These studies are used to understand how the discourses used by health professionals in interviews are related to the discursive resources available in the professional literature. The effect of these discourses on the construction of adolescent mothers by health professionals is also considered.

CHAPTER V.

STUDY 1: HEALTH PROFESSIONAL LITERATURE

This study analysed articles about adolescent pregnancy and motherhood contained within primary health care journals. This analysis was undertaken to identify the discursive resources available to construct adolescent motherhood in the literature for health professionals.

Method

The articles for analysis were selected by making a thorough search of the literature available to primary health care practitioners in New Zealand from 1997 to June 2002. The journals in this search included the New Zealand Medical Journal, New Zealand Family Physician, New Ethicals Journal, New Zealand Doctor, New Zealand GP, Midwifery News, and Kai Tiaki Nursing New Zealand. These journals were chosen because they have wide circulation among primary health professionals in New Zealand. They are sent directly to health professionals who are members of the respective professional associations. For example, the New Zealand Medical Journal is made available to all 4,500 members of the New Zealand Medical Association, the New Zealand Family Physician is sent to all members of the Royal New Zealand College of General Practitioners (over 3000), Kai Tiaki Nursing New Zealand is sent to the 24,000 members of the New Zealand Nurses Organisation. The Journal/New Zealand College of Midwives is sent to the 2000 members of the New Zealand College of Midwives. The selection is a sample of the material available to a range of health professionals and has wide circulation within this group.

The journals were searched for articles directly related to adolescent motherhood and adolescent pregnancy. The literature search terms included 'adolescent', 'teenage', 'teen', 'young', 'juvenile', 'children', combined with any of the following: 'mother', 'mothering', 'mum', 'childbearing', 'parent', 'parenthood', 'parenting', 'obstetrics', 'primipara', 'multipara', 'pregnancy', 'birth'. In addition to these database searches, the

contents page of the New Zealand Medical Journal, New Zealand Family Physician, Nursing Praxis in New Zealand, and Kai Tiaki Nursing New Zealand were checked for articles related to adolescent pregnancy and parenting within this time period. The time frame of five years was chosen to restrict the search to recent articles. Understandings surrounding adolescent motherhood and family structures have undergone considerable change in recent years (Combs-Orme, 1990) and this time frame is to ensure that the discourses identified still have currency among health professionals, as discourses rise in and fall from favour over time.

This search produced material on adolescent motherhood and adolescent pregnancy. Both of these are relevant as much of the construction of adolescent mothers is achieved within what is said about pregnant adolescents. The construction of pregnant adolescents is predominantly based on the assumption that the adolescent will prove to be an unfit mother, rather than pregnancy as detrimental to the adolescent. Consequently, what is said about pregnant adolescents cannot be separated from the discussion of adolescent mothers, and both are considered in this analysis.

The analysis was based on four full-length articles, a news release, and two summaries of one of the full-length articles included in the analysis (see Appendix A for the articles included in the analysis). One article analysed here received very wide circulation. Woodward, Horwood, and Fergusson's (2001) article appeared in the New Zealand Medical Journal, the abstract of this article also appeared in Midwifery News, and short summaries of the article appeared in New Zealand GP and New Zealand Doctor.

Analysis

After selection, the articles were scanned into a computer, subject to optical character recognition and the resulting text files corrected. These text files were then assigned to Atlas.ti 4.1 software and coded as the first stage of analysis. Each sentence was read and assigned at least one code. Many were assigned a number of codes. Each code reflected both the topic of the text and the 'way of speaking' about the topic. For example, the health statistics describing the poor health of adolescent mothers were assigned the code of 'Health'. The 'Health' code also included the way of speaking

about the transmission of adolescent motherhood as 'contagious' through references to adolescents' exposure to single motherhood. The latter codes were then refined from 'Health' to the code of 'Public Health' to reflect the underlying discourse of adolescent motherhood as a public health problem with its focus on disease rates and contagion. The new 'Public Health' code was then re-checked to ensure that all the text previously coded as 'Health' could be understood as belonging to the 'Public Health' discourse. The texts were read and re-read to map key themes that emerged, with areas of commonality identified. As further readings took place these codes were refined through either further unpacking or expansion of ideas or by collapsing categories. As this coding was written up, discourses were identified and these discourses formed the framework around which this critique can be read. The codes were developed, refined, checked and re-checked to produce the basis of the discourse analysis. As such, they represent one possible way of orienting to these selected texts.

Following the identification of the discursive resources, and their organisation into discourses, the subject positions available within these discourses were examined. The positions available for adolescent mothers to take up within each discourse were considered, and the possibilities and limitations for action provided by these subject positions. For example, a 'Public Health' discourse provides a position for adolescent mothers as diseased. As such they require monitoring by experts to ensure that adolescent motherhood does not spread. A 'Public Health' discourse also has positions for doctors and academic researchers as experts qualified to know about and monitor adolescent motherhood and adolescent mothers.

A brief overview of the development of aspects of each discourse is presented. The discourses identified are not static or unchanging, they are socially and historically located. Past uses of these discourses are incorporated into the current ways of constructing adolescent motherhood. This overview draws attention to what present allusions to the discourse refer to and how they emerged. This historical development provides a context for understanding current constructions of adolescent motherhood in the professional literature.

Finally, how the discourses worked together was also examined. Some discourses are complementary and are deployed together to create a natural understanding of the world

that reflects dominant sense making. For example the 'Naturalist', 'Public Health' and 'Economic' discourses are used together in complementary ways to suggest that the fit and unfit can be identified both by biological and economic means and should be separated to ensure that the unfit do not infect the fit. Other discourses do not fit together in complementary ways. These introduce tension as the reader is invited to reconcile the contradictory picture produced by two dissonant discourses or by available positions within a discourse. This tension is evident when the position of the adolescent mother as damaged child is brought together with the position of the young mother as the neglectful parent. It is unclear whether the reader is being invited to sympathise with the young mother for her poor upbringing or chastise her for her poor parenting. These inconsistencies highlight the incompatibility of the 'adolescent' and 'mother' positions. If one is an adolescent, then one is subject to the cycle of deprivation and cannot be held responsible. However, being positioned as a parent within this discourse, positions them as perpetrators of the cycle who should be held accountable for the damage they visit upon their children. Neither of these positions sees the cycle itself as the villain, but those within the cycle. Within this discursive resource, it is incompatible to be at once an adolescent and a parent.

Using discourse analysis in this way, articles about adolescent pregnancy and adolescent motherhood were analysed to identify the discursive resources, discourses, and subject positions made available to construct adolescent mothers. These constructions from the health professional literature were examined in terms of how they make adolescent mothers visible and knowable in certain ways.

CHAPTER VI.

WHO ARE THESE YOUNG MOTHERS?

The academic literature for health professionals drew upon a number of discourses to construct adolescent motherhood. This analysis begins with how the adolescent mother is described by the literature and consequently made visible as an object. This includes the focus on adolescent mothers' age at pregnancy, a preoccupation with this age in comparison to the average age of first birth, and the variety of terms used to describe adolescent pregnancy and motherhood. This shows how the object 'adolescent mother' is defined by the health professional literature.

Pregnant adolescents and adolescent mothers are the topic of consideration in these articles written for health professionals, and are the objects of scientific study. The literature uses a number of devices to construct adolescent pregnancy and adolescent mothers as an object deserving of professional interest and intervention. Firstly, adolescent mothers are described as being a particular age, and this age is associated with a certain level or lack of maturity. This perceived lack of maturity for motherhood is used to justify scientific interest in adolescent parenting. Secondly, the age at first birth is compared to a standard: that of the average, and therefore appropriate, mother. And finally, adolescent pregnancy and motherhood is considered synonymous with other terms that negatively evaluate adolescent parenthood. Using these devices, adolescent pregnancy and motherhood become an object of discussion and study and are objectified by the gaze of science.

Age

Within the health professional literature, age at first birth was used to quantitatively justify what counts as adolescent motherhood. The age of adolescent motherhood is not an unambiguous category; different researchers construct it differently, often without further explanation of why particular ages are included and excluded. Age as a boundary can be seen as a discursive practice that includes and excludes according to a

set of shared understandings of development and maturation. At times these understandings are made explicit, at other times the ages themselves are used to express these qualitative differences in individual development. Age is not drawn upon as a neutral description, but as a reflection of what it means to be a particular age as explained in the following extract:

> Adolescent pregnancy was defined as a pregnancy before the age of 19 years, based on an item in the postal questionnaire "How old were you when you first became pregnant?" Under 19 rather than under 20 was selected as the research team considered that the issues for women aged 19 are more those of young adulthood than adolescence (Romans et al., 1997, p.31).

This age of inclusion and exclusion marks the boundaries of what counts as adolescent motherhood in a numerical sense. The justification for this is that of women having reached a level of "young adulthood" at 19 that is different from the 18-year-old "adolescence". This suggests that increases in chronological age determine the acquisition of maturity and that there are predictable patterns of development, in which women progress towards adulthood at the same rate. This maturation is viewed as separate from the maturing effects of major life events such as pregnancy. Establishing age boundaries around appropriate motherhood obscures the continuity of development across the age span; instead, differences between individuals are attributed purely to numerical differences in age.

By comparison, Dickson et al. (2000) use the following age calculation to indicate the boundaries of adolescent and adult:

> Teenage birth rates were calculated as the number of live births to all women under the age of 20 years at the time, per 1000 women aged fifteen to nineteen (Dickson et al., 2000, p.241).

In this instance no justification is given for the upper age limit. This draws upon a shared understanding of adolescence spanning the ages of 13-20, and of pregnancies beyond this age as no longer causing concern. Woodward, Horwood, et al.'s (2001) study of adolescent pregnancy and parenting also provides no rationale for the inclusion

of specific ages of adolescent pregnancy. However, their study includes women pregnant at age 21, so defining women who may be 22 years old at the birth of their first child as adolescent mothers. This increasing age of adolescent pregnancy is not discussed in their study. MacLeod (2003) also notes that extended schooling has been used to justify increasing the age of adolescent pregnancy to 21 years. This makes sense in response to higher levels of education required for employment and the increasing average age at first birth in the population.

Average Age

Adolescent mothers' chronological age is also compared to the average age of childbearing for women, to highlight the gulf that separates the adolescent from the adult mother. This construction rests on the assumption that what is average is appropriate, for no other reason than most woman are behaving this way. The notion of an average establishes what is normal and evaluates behaviours based on this standard. Use of this standard qualifies and disqualifies people as proper members of the social order (Danaher et al., 2000). Adolescent mothers are positioned as members of a deviant minority group who do not follow the rest of the population of childbearing women, as shown below:

> By comparison, national birth trend data over the past five years indicates that the mean age at first child birth for the average New Zealand woman was 28-29 years. Clearly, there is a marked disparity in pregnancy timing for these young women compared to the rest of the population. (Woodward, Horwood, et al., 2001, p.302).

The "marked disparity in pregnancy timing" sets the young women in contrast to the rest of the population of childbearing women. Adolescent mothers are positioned as the 'other' when placed against the 'norm' of women who give birth in their twenties. However, adolescent mothers are not having children any earlier; it is the norm that is changing. In the past adolescent mothers were only a few years younger than other mothers. As affluent women are now waiting longer to have children, adolescent mothers seem much younger (Luker, 1996). As the age standard against which adolescent mothers are judged changes, they are increasingly problematised. This

comparison constructs the increasing age at first birth as reasonable. This sets childbearing in the late twenties as normal and adolescent childbearing as abnormal, and therefore inappropriate. In addition, an average is determined by including younger mothers as well as much older mothers. The norm against which adolescent mothers are assessed as deviating from is a composite of every childbearing woman, but is here set as an ideal.

This focus on adolescent mothers as a problem compared to average women differs from many of the arguments typically drawn upon to construct adolescent motherhood as inappropriate. It is usually argued that adolescent mothers have not reached minimum levels of maturity for motherhood, and have not completed the psychological tasks of adolescence. In contrast, this widening age of adolescent motherhood included in Woodward, Horwood, et al.'s (2001) study reflects understandings of life course development involving post secondary education, employment, and career development which may not mesh with the lives of all women, particularly those who are already more likely to become parents early. The concern about age at first birth compared to the average age of childbearing constructs an understanding of all women's lives as fundamentally involving the same life chances and choices.

The demarcation of adult and adolescent pregnancy defines them as completely separate life events. This is illustrated by a quote from the professional literature, which reports that:

> Where teenagers themselves were asked about what might constitute an effective pregnancy prevention campaign, the 'need to combat positive attitudes towards pregnancy' was the most frequently endorsed item (Condon & Corkindale, 2002, p.47).

The need to combat positive attitudes to pregnancy makes sense only in the context of adolescence. If this approach were taken to combat pregnancy rates among adults, the notion would be nonsensical. This separation of adult and adolescent is also evident when Bleach (1995) describes pregnancy in general as "an essential, and usually wonderful, aspect of human nature" (p.6). In contrast, this author describes adolescent pregnancy as providing "a unique set of problems for the adolescents involved, their

parents, and society in general" (p.6). The difference between these descriptions highlights the mutually exclusive nature of adolescent pregnancy and adult pregnancy. Adolescent pregnancy is tied to problems for the adolescent, family and society whereas adult pregnancy is understood as "wonderful". Age pervades any discussion of adolescent pregnancy and parenting, and what it means to be an adolescent is entirely separate from what it means to be an adult.

This separation of adult and adolescent pregnancy, and the representation of pregnancy among adolescents as a health issue, has been attached to the view that adolescent mothers will experience poor obstetric outcomes (Trivedi, 2000). This relies on a discursive process of denaturalisation of pregnancy for younger women. What is naturalised is the trend of women choosing to have children at increasingly older ages. The arguments that adolescents are biologically not ready to be pregnant (Trivedi, 2000) or that they will have better health outcomes if they wait a few years (New Zealand Health Network, 2002) works rhetorically to support this position. Trivedi's Waikato study found no differences in obstetric health outcomes at different maternal ages- either for the mother or for the child. Yet the majority of textual talk about pregnancy identifies younger pregnancies as undesirable and consistently highlights as implicitly more appropriate, the shifting of social norms to older childbearing (Singh & Darroch, 2000; Woodward, Horwood et al., 2001). These understandings of adolescent pregnancy appear to blur issues of medical and human developmental concerns over early childbearing. This understanding of insufficient physical development for motherhood has been transferred into discursive formations around maturity, educational, and employment prospects. Despite the predominantly social issues rather than biological concerns implicated in poor outcomes, at present the goal is still to reduce adolescent pregnancies (Bleach, 1995; Nash, 2002).

The use of particular ages to describe pregnant and parenting adolescents focuses attention on a very quantitative notion of what counts as early parenthood. It also brings with it a set of assumptions about age maturation and appropriate life course development. Age is not merely a number, it brings with it a set of assumptions of what counts as appropriate behaviour and maturation throughout the life span. These ages have a psychological meaning that is made apparent in the professional literature. The notion of an average age draws upon understandings of normal life course development

that may change over time, but that represents what should happen because it is what does happen to most women most of the time. What is normal becomes a prescription for appropriate behaviour.

Terminology

A variety of terms are used to describe adolescent pregnancy and parenthood in the professional literature. Adolescent pregnancy is variously described as unplanned, unsupported, unwanted, and unintended. Adolescent parents are also described as single supporting and high risk. There is important work being accomplished with the use of these terms interchangeably. These terms are not equal, and each achieves a different result.

Adolescent pregnancy is often referred to as unwanted pregnancy and attention is drawn towards adolescent pregnancy as a need to reduce rates of "unwanted pregnancies among young women" (Dickson et al., 2000, p.244). In the following extract the conflation of adolescent pregnancy and unwanted pregnancies also occurs as information on adolescent pregnancy rates are then used to inform ways to reduce unwanted pregnancies:

> The marked international variation in teenage pregnancy rates among developed countries suggests that examination of differences in sexually education, availability of contraception and attitudes to sex, parenthood and sole parenthood might provide useful indicators of ways to reduce unwanted pregnancies in New Zealand (Dickson et al., 2000, p.244).

However, no distinction is made between the measurement of unwanted adolescent pregnancies and wanted adolescent pregnancies. The following extract suggests that unwanted pregnancies should be reduced and government surveillance should be undertaken to monitor the rate of unwanted pregnancy among young women:

> Although Government initiatives to reduce the number of abortions and unwanted pregnancies among young women have been undertaken, targets have not been set

> for overall pregnancy rates, nor is this under epidemiological surveillance by the Ministry of Health (Dickson et al., 2000, p.244).

This extract describes an initiative to reduce abortion and unwanted pregnancy, however, adolescent pregnancy is not the same as unwanted pregnancy. The conflation of adolescent pregnancy and unwanted pregnancy is achieved by describing pregnancy as unwanted but supporting this by statistics and surveillance on adolescent pregnancy. The blurring of the boundaries between age and pregnancy 'wantedness' is further achieved with governmental concern only with "unwanted pregnancies among young women"; unwanted pregnancies among older mothers are not made visible. Conflating unwanted pregnancy and adolescent pregnancy implies that the Government is only interested in reducing unwanted pregnancies among young women. Although, as the Government is unable to measure pregnancy 'wantedness', it has an implied proxy measure of unwanted pregnancy through adolescent pregnancy rates, despite acknowledgment in the literature that many adolescent pregnancies are not unwanted. A focus on reducing rates of unwanted pregnancy can be understood as drawing upon the notion that every child deserves to be wanted. Therefore, associating adolescent pregnancy and parenthood with unwanted children is a strong justification for preventing adolescent parenthood.

Adolescent pregnancy is also often referred to as unplanned pregnancy, as shown here:

> Unplanned and unsupported adolescent pregnancy creates a major health risk to parents and children (Condon & Corkindale, 2002, p.45).

This lack of pregnancy planning is also related to severe emotional disturbance among young women:

> The discovery of an unplanned pregnancy is a traumatic shock, often accompanied by anger and disbelief. The young person is confused, anxious and wanting to act (Condon & Corkindale, 2002, p.47).

This serves to conflate adolescent pregnancy, unplanned pregnancy, and unsupported pregnancy, and draw attention to the shock and psychological trauma associated with a

lack of planning of pregnancy. Focusing attention on unplanned pregnancy works similarly to the conflation of adolescent pregnancy and unwanted pregnancy. It is deployed to suggest that all adolescent pregnancies are unplanned and that this lack of planning is detrimental to the health of the adolescent and her child. In addition, a focus on unplanned pregnancy does not suggest any bias towards specific age group, ethnic group, or socioeconomic group. It has been suggested that the focus on reducing adolescent pregnancy reflects a bias against the poor and minority ethnic group members (Luker, 1991). Referring to 'unplanned pregnancy' serves to deflect these potential accusations, while still disproportionately impacting on these groups. Most adolescent women who become pregnant are also poor, they are often members of disadvantaged minority groups, are disproportionately likely to live on welfare, and are less likely to 'plan' their pregnancies. The focus on encouraging pregnancy planning then is also a focus on encouraging a particular type of woman to become pregnant. In addition, the description of adolescent pregnancy as unplanned pregnancy does not alter the argument against adolescent pregnancy, as the collection of population statistics and surveillance will still focus on overall pregnancy rates among adolescents, rather than assessing the level of pregnancy planning. This attention to unplanned and unwanted pregnancies reflects a move away from concern with illegitimacy and unwed mothers (Luker, 1996; Wong, 1997). This shift can be understood as a move towards the rational economic actor who plans and intends actions. Focusing on pregnancy planning deflects attention from the overt morality associated with illegitimacy.

The promotion of pregnancy planning and the reduction of unplanned pregnancy are the explicit goals of the Family Planning Association, an important organisation in fertility regulation that particularly targets their services to young people. There is a strong promotion of a planned pregnancy as a positive outcome and an unplanned pregnancy as an unfavourable result. Literature on adolescent pregnancy and adolescent motherhood often attempts to determine whether early pregnancy is the result of planning, is accidental, or is the result of ambivalence on the part of the adolescent (Condon, Donovan, & Corkindale, 2001; Smith, Weinman, & Nenney, 1984; Stevens-Simon, Kelly, Singer, & Cox, 1996). The preoccupation with determining whether adolescent pregnancies are planned is linked to particular understandings of subjectivity and reflects an understanding of behaviour as having stable and singular causes. Understanding the 'cause' of early pregnancy does not necessarily make any difference

to the adolescent, the pregnancy, or the child, but is here deployed as a method of attributing blame to adolescents for either planning, or alternatively failing to plan their pregnancies.

Adolescent pregnancy is also often described as unintentional; however, the association between adolescent pregnancy and unintentional pregnancy is a flexible one. Adolescents' pregnancies are viewed as accidental on one hand and the result of systematically idealised and unrealistic beliefs about pregnancy on the other. In the following extract adolescents are viewed as inclined towards romanticised and unrealistic views of pregnancy which impact on the efficacy of pregnancy prevention programmes:

> We would suggest that prevention programmes have failed to grapple with these idealised, unrealistic beliefs, and this, in part, accounts for their low levels of efficacy. There has been little emphasis on developing adolescents' understanding of the impact an unintended pregnancy might have on their lives (Condon & Corkindale, 2002, p.47).

However, if adolescent pregnancy is unintentional, and a traumatic shock to those adolescents who become pregnant, then addressing idealised beliefs will have no impact on pregnancy prevention as young women have no intent to become pregnant. Consequently, the understandings of adolescent pregnancy and parenthood as the result of unrealistic beliefs of romantic adolescents or as traumatic unintentional accidents can be seen as deployed by the literature to construct adolescent parents in negative ways. It is negative to be viewed as idealistic and romantic and become pregnant based upon these views. It is also negative to unintentionally become pregnant. These two possibilities are drawn upon to construct adolescent parents as variously consciously immature or unconsciously random in their behaviour, but not as reasonable decision makers. Consequently there are two possible positions available to adolescent mothers in this discussion of pregnancy planning, and neither provides a positive presentation of the adolescent mother.

Unplanned pregnancy is also often related to a lack of support for pregnancy. It is not always clear what form of support is lacking, although unsupported pregnancy among

adolescents is often linked to a lack of financial support. In the following extract support for adolescent parents is constructed as financial with the link to welfare payments:

> More teenage mothers are supported by welfare than older mothers (Romans et al., 1997, p.31).

The vague notion of support is tied to more concrete assistance. Support becomes a synonym for money and a lack of support, a synonym for poverty and welfare. This conflation of adolescent pregnancy with welfare and single parenting is also shown in the following extract where the cost of adolescent pregnancy is described as that of single supporting parents. This combines the notion of single parents with parents who are supported by welfare:

> The cost of adolescent pregnancy to the economy is huge. Support for single supporting parents has been estimated to cost at least $100 million a year in Australia. In the USA, it has been estimated that the cost of supporting pregnant and parenting teenagers with medical care, welfare benefits and other social services is four times that of providing an extensive network of sexual health/counselling for adolescents (Condon & Corkindale, 2002, p.50).

Here the statistics describing the cost of single supporting parents ($100 million a year) are embedded within the argument for the cost of adolescent pregnancy and parenting. These terms are used as if they were synonymous; suggesting both that all adolescent parents are "single supporting" and additionally that all "single supporting" parents are (or even were) adolescent parents. The conflation achieves important work. If adolescent pregnancy can be seen as synonymous with welfare acceptance, then it appears to justify the intervention of the state in the lives of young women. The use of an economic discourse here powerfully suggests that those who pay for the medical care, welfare benefits and social services that support adolescent parents have rights regarding how their money is spent, and consequently determining the lives of the recipients. The connection of adolescent pregnancy to economic dependence justifies providing sexual health and counselling services to reduce rates of adolescent pregnancy. The economic argument for restricting adolescent pregnancy and parenting

is applied to all adolescent parents, as they are constructed as all single supporting parents. This conflation also makes financially independent adolescent mothers invisible.

The use of a range of terminology to describe adolescent pregnancy and parenting draws upon a number of other discursive resources to objectify adolescent parents. The interest in unsupported adolescent parents focuses on the level of financial support and dependence on welfare. Adolescents' pregnancies are variously described as unintentional or the result of systematically idealised beliefs about pregnancy and parenting. This lack of planning for parenthood is assumed to produce children who are unwanted by their young parents. What appears to be a range of terms to label adolescent pregnancy and parenthood achieves important constructive work. It constructs adolescent mothers as producing children that are assumed to be unplanned, unwanted and a lifelong financial burden to the adolescent and the state. By describing adolescent pregnancy in these ways, the professional literature objectifies adolescent parents as requiring scientific surveillance and intervention.

CHAPTER VII.

THE SCIENCE OF ADOLESCENT MOTHERHOOD

Adolescent motherhood has been the subject of health and social scientific investigation for decades. This focus has made adolescent motherhood visible as a certain class of object. The recent history of investigation and discourse regarding adolescent motherhood has drawn upon science to frame this issue, and at this point in history, science has the strongest claim to delineate what there is to know about adolescent motherhood. Previous understandings of illegitimacy and unwed motherhood as immoral and irreligious acts perpetrated by the poor and ignorant on their children have been replaced with psychological and medical understandings of adolescent motherhood as a sign of individual failure and deviance (Luker, 1996). Science functions as "a master discourse, a form of knowledge that is privileged over common sense" (Parker, 1999, p.34). Science is also currently privileged over religious and moral arguments that are viewed as biased compared to the apparent objectivity of scientific scrutiny. Science has described the adolescent mother in particular ways that have a widely accepted claim to truth.

In the health professional literature, four main discourses of science have been drawn upon to construct adolescent motherhood as requiring the intervention of science and management of health practitioners. These discourses include a 'Naturalist' discourse, which engages metaphors of parenting as a biological matter and reduces human behaviour to basic natural functions. This draws strongly on eugenic arguments to construct adolescent mothers as poor breeding stock. A 'Public Health' discourse has also been identified, which draws upon illness metaphors to construct adolescent motherhood as a disease requiring a public health response. An 'Economic' discourse draws upon the language of finance to construct adolescent motherhood as a financial drain on society and early motherhood as a cost to the mothers themselves. Finally, an 'Ethnicity' discourse constructs people as able to be categorised into types, and these types are important in determining aspects of their lives such as behaviour and health outcomes. Membership of certain 'Ethnicities' are also used to assess the extent to which individuals reflect or resist dominant social structures through the adoption of

health care behaviours. These discourses are drawn upon separately and in combination to define the adolescent mother and justify scientific intervention. They are often drawn upon compatibly, as they share institutional support from wider understandings of the individual provided by scientific discursive resources.

Each of these discourses has a subject position for the adolescent mother. The language, metaphors, and understandings of each discourse illustrate the world that is made possible within the discourse, and shows the adolescent mother that is enabled within the bounds of the discursive construction. As Parker (2002) states, "accounts of experiments are texts which we discourse analysts read as screens that hold representations of what a world might be like, and what people and things inside them might be like if the account were true" (p.8). Each discourse positions adolescent mothers in a way that represents the way of being in the world that is created and enabled by the discourse. These different science discourses constitute the 'adolescent mother' differently but provide consistent subject positions, as they reflect the working of wider structures of scientific power and knowledge.

'Naturalist'[1] Discourse

The literature for health professionals makes use of a 'Naturalist' discourse to construct adolescent motherhood. This discourse draws upon images and metaphors that construct reproduction and parenting as a biological matter and human behaviour as able to be reduced to basic natural laws and functions. The use of the 'Naturalist' discourse in this literature is evidenced in the use of phrases such as "rear their offspring" to describe adolescent mothers' parenting, in the focus on the 'natural selection' of individual and group traits, and the preoccupation with physical explanations for adolescent pregnancy.

Throughout the health professional literature, the children of adolescent mothers were described as "offspring" and the parenting by adolescent mothers was referred to as "rearing" these offspring. These two terms were often used together, or in combination with other terms such as "rearing their children" (Woodward, Horwood, et al., 2001, p.301) and "number of offspring parented" (Woodward, Horwood, et al., p.302). The use of these terms is shown in the following extracts:

> This last group consisted of 74 young women who had become parents by age 21 years plus nine who were pregnant for the first time at age 21 years and who reported that they intended to rear their offspring (Woodward, Horwood, et al., p.302).

> Teenage pregnancy is one of the most significant adolescent health issues in New Zealand and Australia. It has a potentially long-term deleterious impact both on the adolescent and, if the pregnancy is continued, on the offspring (Condon & Corkindale, 2002, p.45).

Condon and Corkindale (2002) also described the consequences of adolescent motherhood as "Consequences to the offspring" (p.47). The notion of "offspring" and the need to "rear" these offspring are ways of speaking that derive from the evolutionary and biological sciences and are generally applied to the activities of animals in breeding and caring for their young. Describing the children of adolescent mothers as

[1] Naturalism: "action based on natural instincts." Naturalism "is characterised by a refusal to idealize experience and by the conviction that human life is strictly subject to natural laws". (The Oxford English Reference Dictionary, 1996, p.965).

"offspring" rather than children is not accidental. The use of this term focuses on their biological relationship to their parents and the use of "reared" to describe their parenting focuses attention on the physical aspects of this functional relationship. The repeated use of the phrase "offspring" to describe the children of adolescent mothers positions them like animals within the natural world. This positioning enables the authors to focus attention on adolescent mothers' relative reproductive success.

The families of adolescent mothers are constructed in the same biological way, as shown in the following extract:

> They [young women who became pregnant] also tended to have been reared in families characterised by young and single motherhood, socioeconomic disadvantage and parental change (Woodward, Horwood, et al., 2001, p.302).

Using these terms from the biological sciences focuses attention on the family as a site of biological reproduction, rather than a moral or social structure. This construction of the family is used to emphasise the poor reproductive status of the families of adolescent mothers, as evidenced by their poor economic and social position and by the (re)production of adolescent mothers. Resources from the 'Naturalist' discourse are utilised to suggest that this poor quality breeding is then extended to the next generation. Not only are adolescent mothers the products of poor quality families, they in turn produce poor quality offspring, as shown here:

> We must start breaking the cycle of teenagers giving birth to children who go on to become teen parents themselves. It's well known that these at-risk families have higher rates of poor health, social disadvantage, educational underachievement and behavioural problems (Teen Pregnancy, 2001, p.2).

This constructs the family as the site of physical reproduction and responsible for the transmission of disadvantage.

The 'Naturalist' discourse provides resources for the physical construction of adolescent motherhood by describing adolescent parenting in terms of nutrients.

> The teenage mother competes with her unborn child for basic nutrients (Romans et al., 1997, p.31).

The use of "nutrients" refers to an essential component for the maintenance of life and this competition for essential nutrients means that either the young mother or the baby will suffer. This assumes an adolescent mother who is physically immature and whose growth and development is not complete, even though very early motherhood is rare. In addition, the reproductive notion of adolescence as a physically inappropriate time for childbearing is applied to parenting generally:

> This concept can be extended to emotional nutrients also (Romans et al., 1997, p.31).

This construction of physical immaturity is then extended to emotional immaturity. Emotional aspects of care are ascribed with the biological attributes of "nutrients". This constructs adolescent motherhood as related to essential and concrete deficits, such as the lack of appropriate nourishment, rather than more abstract concepts such as care and nurturance. This use of an unusual combination of ideas "emotional nutrients" constructs adolescent mothers' parenting as deficient in an essential biological manner.

The writers also drew upon a 'Naturalist' discourse when using physical explanations of sexuality and childbearing to account for early childbearing as in:

> Early sexual maturation and early onset sexual intercourse were also associated with an increased risk of early pregnancy (Woodward, Horwood, et al., 2001, p.302).

This attention to physical maturity constructs adolescents mothers as sexually precocious, and is particularly contrasted with the deficits of educational and social achievement that are associated with adolescent motherhood:

> Compared to their non-pregnant peers, young women who became pregnant were significantly more conduct disordered, had poorer scholastic ability, were more likely to have left school without formal educational qualifications, and tended to

> have sexually matured and initiated sexual intercourse at a younger age (Woodward, Horwood, et al., 2001, p.302).

This contrast between the low educational and behavioural achievements of adolescent mothers and their early physical development is drawn upon to characterise adolescent mothers as having physical development in excess of their intellectual capacity.

Using a 'Naturalist' discourse draws attention to the traits of adolescent mothers and their children that may impact on their social and reproductive outcomes. The children of adolescent mothers are constructed as a poor type who suffer multiple disadvantages. These disadvantages include physical, cognitive, financial, psychological and emotional difficulties and shown in this extract:

> Furthermore, their offspring are more likely to display a range of adverse reproductive outcomes including lower birth weight, poor developmental outcomes and behavioural disorders (Romans et al., 1997, p.31).

Romans et al. (1997) use the 'Naturalist' discourse to describe adolescent mothers' children as poor physical and developmental specimens who are described as having poor developmental and behavioural outcomes. This constructs adolescent mothers as unfit for motherhood, and reproductive and generative criteria are used to determine this. Thus, the association of adolescent motherhood with disadvantage often reads as a catalogue of misfortune, as shown in the following extract:

> Specifically, early parenthood has far reaching physical, social and emotional consequences including an increased risk of antenatal complications and mortality, failure to complete schooling, socio-economic disadvantage, welfare dependence, marital difficulties, maternal depression and less competent parenting.
>
> In addition, children born to teenage mothers have higher rates of health problems, physical injury, behavioural difficulties, cognitive problems, and educational underachievement than children born to the older mothers (Woodward, Horwood, et al., 2001, p.301).

These indicators of disadvantage are drawn upon to categorise individuals into types and this comparison is used to justify the need to curb the reproduction of adolescent

mothers. The criteria used to separate the fit from the unfit within a 'Naturalist' discourse are not always physical criteria, as in the extract above where "marital difficulties" and "maternal depression" are listed alongside "physical injury" and "health problems". However, the 'Naturalist' discourse provides the resources to separate and categorise individuals according to a wide variety of criteria and to view the less capable as transmitting disadvantage through reproduction.

Throughout the literature for health professionals there is a tension between early motherhood as problematic because women are becoming pregnant too young and early motherhood as problematic because of the *type* of women who become pregnant at a young age. This is the point at which the 'Naturalist' discourse draws upon eugenic understandings of the right and wrong type of women to become mothers. In the following extract, the age of the mother is used as a marker for other disadvantages that will impact on her ability to be an adequate parent:

> In particular, there is growing evidence that women who become pregnant during their teenage years are characterised by multiple social and psychological disadvantages, which may in turn, impair their ability to cope with the challenges of early motherhood (Woodward, Horwood, et al., 2001, p.301).

It is not early motherhood that is problematic, but the type of women who become mothers early, as they are already multiply disadvantaged. The extract implies that early motherhood is an additional challenge and as such is only achievable by those not psychologically and socially disadvantaged. The tension between age and poverty as the defining characteristic of the inappropriate mother is further shown in the following extract:

> It has generally been accepted that teenage women are more likely to produce low birthweight and pre-term babies. However, using a very large Scottish population cohort, and taking into account a number of confounding factors, including smoking and social deprivation, the age of these young women was shown not to confer any increased risk of adverse perinatal outcomes on their first delivery. Few obstetric complications occurred for first births, but a second teenage birth carried far greater risks of extreme prematurity and stillbirth. Pregnant teenagers are also more likely to smoke than are older pregnant women, they live in more deprived

> social circumstances, and have less antenatal care. Thus for many pregnant adolescents the risks of low birthweight pre-term delivery and stillbirth are a reality (Condon & Corkindale, 2002, p.47).

Here, the link between age and poor outcomes is confounded by the link between poverty and poor health outcomes. Rather than suggesting that the relationship between maternal age and poor outcomes is therefore spurious, attention is drawn back to young mothers as inappropriate, no longer because they are young, but because they are poor. Their deprived social circumstances and lack of antenatal care are drawn upon to re-justify the link between adolescent motherhood and poor outcomes. It is not clear how these women will fair better with later motherhood, but the implication remains that early motherhood selects those who are least capable of parenting.

The 'Naturalist' discourse and the concomitant focus on offspring and poor outcomes, brings with it an understanding of the long term misfortune of continuing to breed from less than optimal stock. Using the resources of the 'Naturalist' discourse brings with it an understanding of people as contributing to the improvement or degeneration of the human race. This is used here to construct adolescent motherhood as contributing to a faulty breeding programme and is introduced with the notion of "second-generation" adolescent mothers. A 'generation' refers to each step on a pedigree or family tree. These are often drawn up to represent the transmission of particular traits. In this context, the phrase "second generation" is used to describe adolescent mothers whose mothers were also adolescent mothers.

> The second-generation pregnant teenager often suffers negative psychosocial and educational outcomes and frequently faces abuse, gets involved in high-risk activities, and is more likely to associate with deviant peers (Condon & Corkindale, 2002, p.47)

This focuses discussion on the ongoing poor reproduction in "second-generation" adolescent mothers and constructs the notion of a breeding programme, in the same way, as it is possible to refer to breeding for particular traits in animals. This understanding of negative traits being transmitted over the generations is also evident in the construction of intergenerational cycles of adolescent motherhood:

> Of particular concern is the identification of intergenerational cycles of early pregnancy and motherhood (Teen Pregnancy, 2001, p.2).

This draws attention to the transmission of deviance over a number of generations.

The 'Naturalist' discourse is also evident in references to the selective nature of adolescent motherhood. Natural selection refers to a biological process in which nature selects the best adapted varieties to survive and to reproduce, and suggests the most genetically adaptive will have higher rates of reproductive success. Within this literature, the use of a natural selection trope is based on the notion that:

> Adolescent pregnancy does not occur randomly in the community but was found in women who came from families with preexisting psychosocial problems (Romans et al., 1997, p.30).

Rather than random, adolescent pregnancy is viewed as occurring in a particular social grouping, as shown in the following extract:

> There was also evidence of further selection amongst those who became pregnant. Those from socially disadvantaged family backgrounds characterised by parental instability and early exposure to young, single motherhood were more likely to become parents at an early age (Woodward, Horwood, et al., 2001, p.302).

Adolescent pregnancy is viewed as selecting those young women with the lowest educational and behavioural achievements.

> Specifically, young women characterised by early adolescent conduct problems, poor school achievement, Māori ethnicity, and family adversity were at greater risk of an early pregnancy. In addition, as shown previously, early sexual maturation and early onset sexual intercourse were also associated with an increased risk of early pregnancy. Hence teenage pregnancy appears to be a highly selective process, whereby an individual's personal adjustment, educational opportunities, cultural identification, and family experiences contribute to their risk of an early pregnancy (Woodward, Horwood, et al., 2001, p.302).

Here, a metaphor of natural selection is drawn upon, although the theoretical principle is reversed. The physical ability to reproduce early is associated with evidence of the lack of fitness for reproduction. Early motherhood is evidence of fitness to reproduce physically, but the type that is reproducing should be selected against for a range of social scientific reasons including poor individual functioning, material deprivation, cigarette smoking, and infant morbidity rates. The discursive resources of natural selection are drawn upon, but the notion of reproduction as the criterion for success is challenged. Adolescent motherhood is viewed as a selective process that identifies not the most able but the least desirable.

The 'Naturalist' discourse provides a number of resources that are drawn upon in the health professional literature. These resources used to construct adolescent mothers are based in the natural world; they rear their offspring and these offspring can be judged as a predicably poor type. This poor type can also be seen as persisting into subsequent generations. In addition, adolescent mothers are unable to adequately nourish their offspring as they have insufficient nutrients available. This physical construction of adolescent mothers also focuses attention on sexual maturation as an explanation for adolescent motherhood. Consequently, the mother of the 'Naturalist' discourse is a biological and genetic mother; she rears her offspring – providing them with physical care and nutrients. In addition, she provides her offspring with a certain class of genetic material and this genetic material is passed down through to subsequent generations. The quality of this genetic material determines the comparative worth of the offspring and by extension, the mother herself. Within this discourse, the mother is merely seen as the vehicle for producing the right (or wrong) kind of child (Kedgely, 1996).

The 'Naturalist' discourse also provides a position for the adolescent mother as an animal within this scientific construction of the natural world. Within the health professional literature the 'Naturalist' discourse is drawn upon to position adolescent mothers as poor parents[2]. The adolescent mother of the 'Naturalist' discourse is a poor biological parent, she provides her offspring with genetic material of inferior quality and this inferior offspring in time beget second generation offspring of poor quality.

[2] This is not a necessary positioning of the 'Naturalist' discourse, as these discursive resources could be drawn upon to position adolescent mothers positively, by highlighting the young mothers' reproductive ability and the advantage of becoming a mother while young. Resources from a 'Naturalist' discourse were drawn upon in the second stage of analysis within a 'Developmental' discourse to draw attention to the easy childbirth and good physical health of adolescent women.

This judgement of their offspring is then used to suggest that adolescent mothers are not fit to reproduce. Understandings from a 'Naturalist' discourse are used to construct adolescent motherhood as like a genetic trait transmitted through parent to child. Motherhood within the constraints of the 'Naturalist' discourse is animalistic and adolescent mothers fail to meet the standard of good breeding stock.

Naturalism and Eugenics

Within the health professional literature a 'Naturalist' discourse has been outlined that constructs adolescent mothers in a biological manner. The metaphors and ways of speaking identified here can be understood by investigating the development of these ideas in a wider discursive environment. This provides a context for the use of a 'Naturalist' discourse within this specific collection of health professional literature, as this discourse has a long history of association with medical science.

The thesis of evolution proposed that species change to adapt to their surroundings. These ways of speaking that arose to account for evolution at a population level were subsequently co-opted to account for differences between individuals (Iredale, 2000). It was suggested that only the most superior individuals should reproduce to ensure the improvement of the gene pool and consequently the human race. Although evolution would ensure the survival of only the fittest, this mechanism of continual improvement has been thwarted by human compassion. Whereas, in the animal world the weak and the infirm were left to die, human compassion for suffering ensured that the weak and inferior survived and reproduced. Not only did they survive, but also, as eugenicists began to observe, the poor and inferior specimens tended to produce large numbers of offspring while the healthy and superior limited their family size. This increase in numbers of inferior stock would over time weaken the human race and cause it to decline into imbecility. The metaphors and understanding of natural selection were used to determine fitness and lack of fitness to reproduce.

As eugenicists aimed to limit what was seen as the increasing number of unfit types that were reproducing, it became important to determine who was 'fit' and 'unfit' (Luker, 1996). Within the eugenics movement, individuals were either superior or inferior to others based their genetic makeup. The genetic inheritance was then used to explain social ills such as poverty, criminality, prostitution, and illegitimacy. 'Eugenics' refers

to the improvement of the human race by biological means. It is generally viewed as the coercion of people's reproductive choices for social ends to improve the quality of the population and reduce financial costs to the state. This is based on the understanding that some individuals are fit and should be encouraged to reproduce to improve the genetic composition of the population, and others are labelled as inferior and their reproduction should be curbed. Those classified as unfit or undesirable include racial and ethnic minorities, the poor, mentally unstable, and sexually promiscuous (Birn & Molina, 2005; Luker, 1996). Within this collection of health professional literature, criteria for determining fitness to reproduce similarly includes poor health outcomes, poor educational outcomes, and behavioural problems. These characteristics are used to classify adolescent mothers as inferior to older mothers who also tend to be healthier, more educationally successful, and less conduct disordered. The current use of a 'Naturalist' discourse blurs the boundaries of age with the classification of fitness.

The most significant era of eugenic sterilization in the United States was between 1907 and 1963 when over 60,000 individuals were forcibly sterilized under eugenic legislation (Stern, 2005). Luker (1996) states that often poverty was used as a justification for lack of fitness to parent, and sexual license was often the charge used to justify the sterilization of women. Stern (2005) reports that having borne a child out of wedlock justified involuntary sterilisation for a notable number of women in California, while Luker (1996) reports that three quarters of women were sterilised for sexual delinquency. Consequently, there is a tradition of "illegitimacy, poverty and women's sexual 'delinquency' as both a product and cause of feeblemindedness and as natural indicators of the need for sterilisation" (Luker, 1996, p.35). These ideas can be traced in the 'Naturalist' discourse as it is used to construct adolescent motherhood in the literature for health professionals. The early sexual maturation of young women and their early introduction to sexual behaviour are highlighted as part of a litany of the negative traits of adolescent mothers and as indicators of their unsuitability for motherhood.

Historically, the eugenics movement considered a wide variety of traits to be inherited, ranging from hair and eye colour to intelligence, industriousness, and shiftlessness. The laws of Mendelian genetics were believed to govern the inheritance of all these traits.

For example, shiftlessness was believed to contribute to pauperism, and eugenicists reported that the offspring of two shiftless parents would produce virtually all shiftless children (Witkowski, n.d.). The inheritance of these traits was proposed to occur through as yet unknown aspects contained within the germ cells and passed on to children. This understanding of inherited deviance was used to construct family pedigrees of supposedly defective lineages. The transmission of poverty, illegitimacy and prostitution was mapped in several famously degenerate family groups and used to justify involuntary sterilisation laws (Stern, 2005). This understanding of families as responsible for transmitting disadvantage and antisocial tendency can also be traced in the literature for health professionals. Adolescent motherhood is related to family disadvantage and this is viewed as persisting through the generations. Although eugenics initially proposed a specific (though unknown) mechanism of transmission, more importantly eugenics provided a way of talking about social problems in biological terms (Dikoetter, 1998).

Stern (2005) also notes that changes in sterilisation laws reflected a shift to emphasise parenting skills and welfare dependence as a justification for involuntary sterilisation, rather than hereditary lack of fitness. This changed the nature of the individual's social and biological drain on the society from the impact of hereditary defect to the problems of poor parenting and long-term welfare dependence. This is also reflected in the literature on adolescent motherhood as young parents are viewed as poor prospects as parents and as long term welfare recipients. These aspects are used to justify pregnancy prevention campaigns in much the same way as the transmission of genetic inferiority has been in the past. In this way, the 'Naturalist' discourse provides the discursive resources to compare the capable and incapable of parenting, the desirable and undesirable for motherhood, without relying on the validity of genetic explanations for disadvantage. Instead economic, educational, and psychological criteria can be drawn upon to determine suitability for parenthood using the 'Naturalist' resources to explain social problems in biological terms.

This understanding of social disparities between people as attributable to differences in biology has its roots in the Victorian era. Social status was believed to be innate and people of differing biological ability found their own economic level (Jones, 1996). The poor and politically powerless were thought to be failures in the competition for

survival and helping them was seen as a waste of time and counter to nature. 'Natural selection' was used to defend the unequal distribution of wealth and power between individuals, and also to justify European domination and colonisation of much of the rest of the world. Jones' (1996) argues that the concern with those people who are viewed as "programmed to fail" (p.173) has returned, as illustrated by the popularity of the bestseller *The Bell Curve* by Herrnstein and Murray (1994), which similarly argues that status is ruled by biology. The 'Naturalist' discourse provides the resources to understand adolescent mothers' poor scholastic ability, conduct disorder, and welfare acceptance as indicators of their poor prospects as biological parents. 'Poor scholastic ability' and 'conduct disorder' can be seen as the new terms to replace the feeblemindedness and delinquency of the previous century. These arguments for the natural order of social status continue to prove attractive as they explain the unequal distribution of material excess and want as ultimately a natural phenomenon that can not and should not be tampered with by social systems such as welfare provision. Consequently, those located at the top of the social strata can enjoy their position of relative prosperity safe in the knowledge that this reflects the natural order of things, rather than exploitation.

The current tendency is to view eugenics as an historical phenomenon (Iredale, 2000), however, aspects of the eugenics movement pervade current thinking. This analysis of health professional literature shows how aspects of eugenic thought appear in articles on adolescent motherhood. In earlier times, the transmission of traits was not solely seen as that of genetics, as it was believed that an individual's life experiences could be passed on to their children. For example, Rose (1999) reports that areas of immoral conduct such as drunkenness and debauchery were viewed as detrimental to individual health, but were also viewed as passed down from parents to children in the form of a susceptible constitution. This is echoed in the current framing of families as transmitting poverty and poor motherhood to their children through an unwholesome environment that is far more than what is currently believed to be genetic. Although the current understanding of the transmission of these traits has changed the proposed solution has not. It is no longer suggested that a simple gene for poverty, school failure, or deviance exist. These traits are conceived of as a complex mix of nature and nurture. However, the solution to this reproduction of disadvantage remains the same. Although biological inheritance may only contribute a small part to the transmission of poor

quality, it remains that these traits continue to be viewed as transmitted through families and as such, these poor families should be discouraged from reproduction. Within this literature the justification of prevention of pregnancy is made through the link to early motherhood rather than motherhood among the poor. However, the justification for reducing adolescent motherhood is made primarily through the link with poverty and familial disadvantage.

Conclusion

A 'Naturalist' discourse is drawn upon in the health professional literature to draw attention to adolescent motherhood as transmitting genetic and biological disadvantage. The resources from a 'Naturalist' discourse make available a position for the adolescent mother as providing poor genetic material and inferior physical care for her child and as consequently a poor prospect as a parent. In more general terms, a 'Naturalist' discourse is used to separate out the 'fit' from the 'unfit' to categorise people as more or less desirable for reproduction, and this understanding can be used flexibly to assess individuals and families on a variety of traits.

'Public Health'[3] Discourse

The literature for health professionals drew upon a 'Public Health' discourse that used words and phrases such as prevalence, risk factors, morbidity, and mortality to construct adolescent motherhood as a disease requiring a public health response. Furthermore, adolescent motherhood was constructed as a contagious disease that required surveillance to ensure that it was contained. This construction of adolescent motherhood encourages surveillance in the lives of adolescent mothers and scientific intervention to prevent the spread of adolescent motherhood.

The metaphors and phrases that constructed adolescent motherhood as a contagious disease are drawn from medical discourses that are similarly engaged in relation to physical illness. Words such as prevalence, risk, morbidity, mortality, and prematurity were used to describe the state of adolescent motherhood. Firstly, adolescent motherhood was described as having certain "prevalence" in the population, as shown in the following extract:

> Aims. To describe the lifetime prevalence of teenage pregnancy and parenthood (Woodward, Horwood, et al., 2001, p.301).

Using "prevalence" to describe adolescent pregnancy and parenthood contextualises it as a disease that occurs at a particular rate in the population. This understanding of disease rates and prevalence is also used to construct unprotected sexual intercourse:

> Perceived positive consequences of childbearing and prevalence of unprotected sexual intercourse (Condon & Corkindale, 2002, p.46).

This understanding prevalence is extended into sexual behaviour that precedes early motherhood.

The disease metaphor is further extended to an understanding of the aetiology of adolescent pregnancy, as shown in the following extract:

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[3] A 'Public Health' discourse is quite separate from the medicalisation of pregnancy. Within the 'Public Health' discourse, it is pregnancy and parenthood of *young* women that is pathologised, not pregnancy generally which is medicalised.

> Adolescent pregnancy is recognised as a major health and social problem in most developed nations and information about its aetiology may result in effective preventive strategies (Romans et al., 1997, p.31).

The focus on aetiology, the causation of disease, further constructs adolescent motherhood as a disease that has certain specific causative factors. This framing of adolescent motherhood is also accomplished with the description of "incidence" and "rates" of adolescent motherhood.

> The striking differences between countries in the incidence of adolescent pregnancy is a stark testimony to the power of these social influences (Condon & Corkindale, 2002, p.45)

The rates of adolescent pregnancy and the need to reduce these rates were also highlighted in the health professional literature.

> These trends have been the focus of public health concern, with discussions centring around free access to contraceptives and improved sex education as means of reducing rates of teenage pregnancy (Woodward, Horwood, et al., 2001, p.301).

> Finally, rates of early pregnancy were elevated amongst those who identified themselves as Māori (Woodward, Horwood, et al., p.302).

The combination of prevalence, incidence, rates, and aetiology from a 'Public Health' discourse construct adolescent motherhood as a disease. These understandings of illness incidence, prevalence, and aetiology, suggest that the disease of adolescent motherhood must be understood, treated and ultimately prevented. Adolescent motherhood is positioned unproblematically as a disease that requires a coordinated prevention campaign.

There is also a focus within the 'Public Health' discourse on the level of risk associated with adolescent motherhood.

> Specifically, early parenthood has far reaching physical, social and emotional consequences including an increased risk of antenatal complications and mortality, failure to complete schooling, socio-economic disadvantage, welfare dependence,

> marital difficulties, maternal depression and less competent parenting (Woodward, Horwood, et al., 2001, p.301).

The same framing that is used to construct risk of medical complications and mortality is extended to educational, psychological and social risk, as this same framing is used to construct marital difficulties and welfare dependence. This draws together a disparate collection of symptoms that are part of the risks associated with early motherhood. This attention to risk serves to construct adolescent motherhood as related to a range of negative consequences and to frame both social and physical consequences of adolescent motherhood as attached to risk.

Understanding adolescent motherhood as indicative of a disease process is also extended to other areas of adolescent mothers' lives as in the following extract:

> Pregnant and parenting adolescents are at a high risk of psychological, social and physical morbidity (Condon & Corkindale, 2002, p.47).

In addition,

> Early pregnancy is usually followed by truncated educational achievement, lessened future employment opportunities and associated financial insecurity, a cluster of related problems which one set of authors has described as "accumulating psychosocial morbidity". More teenage mothers are supported by welfare than older mothers. Sexually transmitted diseases, including HIV, cervical dysplasia and repeat pregnancies at a young age are also all too often part of the picture (Romans et al., 1997, p.31).

Social, educational and financial aspects are described as "morbidity", that is of the nature of a disease or indicative of disease. These extracts construct wider aspects of the lives of adolescent mothers, including psychological and social aspects, as indicative of a disease process. This is also achieved by imbedding social and financial characteristics of young mothers within a list of physical aliments. Financial insecurity, welfare acceptance, and repeat pregnancy are associated with sexually transmitted disease, HIV and cervical dysplasia they are combined as "part of the picture" constructing these aspects as part of the disease of adolescent motherhood. The 'Public

Health' discourse provides the resources to suggest that early childbearing is pathological, and this pathology extends to all areas of adolescent mothers' lives.

Further, the 'Public Health' discourse suggests that adolescent motherhood is a contagious disease that can be perpetuated by exposure to other adolescent mothers. For example:

> Those from socially disadvantaged family backgrounds characterised by parental instability and early exposure to young, single motherhood were more likely to become parents at an early age (Woodward, Horwood, et al., 2001, p.302).

The exposure to young single mothers is given as the source of early childbearing, in much the same way that exposure to the measles virus might cause someone to contract the measles.

> Specifically, there were significant tendencies for women exposed to maternal role models of young and single motherhood, parental change, and socioeconomic disadvantage during their childhood to be more predisposed to early motherhood (Woodward, Horwood, et al., 2001, p.302).

Exposure to young and single motherhood becomes a source of contagion that predisposes young women to early parenthood. The disease of adolescent motherhood can be seen as transmitted through exposure to this contagion.

The use of a 'Public Health' discourse promotes surveillance and control, as shown in the following extract:

> It [this report] also highlights the current limitations of epidemiological surveillance of teenage pregnancy rates and ways it can be improved (Dickson et al., 2000, p.241).

This role of monitoring within a 'Public Health' discourse is shown through two aspects. One involves the monitoring of adolescent pregnancy *rates* to ensure that this is controlled. The second involves monitoring the *lives* of adolescent mothers by

identifying, monitoring, and targeting high-risk families and individuals. The surveillance of adolescent pregnancy rates is illustrated by the following extract:

> Although Government initiatives to reduce the number of abortions and unwanted pregnancies among young women have been undertaken, targets have not been set for overall pregnancy rates, nor is this under epidemiological surveillance by the Ministry of Health (Dickson et al., 2000, p.244).

The use of a 'Public Health' discourse to construct adolescent motherhood requires the collection of statistics of rates of adolescent pregnancy and the epidemiological surveillance of these rates. Within this discourse adolescent motherhood rates are monitored to assess the success of prevention of disease. This also focuses on the need for external governmental control in the lives of these young women.

The second aspect of monitoring involves monitoring the *lives* of adolescent mothers by identifying, and targeting high-risk families and individuals. The following extract indicates how governmental surveillance is proposed to manage at risk individuals and families.

> The NZMA supports Government moves to target resources at identifying at-risk families and trying to break the cycle (Break Cycle, 2001).

This aspect shows how the construction of adolescent motherhood as a disease means that it makes sense to respond to it terms of surveillance and control. This surveillance of 'disease' rates, however, becomes an increased surveillance in all aspects of the lives and relationships of adolescent mothers in an attempt to prevent adolescent motherhood. Increased surveillance causes investigation into areas such as rates of cigarette smoking that would be unexceptional in other populations. Among adolescent mothers, however, cigarette smoking is monitored and added to the litany of concern that characterises these out of the mainstream parents.

> These concerns are further reinforced by the high rates of welfare dependence, single motherhood and cigarette smoking that characterised these women at age 21 years (Woodward, Horwood, et al., 2001, p.303).

These concerns also justify continuing to monitor and assess these young women throughout their lives:

> It is hoped that future studies of this cohort may provide opportunities to address these issues further by assessing the parenting, family environments and life course outcomes of these high risk parents and their children (Woodward, Horwood, et al., 2001, p.303).

This monitoring justifies the long-term involvement of professionals in the lives of those who have been assessed as high risk, based upon the association with adolescent motherhood. Adolescent motherhood becomes a marker for disease that highlights the adolescent mother and their families as requiring professional assessment and intervention.

The use of a 'Public Health' discourse applies models of disease management to the problem of adolescent motherhood. This focuses professional interest on pregnancy prevention, as shown by the following extract:

> Knowledge of the risk factors and life processes that place young women at risk of an early pregnancy and a premature transition to parenthood is central to the development of more effective pregnancy prevention programmes (Woodward, Horwood, et al., 2001, p.301).

Disease metaphors such as risk factors construct adolescent pregnancy as a public health concern and conclude that the appropriate response to this disease is prevention. This preventative approach has advantages for some and disadvantages for others. Adolescent mothers are disadvantaged by a focus on prevention of a pregnancy that is characterised as unplanned, unwanted and foolhardy. Within this discourse, there is no room to construct adolescent pregnancy positively, and the only advantages are for those who appropriately apply reproductive technologies to delay pregnancy, and thus prevent the disease of adolescent motherhood.

The terms aetiology, risk and prevention, offer a particular framing that has origins in public health research. Adolescent pregnancy is suggested as having aetiology, as being transmitted through exposure to young single mothers and as requiring programmes to

manage or reduce it. These medical terms function to constitute adolescent motherhood as a disease. This positioning provides a dominant framework for research in this area and reinforces the requirement for public health surveillance and interventions to manage individuals. A 'Public Health' discourse provides a position for adolescent mothers as diseased. As such they require monitoring by experts to ensure that adolescent motherhood does not spread. This discourse also has positions for health professionals and academic researchers as experts qualified to know about and monitor rates of adolescent motherhood and individual adolescent mothers. This focus on adolescent motherhood as a disease positions adolescent mothers as passive subjects of disease. Consequently, adolescent mothers are positioned as subordinate and requiring the intervention of health professionals.

Defining 'Public Health'

Adolescent pregnancy and parenting has increasingly been framed as a 'public health problem' in medical literature (Lawlor & Shaw, 2002a) and is often associated with disease metaphors in both the medical and social scientific literature (Wong, 1997). Foster et al. (1999) describe adolescent pregnancy as an "epidemic" with a particular "aetiology" and youth as needing to be "inoculated" with sex education (p.32S). These terms are used to understand adolescent pregnancy as "a symptom of society's illness; society must therefore attack this syndrome" (Foster et al., 1999, p.32S). Constituting adolescent pregnancy and parenting as an illness is also attributed to the social aspects, both the causes and outcomes are attributed to the symptoms of a social illness. As such, adolescent motherhood has been unproblematically positioned as a 'public health problem'.

What is considered a 'public health problem' has varied over time. Definitions of public health have evolved from an absence of disease, to a state of well being to a capacity to live and work in the community. Reducing the incidence of disease has historically meant a focus on aspects such as improving water quality, investigating the source of infectious diseases, and encouraging immunisations (Pernick, 1997). This same framing of disease is increasingly being applied aspects of health and wellbeing when individuals violate dominant discourses of normal behaviour and development. This construction of states *associated* with illness as a disease in their own right has also

occurred with obesity (see Caban, Lee, & Fleming, 2005; Kim, Must, & Fitzmaurice, 2005). The practice of first cousin marriage has also been defined as a public health problem, as it contributes to recessive gene defects (Dyer, 2005). Any phenomenon which can be demonstrated to have any biological basis can be understood as a health issue (Murcott, 1980). A 'Public Health' discourse can be drawn upon to set the bounds for normal development in physical, social, and developmental spheres and states outside of this are attributed with the status of a disease.

The contextualisation of health and illness as occurring in particular sociocultural milieu is drawn upon here to suggest that these out of the mainstream social and cultural systems are themselves indicative of a disease process, and as part of the cause of disease. Disadvantage is viewed as associated with poor health and social participation, but what living in poverty means for health is not investigated. Similarly, the notion of contagion is applied to social disadvantage, as disease models are applied to explain the poor health outcomes associated with poverty. An understanding of infectious physical illness is drawn upon as if these understandings can be applied to explain the transmission of social disadvantage.

The evolving definition of public health as a capacity to live and work in the community means that there is a greater emphasis on the state's ability to manage its population economically and efficiently and a concomitant increase in state intervention in the lives of its citizens educated to monitor and regulate their own behaviour (Danaher et al., 2000). This intervention is achieved through increasing levels of surveillance of the poor, including "government surveys into their living conditions, moral habits and work history" (Danaher et al., 2000, p.58). This approach to monitoring the health and wellbeing of the poor is shown here through the classification of adolescent mothers as high-risk parents. In addition, the attention to welfare acceptance and financial insecurity as indicators of psychosocial morbidity shows how the health and wellbeing of individuals is related to their importance in economic terms to the wider society.

Public health has promised and delivered improvements in the health of the population, however, to achieve this, the lower classes in particular have been made subject to the monitoring of the authorities (Danaher et al., 2000). This increase in surveillance has been referred to as descending individualism, where people are more closely monitored

the lower in the social scale they are. Pupils are monitored by teachers, children by parents, and patients by doctors (Danaher et al., 2000). Adolescent mothers are placed within the lower positions in a number of these dichotomies as they are often pupils of teachers, children of parents and patients of doctors, who all work to monitor their behaviour. Within the health professional literature, adolescent motherhood is taken as indicative of a disease process. This indication of disease is then used to justify further monitoring and professional intervention, and this intervention is supported in part by the association of early parenthood with social disadvantage and poverty.

Conclusion

A 'Public Health' discourse constructs adolescent motherhood as a disease that requires prevention, intervention, and surveillance. This understanding of disease is used to assess aspects of individual lives that are associated with health outcomes and allows a broad understanding of disease as including social, physical and developmental aspects that are associated with poor health outcomes. 'Public Health' is used to attribute poor social conditions as causing and caused by disease without investigating *how* poverty and disadvantage may impact on poor health. This allows responsibility for public health to be attributed to individual citizens rather than the state and its institutions (Willig, 2000).

'Economic' Discourse

An 'Economic' discourse draws upon language of finance to construct adolescent motherhood as a cost to society, and to the mothers themselves. This discourse uses terms such as resources, costs and benefits, and calculates the cost of adolescent motherhood. An 'Economic' discourse also provides resources to construct the families of adolescent mothers as a faulty system that produces a faulty output. An 'Economic' discourse draws upon financial discursive resources to determine the cost and value of individuals to the wider society in strictly economic terms.

All the articles analysed drew upon an 'Economic' discourse to construct adolescent motherhood. Condon and Corkindale (2002) provided a comprehensive cost/benefit analysis comparing the cost of adolescent motherhood to the cost of preventing adolescent motherhood, and focuses on the quantifiable financial burden of adolescent motherhood to others:

> The cost of adolescent pregnancy to the economy is huge. Support for single supporting parents has been estimated to cost at least $100 million a year in Australia. In the USA, it has been estimated that the cost of supporting pregnant and parenting teenagers with medical care, welfare benefits and other social services is four times that of providing an extensive network of sexual health/counselling for adolescents. Total payments in the USA now approximate $US7 billion. In Canada, the financial benefit of providing family-planning, rather than parent support for teenagers, was estimated to be tenfold. If interventions as outlined above achieve even a small reduction in incidence of adolescent pregnancy, they would be highly cost effective (p.50).

Within this economic construction items are separated into costs, including "welfare benefits", "medical care", "other social services", and "parent support" that are combined to count the overall cost of adolescent pregnancy. Other aspects are attributed with the status of benefits, that is the reduction of adolescent pregnancy through the application of "family planning" and "sexual health/counselling". The value of family planning and sexual health and counselling is only through a reduction in adolescent pregnancy rates. This constructs these social resources (welfare benefits, parent support, sexual health and counselling) as tradeoffs with quantifiable economic

benefits rather than valuable social services. In addition, focusing on the cost of "single supporting parents" serves to make invisible the social costs associated with other family structures. This implies that two-parent non-adolescent families do not cost the taxpayer in medical care, parent support and social support when these services are often available to all parenting families regardless of status. Financial support of mainstream family structures is not constructed as the burden on the welfare system that single adolescent mothers are. In addition, Geronimus (2004) reports that delaying childbearing would *increase* government payments to support these women, however, the common sense understanding of adolescent motherhood as expensive to the state prevails.

The cost of welfare benefits and social services have a political meaning and these key areas are often the focus of political platforms that suggest that some individuals represent a significant burden to the state. The cost and welfare benefit payments associated with adolescent motherhood are used to suggest alternative "cost effective" strategies could be used. The costing outlined in the extract above positions adolescent motherhood as a wasteful use of resources, and a more "cost effective" manner would be to "provide family-planning" to prevent adolescent pregnancy and achieve a tenfold saving in payments. In addition to the problem being costly, there is also a construction of the solution of adolescent motherhood also representing a cost. This analysis of the cost of adolescent motherhood to others uses a financial argument to suggest that the cost of adolescent motherhood can be averted by simply by spending money on family planning. This cost benefit analysis promotes prevention of adolescent motherhood as the only economically rational solution.

This ties in closely with the focus on welfare payments in adolescent motherhood, as shown here:

> In terms of financial status, 68% of mothers were dependent on some form of welfare assistance and only 12% were involved in education/training (Woodward, Horwood, et al., 2001, p.302).

And

> These concerns are further reinforced by the high rates of welfare dependence, single motherhood and cigarette smoking that characterised these women at age 21 years (Woodward, Horwood, et al., 2001, p.303).

An 'Economic' discourse includes an assumption of financial concern and control. Those who are constructed as contributing financially to the support of others are viewed as entitled to express "concerns" regarding the high level of welfare dependence and low rates of education and training among adolescent mothers. Those unable to provide for themselves financially are viewed as subject to the concern of others, and implied within this concern is a right to remedy this concern through social action. The determining of cost allows decision making according to the economic model. The appropriate financial decision makers are those that contribute to the welfare that many adolescent mothers are dependent on.

This focus on the "resources" required to reduce adolescent motherhood constructs a balancing act where the cost of a problem is carefully weighted economically against the subsequent cost of the solution.

> Resources should be put into identifying at-risk families to try and break the cycle of teenage parenthood (....) The NZMA supports Government moves to target resources at identifying at-risk families and trying to break the cycle (Break Cycle, 2001).

The notion of "resources" is drawn upon here as a marker for intervention. Aspects of social structure that require attention and intervention are marked as requiring targeted economic attention. Assistance is ultimately financial and "resources" are assumed to 'fix' the problem of adolescent motherhood. The social impact of adolescent motherhood is assumed to be reducible to a set of financial relationships with service providers.

The discursive resources of an 'Economic' discourse are also applied to explain the impact of early pregnancy on the individual young women.

> Early pregnancy is usually followed by truncated educational achievement, lessened future employment opportunities and associated financial insecurity, a

> cluster of related problems which one set of authors has described as "accumulating psychosocial morbidity" (Romans et al., 1997, p.31).

All the aspects of interest in this description are those of a fundamentally financial nature and only those problems that have a direct cost associated with them are listed. As such, these 'personal costs' are fundamentally economic costs. This discourse is drawn upon to construct the primary role of individuals as contributing to the economy through education and employment. Using the economic role as an evaluative criterion, adolescent mothers are positioned as problematic.

An 'Economic' discourse was also drawn upon to compare individuals on educational and occupational criteria, to determine the level of personal cost associated with adolescent motherhood. Young women with better prospects are constructed as appropriately accessing abortion services.

> In addition, there was some indication that women with better educational and occupational prospects were less likely to proceed with their pregnancy compared to their lower achieving pregnant peers. This could be due to the greater personal costs that these young women perceive to be associated with early parenthood (Woodward, Horwood, et al., 2001, p.302).

These "personal costs" to the individual vary, as those young women who continue with their pregnancies are seen to have evaluated the cost benefit analysis of the economic discourse and have arrived at an outcome that show less personal cost to them than those who choose to abort. The factors that are considered to be relevant in calculating this personal cost benefit analysis are still those related to financial stability, such as educational and occupational prospects. The notion of abortion and parenthood as moral, personal or familial issues is removed in favour of the notion of the individual as a rational economic being who has assessed the financial costs and benefits of continuing her pregnancy. The adolescent mother of an 'Economic' discourse is an apprentice income producing worker. Motherhood disrupts this appropriate progression from education to employment and as such is viewed as an irrational economic decision.

An 'Economic' discourse focuses on cost and reframes other aspects of adolescent motherhood in terms of finance. The following extract frames an emotional impact in terms of cost, and then compares this cost to a quantifiable economic cost.

> Teenage pregnancy is one of the most significant adolescent health issues in New Zealand and Australia. It has a potentially long-term deleterious impact both on the adolescent and, if the pregnancy is continued, on the offspring. In addition to the high emotional cost, the economic cost is considerable in terms of medical care, loss of educational opportunities, and ongoing social security benefit payments (Condon & Corkindale, 2002, p.45).

Here the impact on the adolescent and child are considered as an "emotional cost" where the psychological aspects of early motherhood are framed as a cost. Psychological health and development are considered not as progressing through life stages and incidents, but as a cost to the individual. Following this framing of the "emotional cost" a much stronger framing of the "economic cost" provides an economic analysis as the important rationale for an interest in adolescent childbearing. The economic discourse is drawn upon to construct a bottom line argument for interest in the health and wellbeing of adolescent and children. An 'Economic' discourse provides the discursive resources to justify interest and intervention in the health of adolescent mothers. The health and wellbeing of adolescent and children aside – this costs money and as a result is deserving of interest and intervention.

Within an 'Economic' discourse, the family was constructed as a factory that produces a viable output. The family is seen as necessary for ensuring the current and future resources of the state. In particular, mothers are responsible for creating healthy disciplined workers. People are seen as resources or commodities that must be managed to maximise their productive output (Danaher et al., 2000).

> Families at high risk for producing a pregnant adolescent daughter are those with unresolved family conflict and related parenting problems (Romans et al., 1997, p.33).

This construction of the family focuses on its capacity to produce an output. In this case the output is a pregnant adolescent daughter, a faulty output which on further

investigation is found to be the result of a faulty family. This economic notion of the family as producing an output constructs adolescent motherhood as a sign of poor family functioning, as shown in the following extract:

> This suggests that preventive strategies aiming to reduce adolescent pregnancy should focus on measures which improve the general functioning of family units, in addition to providing good sexual information (Romans et al., 1997, p.30).

In addition, this focus on functioning considers aspects related to the family environment as separate and isolated from family functioning.

> Poverty, deprivation and low levels of parental education seem less important in the causation of adolescent pregnancy than family dysfunction in this study than in recent reports from the northern hemisphere, perhaps reflecting New Zealand's lack of extreme poverty (Romans et al., 1997, pp.32-3).

Aspects such as poverty, deprivation, and education, which may be considered to impact on the level of family function, are seen as quite separate here. They are separated out to determine the contribution of each in isolation. This reinforces the sense of family responsibility over producing an adolescent mother.

The use of an 'Economic' discourse constructs a number of understandings of people. An 'Economic' discourse sees people of specific value to the economy. Further, this discourse provides resources that are drawn upon to suggest that some people are more valuable than others in contributing to the economy and by extension are more valuable to the economic society. The value of individuals is based exclusively on their financial contribution. Using an 'Economic' discourse suggests that financial independence is a criterion for childbearing, and as many adolescent mothers do not fulfil these criteria, their subjective experience of motherhood is effected. The subject position available for the adolescent mothers within an 'Economic' discourse is predominantly that of an irrational economic decision maker. The adolescent who chooses to continue her pregnancy is either irrational, or has such limited life choices that motherhood and welfare acceptance are considered her best opportunities. At the intersection of welfare acceptance and motherhood the adolescent mother is positioned as of little value to the economy and the wider society.

Economic Rationality

An 'Economic' discourse provides a set of tools for understanding individuals, which include an understanding of the rational actor of economic theory. According to this theory, it is posited that

> All individuals behave in such a way as to maximise their self-interests in a system of scarce resources. This means that they will systematically calculate their "comparative advantage" and choose the path that offers the greatest rewards at the lowest expense. The logical implication is that a rational person will treat other people in a purely instrumental fashion – as mere resources or obstacles in the universal struggle to maximise personal gain. If individuals don't act this way, it is implied, they are simply stupid or irrational (Hays, 1996, p.195).

Within the health professional literature, an 'Economic' discourse is drawn upon to suggest that young women should calculate the cost and benefits of early motherhood and treat their pregnancies in a purely instrumental fashion. Having calculated these costs, the rational actor could only choose abortion, as this is presented as the rational response to the problem of early pregnancy. These decisions on reproduction are reduced to an analysis of the potential for motherhood to present an obstacle to future economic gain.

Luker (1996) discusses this same view of the young mother as a rational actor and suggests that the construction of adolescent mothers as a calculating, knowing rational actor of neoclassical economics is a common stereotype. This understanding suggests that the adolescent mother assesses the cost of having a baby, and compares this cost to the benefits of welfare. Having undertaken this cost benefit analysis the adolescent mother then invests in a course of action that will maximise her economic welfare. Rich-Edwards (2002) also describes adolescents as rational beings who will exploit available employment opportunities by delaying pregnancy. Changes in the economy, she argues, will motivate adolescents to delay pregnancy and parenting. The health professional literature draws upon aspects of this understanding of the rational economic actor when discussing adolescent motherhood. However, within this literature, those adolescents who chose not to proceed to early motherhood represent the

rational economic actor. They are constructed as having accurately assessed the costs and benefits of an 'Economic' discourse and proceeded with the only rational course of action.

An 'Economic' discourse is also used to justify intervention to prevent adolescent pregnancy and parenthood. The cost of adolescent pregnancy to the economy is drawn upon to understand early parenthood as a matter of national economic security (MacLeod, 2002). Adolescent pregnancy and the welfare dependence that is assumed to follow from it is viewed as undermining the stability of the economy. Identification of adolescent pregnancy as a social problem is often about public resources. This is distinct from previous framing of the moral or the medical, because concern is for impacts on the public purse. This fiscal impact is a funding rationale for these particular pregnancies being a 'Public Health' concern rather than an individual concern, and therefore requiring Government resources to halt this financial drain (Bleach, 1995; Woodward, Fergusson, Horwood, 2001). Social concern becomes the effect of individuals on the public purse rather than on social norms, but not about the effect of social structures on individuals and their lives. This social continues to be identified as something individuals are responsible for and perpetuate to negative effect, rather than something that has material or discursive effects that may be socially generated. Adolescent mothers are therefore viewed as agents of social disruption as they refuse to continue their education and aspire to become rational economic actors.

Conclusion

The use of an 'Economic' discourse constructs individuals appropriately acting as rational economic beings who compare the costs and benefits of particular courses of action and make choices based on these cost benefit analyses. Aspects such as moral and familial influences in abortion and childbearing decisions are not considered. The use of an 'Economic' discourse constructs a number of understandings of people. An 'Economic' discourse sees people of specific value to the economy. Further, this way of understanding the world suggests that some people are more valuable than others in contributing to the economy and by extension the economic society. Individuals are evaluated by considering whether they contribute economically, or whether they are a cost to others. Adolescent motherhood is viewed as transmitting long term social

disadvantage, rather than as a valuable contribution young women make to society as mothers. Motherhood is only sanctioned through certain social conditions, such as financial independence and marriage, which may be unachievable for some mothers at any age. This reflects the current understanding of economic participation as the primary way of contributing to society rather than valuing motherhood in its own right (Kidger, 2004).

'Ethnicity' Discourse

The literature for health professionals drew upon an 'Ethnicity' discourse to construct individuals as able to be grouped into types, for example 'Māori', 'Pacific Islander', 'European', 'European/Pakeha' and 'Asian'. An 'Ethnicity' discourse also includes terms such as 'ethnic group', 'race', or 'identity'. This constellation of names and phrases is used to construct a social categorisation system in which people are understood to belong to one particular group which will determine many aspects of their lives such as behaviour, preferences, status, or health outcomes. This is a widely available discourse, used in a variety of social contexts to apparently unproblematically assign individuals to certain categories.

An 'Ethnicity' discourse was drawn upon within the health professional literature to classify adolescent mothers into ethnic groups, and constructs ethnicity as relevant in understanding adolescent motherhood.

> In spite of these uncertainties it is clear that Māori, and to a lesser extent Pacific teenagers, have markedly higher birth rates than Europeans. The Māori rate is nearly five times higher (Dickson et al., 2000, p.244).

In this example the 'Ethnicity' discourse is used to compare the rates of adolescent motherhood between different ethnic groups. The use of an 'Ethnicity' discourse suggests that ethnic categories may be unproblematically assigned to individuals. However, in practice, assignment to ethnic categories is constantly under negotiation, and the professional literature is no exception. Different terms were used in these articles to explicate how individuals might take up or be assigned a particular label from within an 'Ethnicity' discourse. Thus, assignment to categories was described variously as 'ethnic identification', 'cultural identification', 'identify', 'classify', 'ethnicity data', and 'ethnicity definitions'. The choice of language focuses on issues regarding how labels may be assigned to individuals by researchers, or alternatively how individuals apply these categories to themselves, as shown in the following examples:

> Finally, rates of early pregnancy were elevated amongst those who identified themselves as Māori (Woodward, Horwood, et al., 2001, p.302)

> At age 21 years all respondents were asked about their ethnic identification using the 1996 census question and items designed by Ngai Tahu Māori Health Research Unit. Those reporting any Māori identification were classified as Māori (Woodward, Horwood, et al., p.302).

There is constant negotiation over the appropriate method for assigning labels drawn from an 'Ethnicity' discourse. However, the validity of using the labels themselves was not called into question. An 'Ethnicity' discourse is so dominant for these authors that any difficulty encountered in measuring ethnicity is attributed to the measurement system, rather than to the problematic nature of the reality of the object to be measured. The dominance of ethnicity in categorising individuals leaves no space for considering the social meaning of the category, as the construction of racialised boundaries is viewed as natural (MacLeod & Durrheim, 2002).

An 'Ethnicity' discourse provides apparently objective categories into which people naturally fall. However, an examination of the use of this discourse in this literature showed that some categories are accorded different status, as shown in the following extract:

> Those reporting any Māori identification were classified as Māori (Woodward, Horwood, et al., 2001, p.302).

Ethnicity is also used as a negative health statistic alongside such categories as conduct disorder, poverty, and family adversity, as shown in the following extract.

> Young women who became pregnant were characterised by higher rates of educational under-achievement, conduct problems, sexual risk taking, family adversity, and were more likely to identify themselves as Māori (Woodward, Horwood, et al., 2001, p.301).

Māori ethnicity becomes one of a catalogue of problematic aspects of early childbearing. When used in this way, an 'Ethnicity' discourse functions to construct particular groups as problematic.

In these articles an 'Ethnicity' discourse was commonly used to compare minority group members (predominantly Māori and Pacific Islanders) with New Zealand Europeans. In doing so, an 'Ethnicity' discourse was drawn upon to construct the New Zealand European category as the benchmark. Minority group members (Māori and Pacific Islanders) are compared against mainstream New Zealand Europeans.

> The teenage birth rate was nearly five times higher for Māori than European/Pakeha teenagers and the estimated total pregnancy rate was nearly three times higher. For Pacific Island teenagers the relative rates were 3.2 and 2.4 times respectively compared to European/Pakeha (Dickson et al., 2000, p.242).

This use of European rates as the benchmark is also shown in the following extract:

> Finally, rates of early pregnancy were elevated amongst those who identified themselves as Māori (Woodward, Horwood, et al., 2001, p.302).

Europeans are considered the population of comparison for Māori and Pacific Islanders to be measured against. The European rate is the standard and the Māori rate is "elevated", that is, higher than it should be. This comparison of early pregnancy rates is deployed to construct Māori as deficient.

This concern at the particularly high rate of adolescent pregnancy among Māori is further highlighted with access to abortion among young Māori.

> The difference between the pregnancy rates was less marked as European teenagers who became pregnant were more likely to undergo an abortion (Dickson et al., 2000, p.244).

Here, the comparatively low rate of abortion among young Māori is viewed as a concern. Considering that abortion is usually viewed as a negative health statistic, it becomes clear that high rates of adolescent childbearing among Māori women are considered so problematic that increasing rates of abortion among Māori are proposed to overcome this:

> Therefore young Māori who become pregnant appear less likely to seek, or have access to, abortions. While the former is a matter of choice, it is important that any barriers are identified and removed for young Māori seeking abortions (Dickson et al., 2000, p.244).

This extract shows that Māori abortion rates are measured against those of Europeans and have failed to meet this standard. An 'Ethnicity' discourse is used here to construct abortion rates lower than the index population as problematic. If Māori are having more pregnancies and fewer abortions that the population of comparison – New Zealand Europeans – then it is implied within this extract that Māori experience of barrier to accessing abortion that require attention. However it is likely that cultural barriers to accessing abortion may be viewed as positive from the perspective of Maori as uptake of abortion may not be universally desired. Within this extract, the European solution for the resolution of adolescent motherhood is advised for Māori. This is also shown by the extract:

> But *only* [italics added] a quarter of Māori teen pregnancies ended in abortion compared to half for European teenage women (Dickson et al., 2000, p.244).

Māori abortion rates are measured against those of Europeans and have failed to meet the mark. Categories of ethnic identity are drawn upon to determine the extent to which individuals reflect or resist dominant social structures and apply health solutions from the dominant culture. Lower uptake of abortion services is here used as an indicator of cultural resistance. This extract also needs to be considered in the New Zealand context, where abortion is not lawfully available on demand, but is only available if the person performing the abortion believes that it fulfils one of a number of criteria within the scope of the Crimes Act (Bassett, 2001). These criteria are: that continuing the pregnancy would result in serious mental or physical danger to the woman or girl, that there is substantial risk of a seriously physically or mentally handicapped child, that the pregnancy is the result of sexual intercourse between close family members, that the pregnancy is the result of sexual intercourse that is an offence against the Crimes Act, or that the woman or girl is severely subnormal. However, the discussion of abortion within this professional literature refers to matters of "choice" and removing "barriers" to abortion services. This does not recognise the status of abortion as legally only available in New Zealand under specific criteria.

The concern with Māori and Pacific Island adolescent fertility appears to also reflect a fear of the increasing minority population:

> As the proportion of Māori and Pacific young people in the population increases, as expected by current demographic trends, and if the present ethnic-specific rates persist, a rise in overall birth and abortion rates is to be expected (Dickson et al., 2000, p.244).

> There are likely to be a variety of views among Māori on these issues as it has been argued that many support a pro-Māori childbearing position as a means of expanding the Māori population. (Dickson et al., p.244).

These extracts indicate the concern over increasing Māori and Pacific Island population growth due to increasing adolescent parenting and failure by Māori and Pacific Islanders to access abortion services. Surveillance of fertility and abortion data by ethnic classification implies that higher rates of population growth among ethnic minorities are problematic. It is unclear why population growth among Māori is of note, but this draws upon notions of 'race suicide', where increases in population growth of undesirable minorities were feared (Kedgley, 1996). In the past, a higher rate of reproduction among 'coloured' races has been drawn upon to suggest that White people will be outnumbered. Within the New Zealand context, Māori and Pacific Islanders represent a numerical minority, and changes to these demographic trends are drawn upon as of note, and implicitly troubling. The implication of Māori population growth as inappropriate implies that the 'right' and 'wrong' sort is determined by ethnic categorisation.

The co-articulation of an 'Ethnicity' and 'Naturalist' discourse is used to construct an argument that the right sort of people must be encouraged to reproduce and the wrong sort discouraged. The 'right' and 'wrong' sorts are determined by racial and economic standards, which are also conveniently blurred. This blurring of the right and the wrong sort of people with racial categorisations is shown in the following extract:

> Our findings indicate the importance of understanding the impact of teenage pregnancy in New Zealand among Māori. Māori children have markedly worse

> health indices, higher rates of abuse, poorer educational achievement and later, higher rates of imprisonment. In studies carried out in the USA, all these factors relate to being born to a teenage mother, even taking into account the relative disadvantage in which such women tend to live. If a similar relationship exists here, delaying pregnancy among teenage women, and ensuring that they have educational and employment opportunities, could be an important strategy to break the cycle of disadvantage for many Māori women and subsequently improve the health of Māori children (Dickson et al., 2000, p.244)

Here cultural identification is associated with poor health and educational achievement, and high levels of abuse and imprisonment. These statistics are rather weakly related to adolescent motherhood: "all these factors relate to being born to a teenage mother". The combination of both poor social and health outcomes and young motherhood is then used to suggest that control of childbearing among a minority culture is necessary and responsible. This is constructed as in the best interests of the minority group to "break the cycle of disadvantage for many Māori women and subsequently improve the health of Māori children". Given that the reduction in barriers to abortion has been a suggested to control the fertility of young Māori women, this does not seem a strategy that will improve the health of Māori children, but a strategy that will reduce the numbers of Māori children.

In the extract above, Māori children are viewed as more disadvantaged and children of adolescents are more disadvantaged. It is argued that if Māori are more likely to be adolescent mothers, then delaying pregnancy will be good for Māori. However, these authors could make a simpler argument. If Māori have poorer outcomes then it would be simpler to suggest that Māori women should be discouraged from childbearing regardless of their age. However, this conclusion is manifestly unpalatable, and therefore a rather more circuitous link is made between Māori childbearing and disadvantage. The link with adolescent pregnancy and disadvantage can be drawn upon in a way that the link between ethnicity and disadvantage cannot be drawn upon without the justification of age to remove the racial focus. Within current social milieu, it is not possible to use a straightforward link of ethnicity with disadvantage to suggest that Māori should curb their childbearing, but it is possible to construct an argument against adolescent pregnancy using a link with ethnic disadvantage.

This separation of the minority group and the mainstream is further underlined in the following extracts on international comparisons in adolescent pregnancy and motherhood. The co-articulation of a comparison between national and ethnic rates of pregnancy is shown in the following extract:

> Although New Zealand has high overall teenage birth and pregnancy rates compared to other developed OECD countries, a major component of this is the very high rate among Māori and Pacific teenagers. The birth rate among European/Pakeha teenagers in New Zealand is similar to the overall rate in Australia and Canada, and substantially lower than in the UK or the USA white rate (50.9 per 1000). Nevertheless, it is still more than twice as high as many Western European countries (Dickson et al., 2000, p.244).

Here an 'Ethnicity' discourse is combined with a nationality discursive resource to show that if similar ethnic groups are compared across countries, then New Zealand Europeans are faring similarly to other countries such as Australia. This construction positions Māori and Pacific Island adolescents as at fault for causing the high adolescent birth and pregnancy rates in New Zealand. This understands Europeans in different countries as the same (NZ European/Pakeha and the UK and USA White rate) and different ethnic minority groups in different countries as the same (see MacLeod & Durrheim, 2002). There is a genetic link between White populations that arguably could be drawn upon here, but that does not hold for the link between the 'other' of each nationality; NZ Māori, and presumably Black and Hispanic. Rather a sociological likeness is being drawn here to link adolescent motherhood with poverty and marginalisation. This understands the problem of adolescent motherhood as located within particular ethnic communities, rather than related to national factors. The categorisation of adolescent mothers as minority group members is sufficiently homogenous to ensure that sensible comparisons between Europeans of different nationalities and minority ethnic group members can be constructed. Comparing European/Pakeha with other 'White' people allows adolescent motherhood to be constructed as a problem of the 'other', rather than the European/Pakeha. The focus within this discourse is adolescent motherhood as a deficiency of the Māori and Pacific Island population.

This discourse provides a position for young women to take up as a Māori or Pacific Island adolescent mother. Within this discourse, this position means accepting a construction of problematic early childbearing. This construction also serves to make Māori and Pacific Island adolescent mothers more visible as a category. The positioning within an 'Ethnicity' discourse is particularly problematic as it is very difficult to resist the positioning of this discourse. Although this research describes how it is possible to "identify" as Māori, in practice these allocations to racial and ethnic groups are often imposed on patients within a clinical setting. Young women are often positioned as Māori based on their physical appearance, and their behaviour is then interpreted according to this ethnic categorisation. This has implications for the subjective experience of adolescent motherhood for these young women. Within an 'Ethnicity' discourse, the subject position of Māori adolescent mother comes with it a difficult subjective experience; their pregnancies and children are seen as less desirable than the pregnancies of other non-Māori and non-adolescents. Their children are constructed as a sign of an inability to appropriately access abortion services, and increases in fertility are something to be feared and curbed in young Māori rather than an event to be celebrated.

Understanding 'Ethnicity'

Discourses have consequences, and the use of the 'Ethnicity' discourse to construct adolescent motherhood in particular, and health disparities in general, bring with it certain values and understandings of the world. The 'Ethnicity' discourse constructs ethnicity as having characteristics and meaning in itself, and ethnic categorisations as able to be unproblematically applied to others. Using European or White rates as the standard, this discourse compares ethnic groups to one another and constructs minority group members as wanting. Nazroo (1998) maintains that this approach sees ethnicity as a natural and fixed state of individuals. He further contends that that seeing ethnicity in this way means that ethnic minority group members are "encouraged to modify their behaviours to address their genetic and cultural weaknesses" (p.717). This focus on individual deficit and individual level changes fails to take account of structural inequalities that may account for inequalities in health care and health outcomes.

The 'Ethnicity' category is often drawn upon in public health research as a primary explanatory variable. Exactly how ethnicity explains health (biologically, socially or economically) is often unclear within public health research. Ethnicity may characterise a group in terms of common nationality, language and affiliation. Race, by contrast, implies shared genetic inheritance and physical similarities in aspects such as hair type, skin colour, and facial features. Cultural differences are characterised by notions of collective knowledge, attitudes and values, and ways of thinking and acting (McKenzie & Crowcroft, 1994). An indication of affiliation with Māori cultural identity could indicate a common biological history (race), a shared experience of reproduction and motherhood (ethnicity) or a result of a collective knowledge, attitudes and values towards motherhood (culture). Which is being theorised is not engaged with in this literature, and is sufficiently vague to potentially encompass all these modes of ethnic transmission. What it means to be Māori or Pacific Islander within this literature is taken as self-evident and obvious to all. Jones (1996) argues that the most obvious role of skin pigment is as a social label. As such, it is important to understand what is being achieved by the use of this social label in health and social research.

An 'Ethnicity' discourse is drawn upon to unproblematically explain differences in health care rates. Ethnicity is not used to investigate the different meanings of sexuality and reproductive choice, but merely to compare differential rates of problematic conditions such as early sexual intercourse, sexually transmitted disease, adolescent pregnancy, and abortion. Ethnic categories are deployed in the literature for health professionals to blame group members for their poor health status and to suggest alternative, mainstream solutions to disadvantage (Nazroo, 1998). The current focus on the poor being to blame for their position skirts the central question of race (Jones 1996). Jones suggests that "statements about race which would be outrageous if made without qualification can be hidden under a veneer of social concern" (p.177). This can be related to the desire to remove barriers to abortion for young Māori. The suggestion that Māori should curb their fertility would be outrageous if applied to all Māori, however, hidden under the guise of social concern for the poor outcomes for the children of Māori adolescent mothers it appears acceptable.

Alternative understandings of ethnicity could focus on what it means to take up a particular ethnic identity, or multiple ethnic identities, in the context of a wider social

system that includes racism, poverty and out of the mainstream values (Karlsen & Nazroo, 2002). These authors argue that ethnic identity can be seen as both *who is* and *what it is to be* a member of an ethnic minority. The 'Ethnicity' discourse outlined here attends only to classifying *who is* a member of each group, rather than a consideration of *what it is to be* a member of an ethnic minority group. Including this aspect in health literature would understand ethnicity as located within a social system rather than as a fixed state of individuals. For example, Geronimus (2003) states that different rates of adolescent pregnancy among ethnic minority group members may reflect differential structural pressures. Long term socioeconomic disadvantage among ethnic minorities may cause accelerated health deterioration in their mid twenties and thirties. Consequently, poor minorities cannot take for granted their good health through what is generally considered the prime childbearing years. Therefore, imposing appropriate childbearing ages from the mainstream culture on to other cultures may not improve outcomes for minority group members (Geronimus, 2003). Differences in adolescent pregnancy, abortion, and motherhood rates need not be understood as reflecting individual deviance or community pathology, as is often represented in the literature of adolescent motherhood.

Conclusion

'Ethnicity' is drawn upon to unproblematically categorise individuals into groups that have implications for health outcomes and health behaviours. These behaviours are compared to the appropriate solution to poor health as presented by the dominant culture. Ethnicity is drawn upon to categorise and to assess rather than to understand the context of health or investigate what might produce disparities in health care among different ethnic groups.

Summary of Science Discourses

The 'Naturalist', 'Public Health', 'Economic', and 'Ethnicity' discourses use the warrant of science to pathologise adolescent motherhood. The 'Naturalist' discourse uses images and metaphors from the natural sciences to construct adolescents as inappropriate mothers for a number of reproductive reasons. The 'Public Health' discourse constructs adolescent motherhood as a disease state, which requires careful monitoring and control. An 'Economic' discourse constructs adolescent motherhood as a cost to society that must be kept from escalating. An 'Ethnicity' discourse is deployed to separate people into types who are more and less able to conform to dominant social mores of health and development. These categories are used to justify differential surveillance and monitoring of individuals according to their position within each of these scientific constructions. These discourses are deployed in the production of knowledge about adolescent motherhood that is used to justify particular control strategies. The knowledge that adolescent motherhood is problematic for a number of reasons justifies monitoring and control to ultimately ensure that adolescents do not become mothers. The constructions of science make the control responses of determining relative fitness to reproduce, monitoring, and calculating cost appear reasonable, and even responsible.

The production of knowledge is tied to increasing control of society through scientific management. This is shown by the attempt to apply the principles of scientific management to a variety of socially located phenomenon, and this analysis shows how the principles of scientific management have been applied to adolescent mothers. As Rose (1999) states "the government of human subjects has become bound up with innovation and developments in a number of scientific discourses that have rendered knowable the normal and pathological functioning of humans" (p.xxvii). The distinction of the normal from the abnormal is achieved through the terminology of the social sciences. This management works by monitoring only those who do not conform to societal norms.

Co-articulation of Science Discourses

The 'Naturalist', 'Public Health', 'Economic', and 'Ethnicity' discourses fit tidily together. The co-articulation of these discourses construct the separation of people into

the fit and unfit, the European and the 'other', the healthy and the unhealthy, the costly and the wealthy. Together they allow the separation of the right sort of people (those who are fit, European, healthy, and wealthy) who fit comfortably within dominant social structures and should be encouraged to reproduce, from the wrong sort who disturb social structure and whose reproduction should be curbed. The compatibility of these discourses produces a coherent subject, the fit and the unfit being determined at the intersection of these discourses. In these discourses the fit are separated from the unfit in a 'Naturalist' discourse, the healthy are separated from the diseased in a 'Public Health' discourse, and the solvent are separated from the wastrel in an 'Economic' discourse, and European/Pakeha are separated from Māori in an 'Ethnicity' discourse, to explain individual behaviour and as a justification for individual sanctions.

The discourse analysis in the previous sections suggests that each of these discourses was drawn upon separately and works in isolation to present a unified and coherent view of the subject. In practice this is not the case. The discourses are co-articulated throughout the professional literature. The following extract shows how these discourses are drawn upon within the same paragraph to ultimately justify adolescent motherhood as a "cause for concern":

> There was also evidence of further selection amongst those who became pregnant. Those from socially disadvantaged family backgrounds characterised by parental instability and early exposure to young, single motherhood were more likely to become parents at an early age. This suggests that daughters of young single mothers may themselves be at high risk of becoming a young (and potentially single) mother. This highlights the importance of maternal role models in shaping a daughter's fertility choices and is suggestive of intergenerational cycles of early pregnancy/motherhood. In addition, there was some indication that women with better educational and occupational prospects were less likely to proceed with their pregnancy compared to their lower achieving pregnant peers. This could be due to the greater personal costs that these young women perceive to be associated with early parenthood. Finally, consistent with previous research, there was a tendency for women who identified themselves as Māori to be more likely to proceed with a pregnancy (Woodward, Horwood, et al., 2001, p.302)

This extract refers to "further selection" from the 'Naturalist' discourse, and "exposure to young, single motherhood" from a 'Public Health' discourse. In addition, adolescent

motherhood is viewed as a "personal cost" from an 'Economic' discourse and Māori are identified as problematically proceeding with pregnancy from an 'Ethnicity' discourse. This paragraph draws upon these discourses, and frames adolescent motherhood as a result of 'cycles of disadvantage'. This provides a coherent subject position for the adolescent mother as Māori, lower achieving, dysfunctional individual from a dysfunctional family. Conveniently, the lines between the fit, healthy, and the wealthy blur with racial categorisations so that the separation of the fit and wealthy need not explicitly draw on racial criteria.

Stern (2002) states that public health and eugenics are often viewed as antithetical movements separated by the focus on environmental factors in public health and on hereditary in eugenics. However, she states that in practice race betterment was an expansive rubric that drew upon overlapping ideas and practices. In addition, as Birn and Molina (2005) point out, eugenic strategies do not reflect a small number of prejudiced public health officials, but rather reflect the "extent to which health and medical policies absorb and reflect the dominant class and racial logic of the time" (p.1095). Within the literature for health professionals we can also identify the echoes of these eugenic, racial, and economic arguments within a public health framework. Racial lines are still being used to delineate the most and least capable of parenting, economic arguments continue to be drawn upon to justify or restrict childbearing, and the poor and unfit are still viewed as a contagious influence that may infect the unfit and should consequently be restricted from childbearing. The ways these understandings have been drawn upon, however, differ. Within current understandings, they are justified by a widespread understanding of adolescent pregnancy and parenting as an antisocial act that justifies intervention (Geronimus, 2003). This understanding at the intersection of the 'Naturalist', Public Health, Economic and Ethnic discourses lead into a need to monitor and intervene in the lives of these problematic populations to curb their excess reproduction.

'Naturalist' and Economic

These compatibilities are particularly highlighted by the intersection of the 'Naturalist' and 'Economic' discourse that use financial criteria to determine relative fitness. The co-articulation of the 'Naturalist' and 'Economic' discourses was prevalent in the health

professional literature. The catalogue of criteria for fitness to reproduce includes financial aspects such as welfare acceptance, training, and employment. Financial criteria replace physical reproduction and health outcomes as the criteria for reproductive success. The wealthy can be determined as fit, and the poor unfit without any link to reproductive success. This historical connection between the 'Naturalist' and 'Economic' discourses is shown here:

> American capitalists explained that they were destined to, and deserving of, power and wealth because they were, in Darwinian terms, 'the fittest', while the poor were biologically unfit to compete with them (Danaher et al., 2000, p.10).

There is a long history of fitness for marriage and parenthood as determined by economic criteria. Those of 'weak estate' were viewed as unfit for marriage and parenthood, and the label of unfit was extended to the poor and unproductive (Luker, 1996). This provides a position for the poor as biologically unfit to reproduce, a position that is reflected in the linking of poor health, poverty, and welfare acceptance as indicators of adolescent mothers' unsuitability for motherhood. The poor are then intrinsically unfit to reproduce as their poverty alone is in indicator of lack of fitness without the need to posit a link between wealth and genetic superiority.

This focus on wealth as the determining criteria for fitness allows the authors to avoid addressing the implications of reproductive success as the criterion for fitness. The 'excess' fertility of the poor and disadvantaged could be drawn upon as an example of their reproductive success within a 'Naturalist' discourse that that values childbearing. However, physical reproductive success is defined here as failure if it is not also associated with financial independence.

'Economics' and 'Ethnicity'

The literature for health professionals analysed here combined 'Ethnicity' and 'Economic' discourses to draw attention to the cost associated with Māori ethnicity. The link of early childbearing with a lack of educational and employment success and increased rates of welfare acceptance is drawn upon to promote a reduction in childbearing among adolescent Māori to improve the health and wellbeing of Māori women and children.

There has been increasing interest in research on the influence of ethnicity and economic factors in understanding inequalities in health outcomes (Aspinall, 2001; Lillie-Blanton & LaVeist, 1996; Nazroo, 1998). However, research on health disparities between ethnic and economic groups has also attracted criticism. It is argued that ethnicity is a poorly defined variable, and may be used variously to imply that biologic, cultural, or socioeconomic differences influence health (Aspinall, 2001; Lillie-Blanton & LaVeist, 1996; Nazroo, 1998). Measuring economic influences on the health of ethnic minorities has also been critiqued. Measures focusing solely on economic aspects such as income and occupation fail to capture the complexity of environmental deprivation among ethnic minority group members (Hardey, 1998). This deprivation may include the health impact of a lifetime of disadvantage, the influence of the experience of racism on health, and geographical deprivation (Davey Smith, 2000; Nazroo, 1998). Efforts to control for the relationship between economic status and ethnicity are also contentious. Economic status has been seen as a confound often neglected in research on ethnic groups' health outcomes (McKenzie & Crowcroft, 1996) and a tool that serves to conceal the extent of the relative disadvantage of ethnic minorities within each economic classification (Karlson & Nazroo, 2002).

The co-articulation of 'Ethnicity' and 'Economic' discourses constructs ethnic minorities as a burden to society and implies that some population groups are a drain on health care resources (Bhopal, 1997). Constructing adolescent motherhood as costly to others and predominantly a problem of ethnic minorities focuses attention on negative aspects of ethnic group membership. It is important to acknowledge the material effects of living in poverty on individuals' health and wellbeing. However, there is also a need to consider how health issues are categorised as ethnic or economic problems, and the advantages and disadvantages of such classification. Constructing health as related to ethnicity and economics is a way of viewing health that has advantages for some and disadvantages for others. These advantages and disadvantages reflect wider social structures that are enacted through these dominant discourses. The use of 'Ethnicity' and 'Economic' discourses invites particular social actions and forecloses other ways of responding to inequalities in health.

Conclusion

There are strong relationships between eugenics as shown in the 'Naturalist' discourse, and 'Public Health', 'Economic', and 'Ethnicity' discourses. These discourses have long history of interdependence. The literature for health professionals shows that these discourses are still related today, though they are now drawing on the positioning of age to justify interest and intervention in the reproductive practices of the poor, ethnic minorities, and the uneducated. These discourses are deployed compatibly to produce a coherent subject. This subject is the financially dependent, ethnic minority member who is psychologically, physically, and educationally unprepared for parenthood and whose reproduction produces disadvantage for the individual and the state. This illustrates a prototypical adolescent mother as a certain class of being and frames adolescent mothers as unstable, poor, uneducated, Māori. This makes adolescent mothers visible as a certain class of object and adolescent mothers who are not described by these categories as invisible.

CHAPTER VIII.

BREAKING THE CYCLE

The association of adolescent motherhood and poor health outcomes is often used to justify attempts to 'break the cycle' of adolescent motherhood. The cycle of adolescent motherhood is the notion that social and economic disadvantage is linked to a number of negative outcomes such as early parenthood, early school leaving, and unemployment. These negative outcomes occur more commonly among those who are socially and economically disadvantaged. In turn these states are considered as causing disadvantage. Early parenthood is viewed as causing early school leaving, unemployment and welfare dependence. This provides an apparently socially located understanding of disadvantage as caused by and causing poor outcomes for individuals. This understanding of the 'cycle of disadvantage' is common within social scientific research and social policy applications, which attempts to overcome the notion of poverty and disadvantage as the fault of the individual. Within the context of this analysis, the 'cycle of disadvantage' is a discursive resource that positions adolescent mothers as responding to wider social constraint through individual choice.

Individual Choice and Socioeconomic Disadvantage

This apparently socially located understanding of disadvantage is utilised in the health professional literature to provide individual psychological explanations of disadvantage. The metaphor of a 'cycle of disadvantage' is used to construct an understanding of the reproduction of problem people such as adolescent mothers. It begins with the notion of people who fail to adjust to dominant societal norms for acceptable behaviour. These people are more likely to engage in early, and consequently problematic, sexual behaviour. The next step in this cycle is failing to adequately use contraception. This leads to early pregnancy, a failure to access abortion, and ultimately childbirth. Following this, these problematic youngsters enter single motherhood, become dependent on welfare, and continue to produce problem children whose lives will follow the same path. This is the cycle of adolescent motherhood as presented by the

literature, and is presented as the argument for why adolescent motherhood is to be avoided, as it literally promotes the reproduction of problems:

> We must start breaking the cycle of teenagers giving birth to children who go on to become teen parents themselves. It's well known that these at-risk families have higher rates of poor health, social disadvantage, educational underachievement and behavioural problems (Teen Pregnancy, 2001, p.2).

However, this story is not constructed as deterministic. It is possible for the young woman set upon this path to make individual choices to avoid these outcomes at a number of points. This involves making an individual decision to avoid inappropriate behaviour and make the approved choice. The approved choices in the context of adolescent sexuality, pregnancy and parenting are as follows:

> Teenagers shouldn't have sex; if they have sex they should use contraception; if they get pregnant despite using contraception, they should have an abortion or give up the child for adoption; and failing all of that, they should marry the fathers of their babies (Luker, 1996, p. 10).

The health professional literature draws upon these choices as alternatives to disadvantage, chosen by taking up a position supported by dominant discourses. These alternatives focus on the individual's choice to behave in ways appropriate to the dominant social order, rather than changes to the social order that produces the 'cycle of disadvantage'. The approved choice is constructed as equally available to all, and individual characteristics determine whether this choice is made.

The 'cycle of disadvantage' that produces adolescent mothers begins with the construction of people who are at the outset positioned as problematic. These problem people can be identified by their failure to fit into dominant social structures such as school systems and by their failure to mature in developmentally appropriate ways, as shown in the following extract:

> Compared to their non-pregnant peers, young women who became pregnant were significantly more conduct disordered, had poorer scholastic ability, were more likely to have left school without formal educational qualifications, and tended to

> have sexually matured and initiated sexual intercourse at a younger age (Woodward, Horwood, et al., 2001, p.302).

These problem people are constructed as psychologically deficient through diagnosis of conduct disorder, and their poor scholastic success and early school leaving are indicators of a lack of cognitive development. Those who become pregnant are constructed as poor prospects as parents through the association with conduct disorder and lack of educational achievement. Their early sexual activity and sexual maturation are used as indicators of an excess of 'inappropriate' adolescent development. Pregnancy is used as the dividing criterion, and the unsuccessful individuals can be identified as those who become pregnant during adolescence.

People positioned as problematic subjects are partly identified by their early (and therefore risky) sexual behaviour. "Sexual risk taking behaviours" (Woodward, Horwood, et al., 2001, p.303) are reported to be associated with adolescent pregnancy, however, the "sexual risk taking behaviours" in this study are simply the age that sexual activity was initiated (the only measure of sexual behaviour investigated). The authors have used the measure of age at first sexual intercourse as a proxy for "sexual risk taking behaviours", showing that adolescent sexual activity is viewed as risky merely because it is sexual activity during adolescence. Sexual activity is a marker for individual failing. Sexual activity during adolescence is further problematised by the reciprocal relationship between early sexual activity and problematic populations, as shown here:

> One study has reported that by age 15, 8.5% have engaged in sexual intercourse. Such behaviour was more frequent in girls than boys, in children of Māori or Pacific Island ethnicity and among children of parents of unskilled or semiskilled occupational status (Romans et al., 1997, p.31).

Early sexual behaviour occurs among those who are often positioned as problem populations, those of "Māori or Pacific Island ethnicity", and the children of those employed in "unskilled or semiskilled" occupations. Previously in the 'Ethnicity' discourse it has been shown how Māori and Pacific Island ethnic identity are used as problematic categories by their association with disadvantage and deviance. Similarly

"unskilled or semiskilled occupational status" is a phrase used to identify the working classes. In this extract membership of lower occupational groupings is associated with early sexual behaviour, which has already been characterised as risky. There is a circular relationship between the construction of problematic populations and sexuality. An important aspect of the construction of problem people is the engagement in early sexual behaviour. In addition, early sexual activity is problematic because "such behaviour" occurs more frequently among members of problematic populations. Sexual activity consequently becomes a marker of a lack of appropriate social development as suggested here:

> The influence of childhood family and individual factors on adolescent sexual risk taking may need to be addressed through the development of broad based interventions to assist at-risk children and break intergenerational cycles of poor social functioning (Woodward, Horwood,, 2001, p.303).

Here "poor social functioning" is linked with "adolescent sexual risk taking", that is early sexual activity. This early sexual activity is a marker for an inability to develop and function in socially appropriate ways, which is to delay sexual activity beyond adolescence.

The next step in the 'cycle of disadvantage' that leads to adolescent motherhood is the use of or failure to use contraception. Young women who later become pregnant are viewed as failing to access and manage appropriate contraception.

> Teenagers who become pregnant usually have a history of visiting the doctor far more frequently in the year prior to their pregnancy than age-matched peers. These consultations generally concern contraception, which in their case has failed. Young women whose pregnancies ended in termination were more likely to have asked for emergency contraception (the morning after pill) than regular oral contraception during prior consultations. It is suggested that adequate follow-up is necessary after prescribing emergency contraception because the scare will not necessarily be the last (Condon & Corkindale, 2002, p.47).

Those adolescents who have become pregnant have previously attempted to access contraception, but this has "in their case failed". They are also viewed as erratic

contraception users as they are more likely to have requested emergency contraception than regular oral contraceptives. These adolescents who have shown evidence of an unplanned approach to obtaining reliable contraceptives need "adequate follow-up", as they will continue to risk pregnancy. This constructs those pregnant adolescents as responsible for their situation as a result of an inconsistent approach to contraception. Age matched peers are capable of correct contraception (viewed as the regular oral contraceptive), therefore an inability to manage contraception is the fault of the individual. Increasingly available and reliable contraceptives has meant that unwanted or untimely pregnancy has come to be viewed as a technological failure. The availability of contraception and abortion has meant that people have become less tolerant of mistakes (Luker, 1996). This is indicated in the literature for health professionals as the availability of reliable contraception means that lack of contraception use is viewed as a "failure". The ability to avert pregnancy means that pregnancy prevention becomes a moral imperative.

The next stage in the cycle is the response to pregnancy, either termination or maintaining the pregnancy to term. Within the literature, abortion was viewed as a useful tool to curb the increasing rate of adolescent birth, as shown by the following extract:

> In the last decade only an increase in abortions has held the birth rate relatively stable (Dickson, et al., 2000, p.243).

Abortion is constructed as preferable to adolescent pregnancy. High abortion rates are viewed as lamentable, but necessary to ensure that adolescent and 'unwanted' pregnancies do not show a more marked increase. Abortion then is constructed as a useful tool available for individuals to manage pregnancy and so to address the wider adolescent pregnancy rate. However, abortion is inadequately utilised by members of problematic populations. The literature draws upon problematic categories of people and compares their rates of abortion with mainstream groups:

> Although the abortion rate was slightly higher among Māori than European/Pakeha teenagers, Māori who became pregnant were much less likely to have an abortion (Dickson et al. 2000, p.242).

> Therefore young Māori who become pregnant appear less likely to seek, or have access to, abortions. While the former is a matter of choice, it is important that any barriers are identified and removed for young Māori seeking abortions (Dickson et al., p.244).

The comparison here between Māori and NZ European response to pregnancy concludes that "only a quarter of Māori teen pregnancies ended in abortion" (Dickson et al., p.244), that is, not enough (as discussed in the 'Ethnicity' discourse on pp. 108-109). In addition to the ethnicity comparison, women who have been positioned as already residing within the 'cycle of disadvantage' are less likely to terminate early pregnancy.

> Pregnant teenagers are more likely to have a mother who had a teenage pregnancy, and teenage daughters of such mothers are more likely to maintain their own pregnancies to term rather than terminate them. The cycle continues (Condon & Corkindale, 2002, p.47).

Having a mother who was a pregnant adolescent positions these young women as problematic, and their response to their pregnancy is characterised as propagating disadvantage by reference to the continuing 'cycle of disadvantage'. The extract above shows that abortion is considered as a result of choice and an individual matter. Factors such as cultural or familial influences on pregnancy resolution are not considered. For example, all members of the Māori community may not welcome removing barriers to young Māori seeking abortion.

In contrast to those positioned as problematic, the capable choose the socially appropriate form of pregnancy resolution. The following extract shows that appropriate response to pregnancy made by higher achieving peers:

> In addition, there was some indication that women with better educational and occupational prospects were less likely to proceed with their pregnancy compared to their lower achieving pregnant peers. This could be due to the greater personal costs that these young women perceive to be associated with early parenthood (Woodward, Horwood, et al., 2001, p.302)

Those with "better educational and occupational prospects" are more capable and choose the sanctioned alternative of abortion of early pregnancy. They are constructed as undertaking an individual cost benefit analysis of the "personal costs" perceived to be "associated with early parenthood". Implicit in this statement is a position for those with lesser educational and occupational prospects; pregnancy is not of great personal cost to these women. Therefore pregnancy can be viewed as providing a rational solution to those with fewer prospects, but this micro-cultural rationality is not explored further.

The level of single parenting among adolescent mothers was often highlighted as a statistic of disadvantage. Adolescent mothers are viewed as having "entered single parenthood" (Romans et al., 1997, p.31) which propagates disadvantage for them and produces babies with fathers about which there is little professional knowledge:

> Little is known about the fathers of these babies. Over 90% of teenage women are unmarried when they give birth and approximately 60% have no male partner at that time (Condon & Corkindale, 2002, p.46).

This lack of knowledge implies that adolescent women have little knowledge of the fathers of their babies, but the lack of formal relationship between the adolescent mother and the father of her baby impedes surveillance of this relationship and so little is professionally known about the fathers.

The level of marriage, partnership and single motherhood as also highlighted to position adolescent mothers as deficient:

> At least half were single parents, 43% were living in a de facto relationship, and only five (7%) were married (Woodward, Horwood, et al., 2001, p.302).

This list of possible partnership status: single motherhood, de facto relationship, and marriage are a hierarchy from least to most acceptable within wider social norms of appropriate family structure. In the extract above, adolescent mothers are viewed as deviating from these sanctioned family relationships as they are most commonly single

parents, or in a defacto relationship. Very few, "only" 7% raise their children within a relationship with the legal and moral establishment of marriage. Marriage and partnerships were viewed as somewhat mitigating the negative positioning of adolescent mothers and single parenting as compounding disadvantage.

Throughout these stages within the 'cycle of disadvantage' the role of personal choice is highlighted. Individual attitudes are viewed as of primary importance, as "positive and idealised attitudes to pregnancy and parenthood" (Condon & Corkindale, 2002, p.47) determine pregnancy rates. Individual choice based individual attitudes becomes the appropriate way to understand behavioural outcomes such as sexual activity:

> The implementation of pregnancy prevention strategies for men and women might include addressing issues that would enable young Māori women to make choices regarding sexual activity and contraception to overcome the problems, including coercion, peer pressure and alcohol use, identified in recent research (Dickson et al., 2000, p. 244).

In the above extract, the appropriate decision maker is the individual, who should be enabled to make a decision based on "choice". Aspects of the social world are viewed as "problems" such as "coercion" and "peer pressure" that interfere with the functioning of the individual decision maker. These aspects of the social world are not viewed as the way cultural and social values impact on individuals, but as the way they interfere with individuals. Wider social and cultural values regarding fertility, contraception, abortion, education and employment are ultimately reduced to a set of individual attitudes.

The construction of disadvantage as a result of individual decision making makes possible an individual solution. The health professional literature understands the disadvantage associated with early motherhood as remedied through individual pregnancy prevention:

> Delaying pregnancy among teenage women, and ensuring that they have educational and employment opportunities, could be an important strategy to break

> the cycle of disadvantage for many Māori women and subsequently improve the health of Māori children (Dickson et al., 2000, p.244)

This individual solution is particularly proposed to curb the reproduction of members of populations positioned as problematic. These solutions are constructed as in the best interests of those who currently do not wish to take up this alternative. This suggests that because Māori choose not to make reproductive choices sanctioned by the mainstream; that they fail to do what is in their own best interests.

There has been considerable interest in how adolescent motherhood develops in an attempt to "break the cycle" of adolescent motherhood. The research focus on understanding the cycle of adolescent motherhood constructs adolescent motherhood in particular ways. This construction begins with problematic populations such as those who are socioeconomically disadvantaged, Māori or Pacific Islander, and the children of adolescent mothers, constructs their inappropriate response to sexuality and childbearing, and concludes with the outcome of more single mothers and disadvantage. However, it is constructed as possible for individuals to choose to avoid the 'cycle of disadvantage' by making individual decisions. These individual decisions include abstaining from sex during adolescence, using effective contraception, choosing to terminate early pregnancy, marriage, and independence from welfare. This construction of the causes and consequences of adolescent motherhood draws attention to how it is possible to make an appropriate response to each stop between poverty and disadvantage, and so constructs individual responsibility within an apparently socially located understanding of adolescent motherhood.

This 'cycle of disadvantage' provides one way of understanding the role of the individual in responding to social constraint. The science discourses described previously are drawn upon in the 'cycle of disadvantage' to determine who is problematic and requires intervention and who is unproblematic. The purpose of the cycle is to identify how problematic people are produced and break the cycle of this production process. This understanding to disrupt becomes a form of eugenics that continues to identify individuals who pose a threat to dominant social structures such as schools, public health initiatives, and economic participation. This set of criteria are used to determine who will best fit into current social structures and how to alter

individuals to enable them to fit rather than changing social structures to accommodate a range of people.

Solving Disadvantage by Individual Surveillance

As shown in this analysis, the health professional literature constructs the individual as responsible because of their inability to make the correct choices and appropriately utilise medical technology to curb early reproduction. This makes the 'correct' choice equally possible from a position of disadvantage. This indicates that some people are unsuccessful because the refuse to respond appropriately when it is possible to do so. This makes the individual responsible for their ultimately poor outcomes. Within psychological and medical sciences, the understanding of the individual role in reproducing disadvantage predominates. Historically, variables such as poverty and social deprivation have been studied as an alternative to explanations of individual responsibility for poor outcomes for populations. However, they are used in a different way here as the socioeconomic deprivation of adolescent mothers is used as a justification for discouraging early childbearing. Rather than suggesting that poverty should be ameliorated, this argument suggests that childbearing among the poor should be discouraged to avoid

> Continued social and economic disadvantage, parenting difficulties, and poor child health and development (Woodward, Horwood, et al., 2001, p.303).

Within this 'cycle of disadvantage', social explanations are revealed as a concern with a failure of the individual to adjust to poor social conditions and of pregnancy as an expression of that failure, a failure of the individual – not society. The health professional literature identifies social antecedents of adolescent pregnancy such as economic background, education, family composition, and peer experiences (Bleach, 1995; Woodward, Fergusson et al., 2001). These factors allude to concerns such as the distribution of and access to social resources, social roles, norms, subject positions and to the processes through which identity is constructed. However, individual experiences and individual adjustment to social constraint become the focus of prevention. Interventions required are those that 'normalise' responses and adjustments and therefore behaviours of the individual. This social understanding evades the effect that

examining actual social issues, such as access to resources and dominant values, could have on the dominant sense-making framework.

The argument concerned with managing individuals' social adjustment, relates to the dominant discursive concern with the transgression of social norms by individuals. Unsurprisingly 'anti-social tendencies' all emerge as 'risk' factors in the life path that may lead to becoming pregnant during adolescence (Woodward, Fergusson et al., 2001). The young person is identified as behaviourally non-conformist through scientific measures and their 'conduct disorder' identified through diagnostic criteria (Woodward, Fergusson et al., 2001). These tools are a strong strategy of warrant for labelling and managing a 'transgressing subject'. There are young people identified who experience all antecedent factors but who do not become pregnant. These 'successful' individuals are constructed as appropriately adjusting to behavioural norms while the least promising degenerate into further failure (Woodward, Fergusson et al., 2001).

The institutional practices and discourses that attempt to script adolescent behaviour are not always successful, as people are active in negotiating their identity within the available discursive resources. The adolescents that it generally fails to subdue are those for whom these norms of education and employment are least relevant. When the rewards of docility are seen as unavailable, the negotiation of an alternative subjectivity is viewed as more enticing and more relevant. As shown by the 'cycle of disadvantage', institutional practices that produce the 'docile body' of an educated income-producing worker make available the subject position of unemployed welfare dependent adolescent mother. At each turning point where the discursive alternatives to be appropriate exist, there is also an opportunity to resist these and take up an alternative subjectivity that provides different rewards and disciplines from the mainstream. Those adolescents who take up an alternative position from the mainstream and rebel from the appropriate use of such technologies of the self are disciplined and set out as outside the bounds of normal adolescent development.

Foucault provides an understanding of how surveillance by the state has developed into surveillance by family and self to ensure that the individual is constantly subject to control (Danaher et al., 2000). External governmental control has shifted towards the need for self-management. External control is not required for those who have

internalised the values and norms of the society and evidence for this is enact through the management of the body, in the case of adolescent motherhood, through reproductive technology. However, the promotion of self-management is problematic if individuals refuse to internalise the dominant values and norms of the ruling society. This creates a dualistic class system based on management and control. Those who take up and enact the forms of self-management escape the external management of those who would compel them to act in line with the wider norms and values. Those who refuse to make the correct choice indicate an inability to responsibly self-manage and instigate the requirement for others to take over this management. Self-management for those capable of making the approved choice is encouraged. Failure to make this choice indicates the requirement for surveillance to reduce the risk associated with the unapproved choice and the promotion of the approved choice as the only real choice available. Within the health professional literature, adolescent mothers' refusal to apply reproductive technology to avoid early parenthood is taken as indicative of a failure to follow the norms of adolescent development. This indication of disruption and deviance is then used to justify further monitoring and professional intervention.

This continues to locate the solution to the problem firmly within and of the person rather than in and of the society they inhabit and the primary focus is still for the opportunity to alter individual behaviours rather than social conditions that precede these behaviours. The 'natural' focus is on interventions with a goal of individual pregnancy prevention, manifest in a concern with safe sex or less sex. There is little room for interventions that accept adolescent pregnancies or address social conditions and resources. Social factors such as resource allocation and alternative life courses lie well beyond what an individual can be protected from through any prevention programmes. This leads to a lack of focus on what it is about particular social conditions that might lead someone to choose to have sex unsafely, or to become pregnant.

Family Responsibility for Socioeconomic Disadvantage

The 'cycle of disadvantage' is further used to construct the family as propagating disadvantage. The family has an important role in understanding the cycle of adolescent

motherhood, as they provide a social context that explains the development of deviance and disadvantage, and can be constructed as shouldering the blame and responsibility for poor individual outcomes for family members. Within the health professional literature the family is constructed as a group of homogeneous individuals who act in consistent ways. In this way, a 'family' can be assessed and improved in isolation from wider social structures.

The components of family life could be dissected and adjusted, as shown here:

> The results presented here show that women who were pregnant before 19 came from families which they evaluated as having significant problems. The features of their families were their nonnuclear composition ie, where the girl lived without her two birth parents for at least part of her life before she was aged 15, frequent parental rows, a family discipline style which included the physical punishment of the girl after the age of 12 and whether she had a confidante as a child. With the exception of the childhood sexual abuse involving intercourse, childhood sexual abuse itself did not predict adolescent pregnancy (Romans et al., 1997, p.32).

> Measures of family social background included: the age at which each respondent's mother became a parent; the type of family entered at birth; family socioeconomic status at birth; and the number of times a parent left or entered the family home as a result of parental separation, divorce, death, remarriage, or reconciliation from birth to thirteen years (Woodward, Horwood, et al., 2001, p.302).

These extracts show how "features" of families are constructed as if they can be broken down into their component parts to determine adequate functioning in a mechanistic sense. Types of family, socioeconomic status at birth, and discipline style are classified and used to predict the outcome of adolescent pregnancy. In addition, the impact of parental separation and reconciliation is able to be quantified by the "number of times" it occurs between birth and thirteen years. The family is not considered as a larger set of values, morals, and social obligations, but is seen as merely consisting of a number of components which can be added or subtracted to produce a more functional unit. This dissection of the family is used to determine the level of overall "family dysfunction" (Romans et al., 1997, p.32) that may predict later deviance.

In addition, the factors that were investigated can also be seen as reflecting dominant understandings of appropriate family formation. The 'appropriate' family is one that consists of a nuclear family structure where children live with their birth parents consistently until late adolescence and where physical punishment is confined to children. In addition, a child must have intimate childhood friends to achieve appropriate development. This dissection of the family is then used to illustrate the psychological harm that is visited upon young women who do not grow up in a family that conforms to the dominant social order:

> A picture emerges of a lonely girl lacking a confidante, living in a family with major discord between the parents, often in a reconstituted family (Romans et al., 1997, p.32).

This serves to reinforce the dominant social order as the one type of family formation that produces successful children who resist adolescent pregnancy. The measurement of psychosocial factors is used to paint a picture of adolescent despair and hopelessness that places the responsibility for adolescent pregnancy on the careless and potentially abusive parents who head "families with preexisting psychosocial problems" (Romans et al., 1997, p.30).

The family is viewed as both mechanistic and as emotive. The features of families are drawn upon to dissect those out of the mainstream families that contain dysfunction and then reassembled to illustrate the emotional damage these families inflict on their members. Romans et al. (1997) dissects the family of the adolescent mother into their component parts in the extract on the previous page and then uses this to construct the adolescent mother's family of origin as cruel, uncaring, and unsympathetic.

> A picture emerges of a lonely girl lacking a confidante, living in a family with major discord between the parents, often in a reconstituted family, where physical punishment is used on adolescents. The potential push to leave the family unit early suggests that the young woman may actively seek an intimate relationship which provides companionship, absence of major interpersonal disharmony and freedom from physical punishment to counterbalance problems at home (Romans et al., 1997, p.32).

> Pregnant teenagers have been described as "babies having babies, who desperate for love, family and a sense of belonging, find themselves caught up in a cycle of deprivation, early childbearing and further deprivation". Whilst these results are less impassioned, the themes are similar. Families at high risk for producing a pregnant adolescent daughter are those with unresolved family conflict and related parenting problems (Romans et al., p.33).

The family is dissected into its constituent parts: "non-nuclear composition", "frequent parental rows", and "physical punishment". However, this mechanistic construction is ultimately used to provide a "picture" of the adolescent mother. This picture is an emotional one, of a "lonely girl" seeking an "intimate relationship" free from the "disharmony" that characterised her harsh "reconstituted family". Separating aspects of the life course of women who become adolescent mothers are used to suggest that they are lacking emotional support and love. This constructs the adolescent mother as a poor victim of uncaring parents.

The construction shifts to focus on the adolescent mothers as parents providing a poor parenting environment, rather than as children suffering from a poor parenting environment:

> Given the combination of a problematic maternal childrearing history and current socioeconomic adversity, these women and children may be especially vulnerable to continued social and economic disadvantage, parenting difficulties, and poor child health and development. It is hoped that future studies of this cohort may provide opportunities to address these issues further by assessing the parenting family environments and life course outcomes of these high risk parents and their children (Woodward, Horwood, et al., 2001, p.303).

Here adolescent motherhood is constructed as the outcome of poor parenting and social environments or as a predictor of poor outcomes. This indicates the construction of adolescent mothers as children with the responsibility lying with their family for their "problematic maternal childrearing history". This is interesting and potentially discordant with the notion that the cycle will recur as the adolescent mother becomes a parent. When this occurs, she is no longer an object of concern and pity, but is a "high risk parent" who may cause "parenting difficulties, and poor child health and

development". The differential construction of responsibility provided for adolescent mothers reflects their position within the sets of rights and responsibilities available for children. Children, as the receivers of poor parenting, must be accorded pity and compassion. Parents, as the providers of cruel and uncaring family environments must be monitored and subject to intervention. Adolescent mothers have potential to reside within both of these positions, as deprived children and as careless parents. These two available positions are drawn upon to variously invite the reader to sympathise with the young mother for her poor upbringing or chastise her for her poor parenting. These inconsistencies highlight the incompatibility of the adolescent and mother positions. If one is an adolescent then one is subject to the cycle of deprivation and cannot be held responsible. However, if they are a parent, then they are positioned as perpetrators of the cycle who should be held accountable for the damage they visit upon their children. Neither of these positions sees the cycle itself as the villain, but those within the cycle. Within this construction, it is discordant to be at once an adolescent and a parent. This inconsistency parallels McDermott and Graham's (2005) observation that adolescent mothers are viewed as both a vulnerable group in need of support and as agents of social disruption. These two apparently contradictory aspects can be interpreted as the consequences of viewing adolescent mothers as either out of the mainstream mothers whose childcare practices produce social disruption, or as children whose unfortunate upbringing has damaged them. The cyclical understanding attempts to reconcile these apparent contradictions, but has little to say about the construction of blame and responsibility that are entwined within the notion of a 'cycle of disadvantage'.

Solving Disadvantage by Altering Deviant Families

This focus on families as the cause of dysfunctional outcomes provides an additional solution for ameliorating disadvantage, a focus on addressing family deviance:

> Those from socially disadvantaged family backgrounds characterised by parental instability and early exposure to young, single motherhood were more likely to become parents at an early age. This suggests that daughters of young single mothers may themselves be at high risk of becoming a young (and potentially single) mother. This highlights the importance of maternal role models in shaping a

> daughter's fertility choices and is suggestive of intergenerational cycles of early pregnancy/motherhood (Woodward, Horwood, et al., 2001, p.302).

Consequently, this draws attention to family intervention as the most productive method of altering the 'cycle of disadvantage':

> Adolescent pregnancy does not occur randomly in the community but was found in women who came from families with preexisting psychosocial problems. This suggests that preventive strategies aiming to reduce adolescent pregnancy should focus on measures which improve the general functioning of family units (Romans et al., 1997, p.30).

> If we wish to further reduce rates of teenage pregnancy in New Zealand, the influence of childhood family and individual factors on adolescent sexual risk taking may need to be addressed through the development of broad based interventions to assist at-risk children and break intergenerational cycles of poor social functioning (Woodward, Horwood, et al., p.303).

All of this is used to suggest that "prevention of early pregnancy in New Zealand needs to focus on the adolescent's family environment" (Romans et al., 1997, p.33). This ignores the role of poverty and wider social structures on explaining and maintaining disadvantage.

Focusing on the features of family also provides a way of explaining disadvantage that appears to be socially located. The family is drawn upon as a social institution, which attends to aspects of health that appear more than the individual. In practice, however, the family is treated in this literature as a static entity comprised of several homogenous individuals who experience the family in an identical psychological way. This is achieved though quantifying the features of the dysfunctional family, and through identifying those certain features of the family which place the members at risk. The components of the family are theorised as impacting on all family members in the same way and the features of families are transformed into personal attributes of each individual. The family is treated as a group of identical individuals rather than as a social system that impacts on individuals differently according to their social status, gender, and age.

Although this inclusion of a 'cycle' of disadvantage would seem to overcome the problem of considering the causes and consequences of adolescent motherhood as separate, it focuses attention on the fact of motherhood itself. The act of becoming an adolescent mother is foregrounded, rather than any consideration the 'cycle of disadvantage' may have on young people regardless of their parenting status. This is used to invite fear of problem people who will continue to cause problems into the future if they remain unchecked. The social regulation of children is based on the possibility of threat to the social structure that unregulated children pose to the welfare of the state (Rose, 1999). This is shown by the justification of interest in and surveillance of families 'at risk' because of their deviance and conduct disorder. The need to predict and control individuals provides the justification for increased surveillance and control over the family. This understanding of the culture of parenting is a blend of individualism and social structural explanations for disadvantage. Values, traits and expectations of the individual are understood as developing as a result of structural constraints. These values, traits and expectations are then transmitted from parents to their children (Seccombe, James, & Walters, 1998).

Conclusion

Using the example of adolescent motherhood I have illustrated how the notion of a 'cycle of disadvantage' that attempts to locate adolescent motherhood within a broader social and cultural context ultimately constructs the cycle as the outcomes of poor individual decisions and deviant family structures. The construction of the individual cause of adolescent motherhood draws attention to how it is possible to make an appropriate response to each stop between poverty and disadvantage. This constructs individual responsibility for poor outcomes within an apparently socially located understanding of health and health outcomes. Attention is focused on individual intervention as the appropriate response to poor health rather than social change. In addition, a focus on the role of the family in transmitting disadvantage suggests that deviant family structures damage innocent children who subsequently transmit disadvantage to their own unsuspecting children. Families are positioned as responsible for maintaining or avoiding disadvantage. Taken together, these two explanations for

poor outcomes mean that either the individual or the family is accorded responsibility for poverty and disadvantage. As such, wider social structures such as welfare provision, employment opportunities, and educational institutions are not implicated in producing and maintaining the 'cycle of disadvantage'.

CHAPTER IX.

STUDY 2: HEALTH PROFESSIONALS TALK ABOUT ADOLESCENT MOTHERHOOD

This study involved describing the discursive resources available to health professionals to construct adolescent motherhood in interviews.

Method

Participants

The participants in these interviews were 17 health professionals from the Manawatu/Whanganui region. The criteria for participation in this research as given in the information sheet were: "If you wish to take part in the study you should be a midwife, nurse, or doctor and working with teenage mothers" (see Appendix B). Further detail regarding participation was also given on the covering letter sent to later participants: "It is not necessary for your work to be focussed on providing health services for teenage mothers to participate in this study" (see Appendix E). This clarification was made to increase participation in the study. All but one of the participants was currently working with adolescent mothers; one had extensive work experience with adolescent mothers, but at the time of the interview had moved into another area of nursing. One of the participants was not a midwife, nurse or doctor, but had considerable experience providing antenatal education and education support for adolescent mothers.

The health professionals were five nurses, five doctors, six midwives, and one antenatal education worker. They worked for in private practice, at a large local medical centre, in a Family Planning Clinic, at a rural health centre, as a Plunket nurse, as independent midwives or as midwives in the hospital setting. All had worked with adolescent mothers in some capacity and most had considerable experience working with adolescent mothers. Their experience included providing targeted antenatal care and education for pregnant adolescents, providing general practitioner care in a practice with

a considerable number of young mothers, coordinating young mother groups, providing sexuality education for teenagers, and providing antenatal and postnatal care.

Research Procedure

Ethical approval for this project was gained from the Massey University Human Ethics Committee, Manawatu/Whanganui Ethics Committee and the Plunket Society Ethics Committee.

Information sheets outlining the study (Appendix B) were sent to private practitioners through an after hours service with which most private practitioners are affiliated. Information sheets were also distributed to the Public Health Unit and the Women's and Children's wards of Palmerston North Hospital, to a large local medical centre, a collective of independent midwives, a marae based health service, an iwi health provider, the student health service located on the university campus, and to a number of smaller rural medical centres in the Manawatu and Whanganui regions. The Plunket Society also distributed the information sheets to all Plunket nurses in the Manawatu/Whanganui area. The Manawatu/Whanganui region is a provincial area surrounding the cities of Palmerston North and Wanganui. The total population of this region is approximately 220,089 (Statistics New Zealand, 2003). There are more people of European ethnicity (85.1%) and Maori ethnicity (18.5%) in this area, reflecting less ethnic diversity than in the New Zealand population generally (Statistics New Zealand, 2003).

The health professionals responded to this call for participants by telephoning to discuss the study or to make an appointment for an interview. The original distribution of information sheets resulted in only seven participants. Following this disappointing number of responses, the information sheets were sent to named individuals at a number of medical centres. These names were obtained by telephoning local medical centres and asking for the names of all doctors, nurses, and midwives who worked at that medical centre. Following this, a personalised letter was added to all the information sheets sent out (Appendix E), and later a response sheet (Appendix F) and post paid return envelope was added to the information pack. This improved the level of response, and most of the later participants responded by returning the completed

response sheet in the pre-paid envelope indicating that they would be interested in participating in the study. Several health professionals mentioned others who might be interested in participating during their interview, and these people were also sent an information pack. All health professionals who indicated an interest in participating in the study agreed to an interview. The first interview for this study was conducted in November 2002 and the last interview was conducted in June 2003.

Interview Procedure

Each participant was interviewed and the interviews were audiotaped. The audiotape was turned on after the participant reviewed the information sheet and signed a consent form (Appendix C). Most of the interviews took place at the participants' place of work, two interviews were at the participants' home, and one was my office. Most of the interviews were 45-60 minutes long. Two of the interviews were conducted over two sessions, one week apart.

An interview schedule was produced, initially to obtain ethical approval for the project, and subsequently as a set of prompts for the interviews (Appendix D). This schedule was used as a starting point for the interviews; however most interviews followed the direction of the interviewee regarding their concerns or professional experience in providing health care for adolescent mothers. The interview schedule is itself a discursive practice. The questions and prompts represent one way of defining the parameters of interest in examining adolescent motherhood. Other questions could have been included, and as such would have resulted in different ways of accounting for adolescent motherhood. This is not to suggest that the interviewee passively responds to the discourses presented in the questions, but that the interview is constructed between the interviewer and the interviewee. The health professionals both responded to the discursive prompts of the interview schedule, and also resisted them, providing alternative ways of constructing adolescent motherhood. For example, the health professionals spoke about aspects of adolescence that meant that adolescent mothers had special health care needs. They also resisted this with the construction of individual differences in parenting ability among adolescent mothers.

The interviews were transcribed by a professional transcription service, which transcribed for words and punctuation only. Non-words such as "um" or "ah" were excluded from the transcript. Basic grammatical structures such as commas and full stops were added by the transcriptionist to improve the readability of the transcript. Potter and Wetherell (1987) suggest that excessive detail in a transcript may distract from the readability of the transcript, and Parker (2002) cautions against the tightening of transcription conventions as it may indicate an attempt to more accurately represent what was 'really' there, rather than being seen as a constructive practice. Following professional transcription, the transcripts were checked by the interviewer and then sent to those participants who had wished to check their transcripts. Any suggestions or corrections to the transcripts by participants were made. Some participants amended their transcript to make their speech more grammatically correct, and minor errors such as names of community programs were corrected.

Analysis

The interviews were read and coded, with most sections allocated one or more codes. In the interview analysis, not every sentence was coded, as often large tracts of speech were unrelated to the focus of the study. Also, often a whole paragraph would be assigned one code. This was very different from the very dense coding structure of the professional articles. These codes were developed to summarise the main idea, for example the code 'Teenage Characteristics' quickly developed from the discussions of the variety of attributes that were typical of adolescents. Following this initial coding, each extract allocated to this code was examined and grouped into one of the subheadings, such as physical health, cognitive aspects, and body image. Examples from each of these subheadings were selected to illustrate the rhetorical work that was being accomplished by describing adolescent mothers in this way. From these groupings the wider discourses were identified. The focus on the adolescents having particular shared characteristics was seen as part of a wider discourse of development, that was labelled the 'Developmental' discourse. The codes and their associated extracts were used as evidence to illustrate the broader discourses being drawn upon by health professionals in discussing adolescent motherhood.

Codes for the second stage of discourse analysis for this project were derived from the interviews and also codes were imported from the first stage analysis to deliberately compare those aspects which were important from the first stage. For example, biological constructions of adolescent motherhood were highly visible and very important in the analysis of the health professional literature. Consequently, these aspects were investigated in the second stage of analysis. Differences and similarities between the two analyses were also noted and discussed.

CHAPTER X.

ADOLESCENT MOTHERHOOD

This section will focus on two important discourses that were identified in the analysis that have been labelled the 'Developmental' discourse and the 'Motherhood' discourse. These discursive resources will be described with examples of how they were used by the participants. The intersection of these two discourses construct what it means to be an adolescent mother, and provide a particular position for women who are positioned as adolescents within the 'Developmental' discourse and mothers within the 'Motherhood' discourse. Examples from the data will be used to demonstrate how these two discourses were used together in practice to construct adolescents as 'bad' mothers. Finally the implications that this construction has for the health care of adolescent mothers will be explored.

'Developmental' Discourse

The health professionals commonly constructed adolescent mothers as 'adolescents' or 'teenagers'. That is, they used a 'Developmental' discourse to talk about young mothers as having a set of shared characteristics common to the developmental stage of 'adolescence' and which, in turn, determined their mothering abilities. Throughout the interviews, the talk was oriented towards the young mothers as 'adolescents' rather than as mothers. Although this was only one of the discourses that health professionals used to construct adolescent motherhood, it was the most often utilised across all the interviews.

The 'Developmental' discourse includes adolescence as a developmental category, which is distinguished from childhood and adulthood and described by one midwife in this way:

> Its that, I think its like, young people are on the back foot anyway because they're not children and they're not adults, they're that in between group and then to have

> something as huge as pregnancy there as well, its like, so isolating for young people, that's what I feel anyway (Nurse 4).

In the above extract, childhood and adulthood are seen as clear categories, and adolescence, although also a category to which people can belong, is seen as in-between. This membership of an "in between" group is not given the permanence of adulthood or childhood and is consequently seen as isolating. In the following extract, this separate category of adolescence is given more permanence but this stage is also defined by exclusion from those two other categories, childhood and adulthood:

> Teenagers are not adults and they're not children and they're really in their own development stage and that as a health professional, for me as a midwife if I have young women and care for them, then I need to take that into consideration (Midwife 2).

The adolescent is defined by the lack of position within the clear categories of childhood and adulthood (MacLeod, 2003).

The development from childhood, through adolescence, towards adulthood was described using the stages of developmental psychology as shown here.

> I think health professionals really need to keep in mind that they're at a developmental stage where they strive for independence or you know like, if you go by Erikson, they're trying to form their independence and of course so in that process they try, they have to cut the cord between the childhood where they were at, the child they were and then strive towards independence and become a fully fledged adult. So with that it means they want to be different, absolutely different than adults at times (Midwife 2).

Intertwined with developmental psychology stages were biological metaphors of needing to "cut the cord" of childhood as the adolescent becomes separate from their parents. They are also seen as developing towards 'leaving the nest' through becoming a "fully fledged adult". The use of these biological metaphors attributes developmental psychology with the factual basis of biology. This serves to distract from the culturally

constructed nature of striving for independence and differentiation from adults as they are compared to biological processes.

Positioning adolescent mothers as 'adolescents' focus attention on their position with a transitional stage from childhood to adulthood. The transition though adolescence was constructed as a normal part of the development of a young person and as a stage of life that must be traversed to achieve maturity as an adult. Although adolescence was seen as a time of difficulties, this development towards maturity was generally seen as quite separate from the maturing effects of life experiences such as pregnancy and birth. Thus, development through the stage of adolescence is a process of simply adding years to the young women's age, rather than negotiating particular life stages and skills. The health professionals described the development of adolescents as requiring only time, which would result in:

> Just the general maturity and confidence, quite different when you've just got a little bit, a few years under your belt (Nurse 3).

Although some participants said that individuals matured at different rates that were not directly tied to their age, the maturing effect of age itself was generally seen as paramount.

The health professionals used this 'Developmental' discourse, to construct adolescents as members of a group who share a number of cognitive, social, emotional and behavioural characteristics. Sometimes, the speakers expected the interviewer to understand and share the same cultural construction of adolescence. They often used explanations such as: "just a typical teenager". Often, additional descriptions of adolescent behaviour were offered:

> I think one of the reasons [they don't attend antenatal classes] is just being a teenager, I can't be bothered. I don't need it, that kind of thing, or just poor time management (...) Just again typical teenager behaviour like often smoking, drinking, partying, you know (...) it's just the normal teenage situations that you have to be aware of... (Midwife 4).

This speaker drew upon the shared understanding of what it means to be an adolescent to invoke an explanation of lack of attendance at antenatal classes, and then provided some specific examples of what it means to be an adolescent, to be lazy, disinterested, and disorganised.

In addition to this, becoming a mother was constructed as not altering the mothers' fundamental adolescence, as shown in the following quote:

> Just because they're having a baby doesn't make them grow into adults, and people, health professionals I think, think that, that if a teenager has a baby that she becomes the mother, that's true, but she becomes a teenage mother and so therefore she is still a teenager, she might have made one step a bit further onto adulthood and maturity, like maybe like with her peer set, just because the baby's there all the time and there's no way that she can't have, she has to do something with this other being there, but it doesn't mean she is, the self interest and self image and all that sort of stuff, it's still there, so when they parent, they parent differently than adults (Midwife 2).

This quote describes the young mother as unable to escape a certain level of maturity that motherhood brings: "there's no way that she can't have, she has to do something with this other being there", but constructs the adolescent mother as reluctantly dragged into this increment of maturity. Even given this, the quote constructs the adolescent as fundamentally developmentally unchanged by the process of motherhood. The statement shows that parenting by the adolescent is different from parenting by older mothers. This constructs the developmental life stage (adolescence or adulthood) as the most important determinant of the parenting.

Adolescence may be characterised by a number of difficult stages, but was a normal part of achieving development. The importance of seeing the stage of adolescence as normal is illustrated by the following quote:

> Well they're still, just because they become mums, they don't stop being teenagers. So they've still got the teenage tendencies, problems, whatever you like to call it, they've still got those things going on in their head, whereas people that are, mothers that are in their late 40s or so have been through the teenage years, they're

> quite passed it well and truly and they've got a different set of things that are concerning them at the time (Nurse 3).

The speaker is unsure how to characterise teenage issues and stumbles over "teenage tendencies, problems, whatever you like to call it". The word "tendencies" indicates something that is neither positive nor negative, just a part of a particular developmental stage. "Problems" characterises adolescents as having negative aspects. The indecision between these two descriptions is covered over by "whatever you like to call it", indicating that the speaker can call them whatever they would like, the issues at hand remain the same and are intimately entwined with adolescence. These difficulties or tendencies of adolescents are, however, normal for the adolescent, just part of adolescence.

Adolescent Characteristics

These interviews contained a prevalent construction of adolescents as members of a group who shared typically adolescent attributes, situations and characteristics. The health professionals often responded to enquires about adolescent mothers by stating that they were "just a typical teenager" or that they lived in "normal teenage situations", as shown in the quote below:

> Then there's just again typical teenager behaviour like often smoking, drinking, partying, you know (...) it's just the normal teenage situations that you have to be aware of (Midwife 4).

> Teenagers live by the seat of their pants; they don't think ahead generally (Doctor 5).

The characteristics, situations and attributes that were constructed as constituting a typical adolescent are outlined below. Not all of these attributes were drawn upon by all health professionals in this study, but together they form a collection of what it means to be an adolescent.

Across the health professionals' talk, an 'adolescent' was constructed as displaying poorly developed cognitive abilities. The typical adolescent was constructed as "distracted", "dopey", having a lack of foresight, and a short attention span as shown in the following quote:

> Midwife 1: The most striking thing for me is the concentration, that they don't have very long attention span yet. It's different for older women.
> Mary: Why do you think that is?
> Midwife 1: They're teenagers, distracted.

The distraction of adolescents is seen as inherent to this developmental life stage, just part of adolescence. The adolescents' inability to plan was seen as the cause of their pregnancy, their poor attendance at health visits and antenatal classes, and their haphazard approach to baby care. As one midwife stated:

> These youngsters, oh well, pregnant, baby, we'll have it to love and all the rest of it, but you don't think further ahead (Midwife 6).

A midwife used the following description of one adolescents' poor knowledge of the basics of baby care to illustrate her lack of common sense:

> You know, you do get some younger, quite young like we've had wee women, woman who didn't realise you had to feed your baby every four hours and sort of you know, 8 hrs later thinks the baby really really needs a feed. Oh! I'm meant to feed it? (Midwife 5).

This shows the adolescent's inability to know the most basic aspects of baby care. The health professional illustrates the adolescent's lack of knowledge not by saying "Oh! I'm meant to feed it every four hours?" something that a young woman could reasonably not know, but constructs the young woman as not knowing she had to feed the baby at all, a lack of knowledge that borders on the ridiculous and constructs the adolescent as dim-witted.

The typical adolescent was also constructed as possessing a number of socio-emotional characteristics. These included being self-centred, moody, insecure, irresponsible, unreliable, and having low self-esteem. The adolescent was also constructed as self-centred and self obsessed by the health professionals in this study. One midwife stated that health information needed to be provided in a way that acknowledged adolescent mothers' inability to prioritise their pregnancy and child over themselves:

> If you give advice say, it's very important you put it in a way so it benefits them, only them, because they're No. 1 in the world, so instead of saying well if you for example breast feed your baby will be really well off because it gets a lot of, the immune system is boosted say for the baby and it's really good because it will thrive, it is the best food for the baby. It's probably not going to make any difference to them. But if you say you're breast feeding and boy, your body will get so much better because you're doing it, it will make more sense and that's what they will grasp (Midwife 2).

This self centred approach to pregnancy and childcare is contrary to our notions of appropriate motherhood and was often contrasted to what would be of concern to an older mother. This midwife stated that the adolescent mothers' preoccupation with self and concern with aspects such as stretch marks and body shape rather than the health of her baby would seem ludicrous to an adult, but was just the way that adolescents were:

> Say we might have, I thought we'd talk about water birth tonight, but we get there, and altogether and everybody's talking and chatting and they're really concerned about their stretch marks, because it's to do with that image you see, they don't want to have stretch marks. It might mean that for an hour and a half which might be nearly the whole session or the whole evening, we've got to talk about stretch marks so they can voice their concern, they can voice, yes, their concern about their self image and actually feel supported in that, and then maybe right towards the end you can say, as a health professional, look, if you drink your baby drinks, so what are you going to do about that? And then the message might go in because they have actually dealt with the whole self image thingy. And so an adult might just think this is absolutely ludicrous because, so what if you've got stretch marks, it's much better for this baby to come out healthy, what can they do? Well that's

> just not how it works for young women, and we just need to understand that and change our way of providing the care for them (Midwife 2).

Adolescent concern with body changes are compared to the adult response and characterised as ludicrous in comparison to important issues such as a healthy baby. These concerns of young women are constructed as inevitable however, just "how it works for young women". This construction of adolescents as self-centred and "No. 1 in the world" constructs them as egotistical and less concerned about their babies than themselves.

Adolescents were constructed as obsessed with body image and body shape concerns. These concerns were considered as immature but developmentally appropriate. Many participants stated that this concern with body image was just "how it works for young women" and therefore inevitable.

> I think about pregnancy and I think about how, the discomforts of late pregnancy and how they moan about the aches and pains and how they hate getting fat and, I mean they're real cute, but quite unaccepting about what's going on, and quite disgusted really, quite disgusted about what's happening in their body changes and how that baby's actually going to come out of their body (Nurse 2).

The immaturity of the adolescents' body image concerns is particularly highlighted in the above quote by describing their concerns as "real cute". Their disgust at the physical changes and bodily process of birth is similarly unrealistic and immature. The quote above shows the young mother is not as concerned for the wellbeing of her baby, that their interest is focused on the physical changes of pregnancy, which they find disconcerting.

They are also described as suffering from denial when faced with pregnancy and naïve about pregnancy choices and resolution. Adolescent mothers were constructed as both idealistic and naïve. Although these are different characteristics, they were both seen as the antithesis of the more realistic older mother. The idealism of the younger mother was related to her positive attempts to parent her child better than she had been parented. Many health professionals applauded these good intentions, but stated that

good intentions were far from reality for many young women. The midwife quoted below had been describing the good intentions of many young mothers, but explained that these intentions were seldom the reality for young women and their children:

> They're so stunned by the whole thing, labour hurts, this baby's made me feel awful and maybe I've got stitches and the bloody thing cries at 2 o'clock in the morning and I just want to go to sleep. Um, and so no matter what those good intentions they have before, it does deteriorate rapidly (Midwife 6).

This shows that the unpleasant reality of childbirth and motherhood as overwhelming the young mothers' idealistic good intentions. The shock of labour and birth is viewed here as the turning point of reality, after which the situation deteriorates. Describing the baby through the hypothetical adolescent mother's voice as "the bloody thing" further indicates how health professionals attribute adolescent mothers as blaming their babies for the shock and pain of delivery. These difficulties are not viewed as part of a transition to motherhood that may be difficult for women in general, but as a shocking introduction to reality for the naive but well intentioned adolescent mother.

Adolescents' dubious lifestyle priorities were also mentioned by a number of health professionals. These related to different financial priorities, prioritising outings over attending health visits, and concern for clothing and image above practicalities. The following quote indicates the different set of priorities of a younger mother:

> I have a young mum that's 14 who, she could bath a baby brilliantly, the physical cares were excellent, but her main objective for a particular duty, having just given birth was she wanted to watch the Saturday night Colgate feature on TV, that was her priority. And I thought well actually love you've got a wee baby, and it may not fit (Midwife 5).

Financial priorities were also highlighted as deficient, as in the following extract where a midwife describes adolescent mothers as having enough for lotto tickets, smoking, and spending extravagantly on gifts while their family has insufficient food.

> They haven't got the money, and finances has become an issue. But there are things um, for a lot of these kids the smoking and the lotto ticket and everything

> else are far more important than things for the baby. And then when they get pregnant their friends will come in with these exotic, exotic toys that cost an absolute fortune, and their family's missing out on food because they're not, they're buying the flash things that you see on television (Midwife 6).

The immaturity of these poor financial priorities are also highlighted by the young mothers choosing to spend their money on toys that have been seen advertised on television. The adolescent mother is positioned as a child unable to avoid the enticing advertising of toys, but is placed in the position where her poor priorities cause want for her unsuspecting family.

The typical adolescent was also described as prone to poor eating habits, risk taking behaviours, an active social life, and risky living situations. The adolescent's nutrition during pregnancy was the subject of comment by many of the health professionals in this study. Generally adolescents were suspected of having very poor diets that consisted of many cheap and convenient takeaway meals, as indicated in the following quote: "Teenagers eat a lot of takeaways and muck and you know" (Nurse 5). The teenagers' poor diet was variously attributed to a lack of knowledge, a desire to maintain a social life with young friends and a desire to avoid putting on weight during pregnancy. The nourishment adolescent mothers provided for their children was also seen as less than ideal, as described here:

> They didn't have the fundamental information on what is a good diet for my baby, is it okay to give my baby Milo in a milk bottle, a bottle for their milk, is it okay to give my baby a king size Mars bar for breakfast as well as some Cheezels (Educator).

Part of the construction of 'good' motherhood is the provision of a healthy diet for the baby, and for the mother herself during pregnancy to provide optimal growth for the baby. Many health professionals indicated the ways that adolescents did not ensure that they or their children received an adequately nutritious diet.

Adolescents were also seen as socially gregarious, requiring sustained peer interactions and an active social life:

> Well if they're getting around a bit, you know like getting out and about which is what all young teenagers like doing, they like getting out and about and going out to this and going out to the next thing (Nurse 3).

> The fact that they don't actually want to be tied to these kids, they want to, they still want to go out with their friends and play and do all the things that teenagers should be doing (Midwife 6).

This last quote emphasises that this was seen as necessary behaviour for adolescents, what they *should* be doing.

> And after the first week she decided, I'm bored [laugh]. In fact, I want to go back to work. I don't find it much fun looking after this baby. And she started going out at night for long periods of time and of course that's when her mum got involved again and kept phoning me and saying you know I'm really worried about her, that she's not looking after the baby, that she lets him cry, she just feeds him and she puts him down because she's bored with him, and she's, there's so much dressing and undressing you can do (Midwife 3).

The above quote shows that the adolescent mother is constructed as a child playing with a doll; when she becomes bored she wants to toss it aside. Childcare is seen as not engaging for an adolescent and the dressing and undressing of a child is like a doll. Describing the care provided by the adolescent mother in this way means that when the young mother does interact with her child she is constructed as merely engaging the child as an inanimate object. When she does not provide this care she is viewed as having bored of the game. Within this set of possibilities, the adolescent cannot be constructed as a mother who is genuinely responding to her child with interest and affection.

Adolescents were attributed with one positively regarded aspect, good physical health; they were described as being beautiful, dynamic, and energetic. Many participants described adolescence as a good time for childbearing physically, with easy birth and recovery and healthy babies. In addition, adolescent mothers were often constructed as very capable of undertaking the physical care of children, with good skills and more

energy and patience than some older women. As indicated in the following quotes, adolescence was seen as a healthy time for most young people, and this health extended to the health of their babies.

> Usually teenagers are healthy, strong people who grow pretty healthy babies (...) usually they've got, they're healthy, they're very young, very forgiving bodies (Midwife 4).

The physical health of the younger mother was often related to the energy of youth, as shown in the following quotes:

> Not all of them [older mothers] are that great either, and then of course they don't have the patience and the energy that a young mum has (Nurse 5).

> I looked at some of these, and they're beautiful. Often they don't know they're beautiful, particularly the young girls, like, they'd be stunning in their pregnancy like their skin and they'd often have a glow around them that the rest of us just envy so much (Nurse 1).

Adolescence was also described a physically a good time for childbearing, and this was often illustrated by an easy labour and birth.

> But as a rule they're, they're reasonably, they cruise through these pregnancies and a lot of these teenage mums have a very good labour and actually birth quite quickly (Midwife 6).

> I think physically we were made to have children younger and I do honestly believe that and I think that looking at women who have children later, it's physically very hard on them (...) So I think energy wise we were supposed to have them younger (Nurse 1).

> They bowl along and they turn up in labour and have the baby and, they're certainly, physically, I think that they have babies very well and most of them jump up off the bed really quickly afterwards and they get on with their lives basically after, physically (Midwife 1).

The physical aspects of adolescence were separated from the other aspects, which may pose more difficulty for adolescent mothers. Twice in the quote from Midwife 1 above the speaker stresses the physical capability of the adolescent mother in order to suggest that they may not be as capable in other areas. This is particularly shown when the speaker states "they get on with their lives basically after, physically" to ensure that the listener understands that they are not able to get on with their lives in other ways following the birth of a baby. This construction of physical capability contradicts some of the health literature that draws attention to the obstetric complications faced by teenagers.

Many adolescent mothers were also described as very capable of providing the physical care the baby required.

> I've met some wee women that I have to say put some 40 year olds to shame with regards to common sense and practical skills of looking after a baby. I have a young mum that's 14 who, she could bath a baby brilliantly, the physical cares were excellent (Midwife 5).

Adolescent mothers are constructed as physically capable of baby care, and a comparison is explicitly made between the care by an adolescent mother and that of an older mother, in this case a 40-year-old. Again, the above quote goes on to suggest that other aspects of baby care could prove problematic, but that ability to carry out the physical care was within young mothers' capabilities.

In summary, adolescence is seen as a necessary and normal part of development, but a time when adolescents are seen as self centred, naive, image conscious, sociable and healthy. The result of this is a construction of adolescents as physically capable but intellectually and socially immature. These traits were seen as aspects of adolescence that would be resolved with time and maturity. This construction of adolescent mothers as first and foremost adolescents, means that their behaviour is critiqued as the behaviour of adolescents, not as mothers. Therefore they are criticised on the basis of their youth and any deficits in parenting behaviour are attributed to their youth.

The behaviours described above as teenage characteristics can be understood as universal; it is possible for men and women of all ages to display the characteristics described by health professionals as signs of adolescence. For example, aspects such as priorities vary considerably among individuals yet, poor priorities are seen as a hallmark of adolescence. Similarly, concern with body image and ability to plan are characteristics that are not solely adolescent. Health professionals also characterised older mothers as interested in planning pregnancy and interested in reading about pregnancy, aspects that were seen as wanting in adolescent mothers.

The health professionals rhetorically manage the judgement of adolescent mothers by attributing it to 'adolescence' rather than to individual failing. It is clear from the quotes that the way adolescents behave is a result of adolescence, and is consequently not something that can rightly be held against them. In one way this frees adolescent mothers from individual responsibility for their actions, as they are constructed in their mothering as doing only what any normal adolescent wants to do: socialising, eating junk food, and obsessing about their body image. However, this also denies them respect and confidence as mothers, as they are ultimately constructed as adolescents who cannot be expected to behave as proper mothers.

Developmental Theory

Developmental theory pervades health professionals' understandings of adolescence, providing the framework they use to understand and assess adolescent mothers. The basis of mainstream developmental theory is that psychosocial development occurs over the lifespan in universal stages. Development progresses as the individual masters specific tasks that are relevant for each stage of life. Adolescence is viewed as a transitional stage between childhood and adulthood that prepares the person for adulthood (MacLeod, 2003). Erikson's stages of development for early adolescence include physical maturation, formal operations, emotional development, peer group membership, and heterosexual relationships. The tasks of later adolescence include autonomy from parents, sex role identity, internalised morality, and career choice. The appropriate mastery of each stage is viewed as necessary for ongoing development and failure to master a particular developmental milestone results in a developmental impasse which will resurface and undermine the mastery of subsequent life stages

(Chatterjee, Bailey & Aronoff, 2001). Within developmental theory, these stages of development are viewed as separate from life events such as motherhood. As Flanagan et al. (1995) state irrespective of individual differences "it is clear that adolescent mothers are adolescents first. Motherhood does not confer adulthood, nor does motherhood necessarily hasten developmental progression" (p.276).

The assumption of the life span model of development is that the trajectory of development is universal, and this model of development fails to attend to experiences of diversity and culture. Chatterjee et al. (2001) suggest that individual development is based on the cultural variation of the society. Their research suggests that the more technologically complex the society, the more prolonged the adolescent phase of development. Further, there are differences in the social construction of adolescence *within* societies: the more technological management within the group the longer the adolescent role. It is suggested that richer communities and richer nations have a prolonged period of adolescence as it takes longer to acquire the necessary knowledge structures to maintain their place in society. What is defined as expected and normal within mainstream privileged communities may not be relevant for marginalised community members. The stage of adolescence in particular has not been widely investigated as culture bound, but the utility of the concept has been applied across a range of cultures and social groups (Chatterjee et al., 2001). These authors highlight the importance of these differences for groups that are culturally different from the mainstream and identify Māori as one of these groups for which the concept of adolescence may not reflect that of the dominant group. The biological and social roles of adolescence vary according to the social structures of the society and communities

The health professional literature draws strongly on the framework of developmental psychology to characterise adolescent parents. Age and stages of maturity are assumed to play a crucial role in explaining parenting among adolescents. Within health professional literature and the interviews with health professionals there was a repetitive theme of the requirements of adolescent development and fundamentally incompatible with parenting, and the attempt to combine parenthood with adolescent development will inevitably result in sabotaging either the adolescent or her child's development.

'Motherhood' Discourse

An important resource used by the health professionals was a 'Motherhood' discourse. The 'Motherhood' discourse includes the prescription of certain behaviours as appropriate for mothers, and of others as inappropriate. The discourse provides a variety of subject positions such as a 'good' mother or 'bad' mother, 'adolescent' mother, or 'older' mother, and accordingly, women may be positioned, or position themselves by displaying the behaviours which belong to each of these categories.

The following extract uses an ideal situation for childrearing to contrast with the deficient situation that the adolescent mother raises her children in. The ideal involved a "devoted couple" who is well beyond adolescence and raises their planned and adored child in a loving relationship:

> I think planned pregnancy, 30 yr old parents, in their 30s parents, totally devoted to every little move little Johnny makes, photographed at right, left and centre, support each other, best thing they've ever done, loving relationship. Quite different to how teenage mother's bringing up her kids (Nurse 2).

Although this characterisation of the difference between the adolescent mother and the devoted couple is drawn upon to highlight the deficiency of the adolescent mother, the speaker immediately continues on to describe the adolescent mothers situation as not necessarily negative for her child:

> Not necessarily a bad thing, not necessarily a bad thing, perhaps the child will be far more resilient. The, certainly though, the love that the teenage mother feels for her baby, especially in the first year is exactly the same as the love that that devoted couple feel, so you couldn't compare the affection in that first year from either, I would say it would be on a par that would be my opinion. Possibly it starts to deteriorate after that. As the child gets older and gets a mind of its own, the couple that have the support and the money of each other are going to go down a different road than maybe the teenage mother who's trying to find herself, yes, I think it starts to deteriorate after the first year. Not always, but often (Nurse 2).

Throughout the interviews many health professionals drew upon a similar understanding of the differences in the mothering of adolescents and older mothers. Attention was often drawn to the young mother's love for her children and bonding with them. The love and attachment with her baby was seen as equivalent to that of the older mother, but other psychological and social factors were seen to impact on the health and development of the child. The health professionals understood adolescent mothers as capable of the most basic aspect of 'good' motherhood, love and bonding with their babies. These aspects can be seen as reflecting motherhood as a basic natural instinct that is attached to physical motherhood (MacLeod, 2001). This separation of 'good' motherhood as a skill compared to a natural process is highlighted in the following extract:

> Because they're young and so, it's not something that comes, parenting skills don't come naturally, you have to be taught parenting skills, I mean there are obviously, you feel for your child because you're a parent but apart from that you need to learn those parenting skills (Doctor 4).

The natural feelings of bonding towards the child are taken for granted, and as the minimal requirement for adequate motherhood, as "obviously, you feel for your child because you're a parent", but this is separated from the skills that must also be learned to qualify as a 'good' mother. The adolescent mother is constructed as possessing the feelings that any mother would feel, but does not have sufficient skills and abilities to qualify as a 'good' mother. This lack of care provided by adolescent mothers is described here:

> The kids, the babies are a worry and the toddlers you see them, they need, actually some of them I'd like to give them a good bath and brush their hair and give them a feed and put them in clean clothes and take them home and out of there, but you can't take them all home (Midwife 6).

The midwife above describes that neglect that some children suffer at the hands of their adolescent mothers. This neglect is focused around ideas of cleanliness and the mother failing to maintain a basic level of care. The positioning of the adolescent mother as a 'bad' mother is achieved through the comparison with the midwife herself, as she stands

in for the 'good' mother and 'good' home that these children lack. The midwife epitomises the professional mother who cares appropriately for children and wishes to save these neglected children from their careless mothers. These understandings of adolescent mothers as lacking parenting skills is in contrast to the previous section where adolescents were viewed as capable of the physical care of the baby but had other developmental attributes that made them incapable of being 'good' mothers. These can be seen as deployed in different ways to highlight the areas of ability and inability that characterise the young mother.

Most constructions of 'good' motherhood in the health professionals' talk was illustrated by examining how adolescent mothers deviated from the attributes of 'good' mothers, or how they differed from older mothers, (who were usually automatically attributed with 'good' mother status). The 'good' mother is the unseen backdrop against which the adolescent mother is the pathologised other (MacLeod, 2001). The following quote shows how the adolescent mothers' behaviour was used to describe an alternative 'good' mother position:

> They, well, they'll either go absolutely overboard and just the kid's lugged around the whole time, which doesn't do baby any good at all because they actually need a fairly placid, peaceful existence to begin with. Or else they, "Oh, I've got a baby there, I suppose I ought to feed it, it's crying", um, they don't, I mean think like lets get and sort of vaguely have a routine in our lives, and go out and go for walks and think about food and rather than just diving down and getting fish and chips and, they don't sort of think about the whole family thing because maybe they haven't been in a family thing (Midwife 6).

This quote shows how the 'good' mother is contrasted and defined by the 'bad' mother's behaviour. The 'good' mother does all those things that the young mothers described here do not. In general, 'good' mothers were viewed as attending to the child's needs first and placing their own needs second. Here, this is shown by the young mother either lugging the baby around or alternatively, reluctantly caring for the child at all: "I suppose I ought to feed it". The quote also implies that the 'good' mother eats a nutritionally adequate diet, during pregnancy and after, to ensure good health, unlike the diet of takeaways and packet meals of the 'bad' mother. Convenience foods

and lifestyle were seen as incompatible with the appropriate situation for raising a child, that is, within an intact nuclear family structure that involved preparing meals at home, restricted social life, and a structured routine.

Other characteristics of the 'good' mother included the expression of emotions such as pride in pregnancy and parenthood, and joy in motherhood. Being interested in reading about and planning pregnancy was also seen as an important part of 'good' mothering. Some health professionals indicated that older mothers had considered what sort of mother they would like to be and this planning was seen as an important aspect of 'good' mothering.

> They haven't read much, they haven't experienced many other friends with babies, because when you're in your 30s or whatever you've seen quite a few kids around and you think well, and you've seen different situations and you think well, I'm not going to do that with mine (Nurse 3).

'Good' motherhood involved speaking to the baby, and stimulating the baby's development. Part of this care also involved having realistic expectations of the child's development and responding accordingly. The appropriate response included being able to administer appropriate discipline that was sensitive to the child's stage of development, and did not include smacking, speaking harshly to the child, or ignoring the child. Appropriate language use around the child was also seen as part of 'good' motherhood. How adolescent mothers may respond inappropriately and call the child names, was shown in the following extract:

> Like the difficult 2 yr old or, and you hear such and such, she's a little shit, or the bitch, she's such a bitch today, we're only talking about an 18 month or a 2 year old, well they're just not, but it's not like that. So you have to cringe when you hear that language and you just think how are we going to turn this around? (Nurse 2).

The nurse views words such as "bitch" or "little shit" as inappropriate when applied to young children, and their usage is used as a marker to identify the 'bad' mother. In the extract above, the nurse cringes and wonders how this situation can be turned around.

As such, this nurse shows that the inappropriate language is not viewed as merely descriptive, but is used as a marker for other inappropriate parenting behaviour that must be remedied. The language is viewed as indicative of problem parenting and the use of these words towards small children precludes the adolescent from being positioned as a 'good' mother. The meanings of these words are not viewed as situated, but as reflecting an inherently flawed understanding of childhood as "it's not like that". The nurse is positioned as knowing the true nature of the child. The adolescent mother is positioned as lacking knowledge, and this lack of knowledge creates risk for the child.

Financial security was also seen as an aspect of 'good' motherhood and financial constraints were implicated in adolescent mothers being unable to achieve 'good' motherhood. The notion of financial security was often introduced subtly and reflected understandings of the appropriate mother not needing to be the major family breadwinner. In the following extract the adolescent mother was not able to manage the tasks of 'good' motherhood because her poor employment opportunities would mean that she was unable to spend time reading to her child:

> I mean a young woman whose best hope is to be a cashier or something like that, she's going to be earning little money, she's going to have little time on her hands. How's she going to bring up her child? How's she going to have the time to sit the child on her knee and read it stories and all that sort of thing without having the background you know of a family home where the children have got security. She won't have that (Doctor 2).

Although the speaker draws attention to the adolescents' poor occupational prospects as leaving little time for children, it is unclear how good education and employment prospects will increase her time with her children. Consequently, to be positioned as a 'good' mother, she needs to be financially dependent on a partner who is capable of providing a family home, leaving the mother free to spend time with her children. This financial dependence of the mother allows the family unit financial independence from the state, and so avoids the positioning of the mother as a 'bad' mother through welfare dependence.

Motherhood and Social Class

These aspects can all be seen to reflect one sort of motherhood – that is middle class motherhood among educated women. Such women can be expected to read about and plan pregnancy, to take pride in their developing pregnancy and the positive response that they receive to their pregnancy. Having access to the norms of appropriate development and the current professional wisdom on appropriate discipline, they are likely to respond to their children in ways viewed as positive. Motherhood in this group has meaning in a particular way that it does not for poor working class women under 20. Many of these young women are not planning pregnancy and consequently have not considered the type of parent they intend to be. They do not see motherhood as something that must be undertaken only after they have reached maturity, but as a route to maturity and adulthood (Davies et al., 1999). In addition they may read little and see motherhood as a natural and spontaneous role that they will develop (Abel et al., 2001) rather than a set of correct behaviour and principles that must be mastered.

As such, the 'good' mother is as much who she is as what she does (Chase & Rogers, 2001). The 'good' mother is a White, middle class, married, heterosexual. MacLeod (2001) argues that the literature on adolescent parenting relies on the invention of 'good' mothering. The characteristics of the 'good' mother are the taken-for-granted assumption that the discussion of adolescent motherhood is based upon. The relationship between the mother and child are foregrounded and the wider structural relations are obscured (Burman, 1994).

Hays (1996) describes the methods of appropriate child rearing among middle class women in paid work as "child-centred, expert-guided, emotionally absorbing, labor-intensive, and financially expensive" (p.8). This description may be in contrast to the lives of adolescent mothers and their views of childrearing. Although not all adolescent mothers are members of the lower classes, they are disproportionately likely to be lower class. These class differences are likely to impact on the evaluation by health professionals on the adolescents' mothering. This reflects an on-going colonisation of working class by middle class values of development and motherhood. This is justified by suggesting that these values are good for the working class, and will allow them to achieve a stage of better development. The examples modern mothers provide of what

it is to be a 'bad' mother indicate this simpler style of parenting (Hays, 1996). Intensive mothering is viewed as 'good' mothering whereas simple parenting is seen as inadequate.

Adolescent Mothers

The consequences of combining the 'Developmental' and 'Motherhood' discourses to construct adolescent mothers were: First, these discourses offer positions that are potentially contradictory because the behaviours attributed to adolescents are not those appropriate for mothers. Second, adolescent mothers were constructed primarily as adolescents - as dopey, distracted, self-obsessed, and image-conscious - which meant that young mothers were most likely to be positioned as 'bad' mothers on the basis of their age alone. Third, this primary positioning as adolescents in a life stage discourse meant that their subject behaviour in general was most likely to be constructed as that of a 'bad' mother. Thus, the contradictions in the two discourses were often used to position adolescent mothers as 'bad' mothers in the health professionals' talk. These three aspects of the analysis are illustrated in turn below.

The subject position of an 'adolescent' in a 'Developmental' discourse does not fit well with the subject position of mother, and the health professionals often attempted to make the two different positions clear. One nurse explained:

> Well they're still, just because they become mums, they don't stop being teenagers. So they've still got the teenage tendencies, problems, whatever you like to call it, they've still got those things going on in their head, whereas people that are, mothers that are in their late 40s or so have been through the teenage years ...and they've got a different set of things that are concerning them at the time (Nurse 3).

Separation of the adolescent mother from the adult mother is achieved here by comparing adolescents with much older mothers in their late forties. This comparison emphasises the different concerns of these groups who are separated by 25 years of age because the same gulf of separation may not be as apparent if adolescent mothers were compared to mothers in their twenties. One reason that such extreme comparisons must

be used is that, although child and adult are very clear subject positions, adolescence does not always have the same well defined status. It has unclear boundaries that are further confused by the addition of motherhood status.

The separation of the adolescent mother from the older mother is also achieved when it is shown that the adolescent mother cannot cope with the demands of motherhood that would be commonplace for the older mother. In the following quote the midwife explains how difficult coping with two children closely spaced would be for the younger mother and concludes that this level of demand would be untenable for the young mother.

> And the ones that I have been involved they've found it really really difficult and the baby had to be adopted out or given to somebody else to care for: it's just very difficult (Midwife 2).

However, having two children closely spaced is commonplace among adult mothers and is unlikely to be viewed as a difficulty and not considered as grounds for adoption. The doctor quoted below also concluded that closely spaced children were particularly problematic for the younger mother:

> It's hard enough bringing up one child, and it's hard enough bringing up one child with a partner, it's really difficult. Without support and without, and then if you want two or three children it's, things go wrong shall we say (Doctor 3).

The doctor here suggests that more than one child would be very problematic and concludes with the very vague warning that "things go wrong" to suggest that unspeakable and unpredictable difficulties will befall the young mother with more than one child. Also, the doctor above has already categorised the adolescent mother as single and unsupported and this unquestioned categorisation is drawn upon to justify the outcome that "things go wrong". It is not clear whether the youth of the mother is the cause of these outcomes or the assumed single status and lack of support, and ultimately it does not matter, as the speech works to construct the adolescent mother as teetering on the brink of tragedy. These quotes are also used to separate adolescent mothers from older mothers and suggest that normal life course progression such as having further

children is not possible for the less capable adolescent mother. In this way, the same practice is viewed very differently for an adolescent mother compared to an older mother.

As the young woman was positioned primarily as an 'adolescent', then her behaviours were ascribed to this primary positioning. 'Adolescent' behaviours are not appropriate to 'good' mother behaviours and so the adolescent mothers were positioned as 'bad' mothers. The adolescents were constructed as self obsessed and less concerned about their babies than themselves. Health professionals talked about the concern with body image, young mothers' desire for social activities, and their ignorance about nutrition, as attributes that were detrimental to parenting. Such a self-centred approach to pregnancy and childcare is contrary to our notions of appropriate mothering and this was often explained by using the contrast with the concerns of an older mother. For example, one participant stated that the adolescent mother's preoccupation with self and concern about stretch marks and body shape rather than the health of her baby would seem ludicrous to an adult, but this was just the way that adolescents were.

Much of the positioning was achieved by comparing adolescent mothers to older mothers. The older mother was positioned compatibly as both the 'adult' and the 'good mother' who makes responsible choices for her child.

> I think sometimes their priorities are, yeah, different, you know, they're concerned about I suppose like clothing, the baby has to have the right pram and the right clothes, but perhaps she doesn't have the best accommodation or um yeah, that's all, that image is all important for them and an adolescent that's quite true, but perhaps there are other things that perhaps we would see as being I don't know, you know, say a 28yr old may not see the importance of having nice baby clothes where she thinks perhaps the accommodation they live in and the amount of food that they get is more important (Midwife 5).

The quote above shows how the speaker is working to achieve a non-judgmental approach to adolescent mothers parenting whilst trying to suggest that their priorities may not be ideal. The speaker begins by suggesting that prioritising nice clothing over accommodation needs is typical for an adolescent and "that image is all important for

them and an adolescent that's quite true". After acknowledging the importance of image she attempts to suggest that the ordering of priorities may not be ideal, not by stating this outright, but by comparing it to the choices an older mother might make. The speaker shows this tension by beginning this comparison with "but perhaps there are other things that perhaps we would see as being I don't know, you know," and appears to feel uncomfortable as a member of the judging "we" in this sentence. To overcome this dissonance between a desire to be neutral about the choices of adolescent mothers and a desire to illustrate the different approach of an adolescent mother, the speaker moves from "we would see" to a more distant "say a 28yr old may not see". By illustrating the different choices of an older mother, the speaker achieves the comparison she was trying to make without making the apparent judgement of the adolescent mother: "a 28 year old may not see the importance of having nice baby clothes where she thinks perhaps the accommodation they live in and the amount of food that they get is more important". It is, after all, not the speaker suggesting that these choices are inappropriate, but the comparison with the hypothetical 28-year-old mother. And it is impossible to disagree with the 28-year-old mother that prioritising accommodation and food, two basic necessities of life, over the frivolous concerns of appearance, is the correct choice. This comparison of older mothers and adolescent mothers was often made either with women of a specified age, as above, or by comparing the adolescent mother with a "more mature woman":

> Whereas a more mature woman knows that the baby's there and has to be the first, you know, has to take the first preference or priority and she wouldn't be looking at having a night on the town, that type of thing (Doctor 4).

Again the older mother is constructed as a woman who makes the right choices, and wouldn't be looking to engage in social activity at this time. Health professionals indicated that adolescent mothers behave as 'adolescents' and consequently do not make behavioural choices compatible with 'good' motherhood.

The main implication throughout these descriptions is that the normal stage of 'just being a teenager' is largely incompatible with the 'good' mother position. At times this point was made explicitly, such as when the social activity of adolescents was seen as detrimental to the development of routine and good sleeping habits in young babies. At

other times the talk drew upon the socially available position of the 'good' mother (or at least, one social group's version of the 'good' mother), to illustrate how adolescents deviate from these practices. The primary subject position of 'adolescent' was made compatible with the position of 'bad' mother within the 'motherhood' discourse. The health professionals often did not explicitly describe what it means to be a 'good' mother, but drew upon the shared notion of appropriate motherhood to contrast the mothering of adolescents. In addition, they are not constructed as 'good' or 'bad' mothers, but as 'adolescent' mothers, mothers for whom adolescence is such an inevitable aspect of their functioning that their adolescence is always at the forefront of their motherhood.

Because the young mothers were primarily positioned as 'adolescent' on the basis of their age, any of their behaviours were more likely to be interpreted in terms of this 'adolescent' subject position. This resulted in some anomalies in the descriptions. For example, the behaviours attributed to 'good' mothers included pride and pleasure in pregnancy and parenting, but only if the mother was an adult. In contrast, adolescent pride and pleasure was constructed differently. Health professionals said that many young women responded with pleasure at the thought of a pregnancy, even if the pregnancy was unplanned. However, this enjoyment was described as a naïve and immature reaction that failed to acknowledge the hard realities of parenting:

> Some, the younger women tend to get all clucky and if they want to carry on this pregnancy, it's lovely and the scan was gorgeous and nobody sort of seems to take on board that this is going to be you know years of broken sleep and years of not being able to go out, years of dirty nappies and so on and so on and so on, they think it's wonderful, they think it's like ... It's immature, I mean these are immature people, they have an immature reaction to it (Doctor 3).

This construction attributes naivety and idealism regarding parenting to adolescents and implicitly suggests that maturity will cure women of these unrealistic views of parenting. Yet this same joy in motherhood is seen as a requirement of the 'good' mother when combined with adulthood. Although this happiness is viewed as a requirement of 'good' motherhood in older women it is viewed differently here.

> I understand that some young girls are quite happy with the idea of being pregnant, um, and perhaps its more the idea than the reality that they're happy with (Doctor 5).

This level of happiness is evidence for the young mothers' lack of understanding of the reality of motherhood. The adolescent mother who shows evidence of happiness in pregnancy that is usually attributed to the older mother is merely being unrealistic. It is not possible for a young mother exhibiting pride and happiness in pregnancy to position herself as a 'good' mother. To show positive feelings towards her pregnancy positions her negatively as being unrealistic about the demands of pregnancy and childrearing.

A positive attribute often ascribed to adolescent mothers was their ability to provide the physical care the baby required. Their youth and health were seen to contribute to good births, and their energy and practical abilities often surpassed those of older mothers. Nevertheless, their adolescent behaviours continued to deny them the 'good mother' position. The following quotes work towards the condemnation of younger mothers on the basis of adolescent taste in TV shows, or desires for a night out, despite good practical mothering:

> I have a young mum that's 14 who, she could bath a baby brilliantly, the physical cares were excellent, but her main objective for a particular duty, having just given birth was she wanted to watch the Saturday night Colgate feature on TV, that was her priority. And I thought well actually love you've got a wee baby, and it may not fit (Midwife 5).

> So, and caring for them in the sense of say bathing and clothing and things like that, I think probably, no, I think its more, its not that they get neglected from that point of view, its more that you know that a 16-17 year old has, wants to go out and have fun... Whereas a more mature woman knows that the baby's there and has to be the first you know has to take the first preference or priority and she wouldn't be looking at having a night on the town, that type of thing (Doctor 4).

In another extract a nurse begins by describing the adolescent's need to "get out and about" as detrimental to mothering in that it interferes with a feeding and sleeping pattern:

Nurse 3: If you're going to be carrying a baby around town all day, you aren't going to get it into any sort of a pattern without, not talking about a structured routine, but just sort of a pattern so that, you know.

Mary: Mmm. Why do you think they might be inclined to follow the baby's lead in that way?

Nurse 3: And it's not all wrong following the baby's lead.

The speaker and I negotiated what it means to be a 'good' mother. Initially, the speaker suggested that a 'good' mother introduces her baby to a good pattern of wake and sleep times and this does not fit with adolescent behaviour of being out and about. In response to the characterisation of lack of routine as "following the baby's lead", she acknowledges that structure in childcare is not a required aspect of 'good' motherhood (as it was in the recent past), and that flexible approaches to childcare may not be "all wrong". Health professionals differed in whether or not a structured routine was always an important aspect of baby care. This can then be seen as an aspect of the motherhood discourse that can be more flexibly negotiated. At present the role of routine in childcare is unclear, and it is possible to construct the structured routine-following mother as a 'good' mother, but it is also possible to construct this mother as not responding flexibly to the needs of her baby. What it is to be a 'good' mother has flexibility in this aspect, which is not possible in other aspects of childcare such as nutrition. This acknowledges that structure in childcare is not a required aspect of 'good' motherhood as it was in the recent past (Kedgely, 1996), and that flexible approaches to childcare can also be constructed as 'good' mothering. Although, the speaker initially contrasted the 'adolescent' and 'good' mother positions to imply that adolescents are unable to be 'good' mothers, the introduction of a different discourse served to disrupt this rhetorical work.

Conclusion

Drawing upon the 'Motherhood' and 'Developmental' discourses in these ways functions to position adolescent women who have children as 'bad' mothers. For women in this society, what it means to be a particular type of mother can be negotiated using the 'Motherhood' discourse in which certain attributes, actions, and emotions are

ascribed to the 'good' mother. Furthermore, the subject positions of 'adult' (in the 'Developmental' discourse) and 'good' mother function compatibly. Young mothers have far less space for this sort of negotiation. By the virtue of their age they are doubly positioned as 'adolescent' and, because the subject positions of 'adolescent' and 'bad' mother are generally compatible, as a 'bad' mother. They can attempt to resist what it *means* to be an adolescent mother, but they are unable to resist being positioned as an adolescent mother. At present the intersection of these two subject positions has a powerful meaning in our social world, which makes it extremely difficult for young women to resist this negative construction of adolescent motherhood. It is important to note that (although not apparent in these quotations) most of these health professionals were working rhetorically to manage a positive and supportive presentation of the young mothers. However, the negative constructive power of this double positioning is inescapable, even for overtly sympathetic speakers. In addition, this positioning does not conclude at the end of adolescence, as adolescent mothers and their children are separated out and constructed in various negative ways throughout their lives (see Furstenberg, Brooks-Gunn, & Morgan, 1987). These dominant discourses as drawn upon by the health professionals in this study to construct adolescent mothers, have important implications for young mothers who must resist the 'adolescent' position to have any of their behaviours seen as those of 'good' mothers.

The health professionals rhetorically managed the judgment of adolescent mothers by attributing it to adolescence rather than to individual failing. This analysis has shown that the way that adolescents behave is seen as the result of simply being teenagers, and is consequently not something that can be justifiably held against them. In one way this frees adolescent mothers from responsibility for their actions, as they are constructed as behaving, even if they are mothers, in ways that any normal adolescent must (and developmentally should): socialising, eating junk food and focussing on self and self-image. However, this construction also denies young women respect and confidence as mothers, as they cannot be expected to behave as proper mothers. This dubious parenting provided by inconsistent adolescent mothers also legitimates health professionals surveillance of and intervention with adolescent mother (MacLeod, 2001).

The characteristics attributed to adolescents by the health professionals in this study have important implications for adolescent motherhood, as they are contradictory to

many of our current societal conceptions of appropriate motherhood. Mothers are generally constructed as concerned with others rather than focused on the self, as home based rather than socially interested, and as providers of healthy living environments, including healthy food and safe and clean physical surroundings. Therefore adolescents as constructed by health professionals, violate many of the tenets of 'good' motherhood. This construction of adolescent mothers is only compatible with mothering in physical aspects, in the way that they are constructed as healthy physical specimens who often labour and birth easily. Therefore adolescent mothers need to struggle against this categorisation as adolescents to be seen as a 'good' mother.

The socially available constructions of adolescent mothers used by health professionals are very likely to have an important impact on the relationships of doctors, nurses and midwives with young mothers. If doctors, midwives, and nurses talk about the behaviour of young mothers in ways that are essentially negative, then those women may well avoid situations in which they are inevitably seen as deficient. There is evidence that young mothers do often feel stigmatised and alienated by health professionals (e.g. de Jonge, 2001; Melhuish & Phoenix, 1987-8). If young women are distrustful of health professionals, then they may be less likely to follow professional advice or even seek such advice. If the health outcomes for young mothers and their babies are to be improved, it is important that these mothers feel confident in and fully supported by those who care for their health and the health of their children.

CHAPTER XI.

INDIVIDUAL DIFFERENCES

This chapter will explore how adolescent mothers are constructed using resources that construct each individual as different from all others. 'Individual Differences' are used to suggest that not all adolescent mothers are equal and that differences in mothering ability need to be considered as well as adolescent characteristics. This is used to suggest that not all adolescent mothers have difficulty adapting to their new role. The use of 'Individual Differences' to construct exceptions to the rule of the inadequate adolescent mother allows the group characterisation to remain and those few atypical adolescent mothers to be viewed as anomalous cases. Specific individuals are viewed as better or worse adolescent mothers, but they are accounted for as exceptions to the rule rather than a challenge to the categorisation of adolescent mothers. Within this discourse, attention is not drawn to the global developmental issues of adolescence, but the specific differences that set some mothers outside of the categorisation. 'Individual Differences' among adolescent mothers were drawn upon in many different ways to suggest that the categorisation of adolescent mothers as different from older mothers was flexible and had anomalous cases, but that ultimately the categorisation of adolescent mothers was valid for most mothers most of the time.

The interview topic of the 'Health Care Needs of Teenage Mothers' (see Appendix B) provided the initial resources to view adolescent mothers as a category to which particular attributes and circumstances applied. Health professionals readily spoke to these categorisations as outlined in the 'Developmental' discourse discussed earlier. The previous section relied on adolescent mothers having differences based on their age, which would be overcome with the addition of a few years development. In apparent contrast to this, the 'Individual Differences' resources were drawn upon to suggest that the effects of age were not equally deterministic for all young women. They also understood the category of adolescent mothers as having exceptions. In spite of their shared youth, some young mothers fared better than others. These exceptions were often introduced in the context of disclaiming the universality of the categorisations. As such, they performed particular work – acknowledging that the categories did not fit all

adolescent mothers all of the time, but ultimately supporting the validity of the generalisation for most adolescent mothers most of the time.

Throughout the interviews the health professionals understood adolescent mothers as all different:

> I mean it differs for each teenager (Midwife 2).

> I think everyone's experience of pregnancy is different, it's individual (Doctor 3).

> I think young people having babies are as diverse as anybody else (Nurse 1).

Many health professionals drew upon the notion that every individual adolescent mother was different. As well as a different experience of pregnancy, adolescent mothers were viewed as maturing at different rates as described by this doctor:

> But I would think that while that's age dependent it would be not age dependent in the sense that you know they're no good at 16 but they're very good at making decisions or whatever at 18 because it's going to be different for every single person (Doctor 1).

Although the speaker draws upon the notion that young people mature at different rates, it still supports the underlying understanding that age matures each person that was so prevalent in the 'Developmental' discourse. Within each of these extracts the individual differences are different for every person, there are no categorisations or types. This focuses on diversity as each person has a unique experience.

At times the introduction of an 'Individual Differences' discursive resource had little impact on the categorisation of adolescent mothers. In the following extract from a midwife the introduction of 'Individual Differences' makes no impact on the overall argument that adolescent mothers have a difference perception of the health care system that older mothers:

> Well they just don't, basically. They perceive the health care system, I mean I'm talking only from my experience, I mean I'm sure there are different ones, but they

> perceive the health care system as being in the adult world and it's these knowledgeable health professionals, they're going to tell them what to do and they're also going to judge them (Midwife 2).

The 'Individual differences' disclaimer "I'm sure there are different ones" is inserted into a strong argument for adolescent mothers' different perception of the health care system. This means that diversity in adolescent mothers can be acknowledged and sidelined. Adolescent mothers can still be judged as a group, in spite of the recognition that they are not all equal. There are exceptions to the general rule of adolescent mothers, but this is used to support the generalisation. The exceptions: "I'm sure there are different ones", are not sufficient to undermine the generalisation that is being made about adolescent mothers.

Similarly the following extract describes a range of characteristics that are typical of young pregnant women seeking a termination.

> It's interesting, I could sit here and, our termination group that we do, I could just about have a pro forma written up - requests termination, no or not effective contraception, smokes, usually gets pissed every weekend or every second weekend, often has sex when pissed, alters the partners, doesn't know the name of most of them, no STD checks, often doesn't use condoms, knows that she's not to follow good sexual help advice etc and that's being unfair to everybody who has a termination, they're not all like that, but by God there's a solid core of people who you could just about put and out print it and not even bother asking them the question because you know that they're going to be like that very solid core of behaviours that are there. And that's all the risk taking behaviours and the sort of defiant attitude. So they are a particular group that we do see (Doctor 1).

The disclaimer of the universality is the weak "they're not all like that" that has little impact on the long list of the disruptive traits of those who seek a termination. In addition, those who are "like that" can be viewed from the outside as the health professionals need not "even bother asking" as they already know the answer. The young women's sexual and reproductive health can be read from the risk taking behaviours and defiant attitude of the young women.

The notion of 'Individual Differences' was often drawn upon to suggest negative characteristics of adolescent mothers were the norm without necessarily applying this judgement to all adolescent mothers. The following extract indicates how poverty, lack of education, inability to cope, and lack of intelligence are the norm for an adolescent mother. Exceptions to this are noted, but the negatively constructed category of adolescent mother remains.

> Um, they haven't done well at school, um, they're not particularly well off families they've come from, they're not well educated, you know, all those sort of factors seem to come into young women who come in who have had babies, yeah. Not all of them, but a lot of them. Particularly the ones who keep their babies, yeah (Nurse 5).

Although this speaker allows a position for an adolescent mother who is more affluent and educated, it still remains that within this nurse's construction most adolescent mothers are poor and ill educated. In addition, choosing to keep their babies is viewed as an indicator of poor educational and economic status. Another midwife explained the poor outcomes for adolescent mothers who have further closely spaced children.

> Usually it looks they go to pieces, a second child needs to go somewhere else really, especially if it's very close to the first baby, but in saying that, there are some that have you know successfully done it, but I think it's in the minority (Midwife 2).

> Um, and at a level that they understand; and that has to be done on a case by case basis because you've got some very intelligent young mums out there, um, who are able to completely understand and access their own information, but that's not the norm (Educator).

> What are they you know, are they into drugs or are they not. I mean not every young mum is, but it's a possibility. All that sort of thing can happen (Nurse 4).

In each of the extracts above, the acknowledgment of exceptions is not powerful enough to overturn the generalisation being made. The acknowledgment of individual difference disclaims the universality of negative traits of adolescent mothers, but

continues to present a picture of the typical adolescent mother as a poor, uneducated, unintelligent, potential drug user who copes poorly with her children. Each of the speakers makes a general characterisation of the typical adolescent mothers. This means that other adolescent mothers are possible, but they are positioned as not the typical or usual adolescent mother. There is a position available for a positively constructed atypical adolescent mother. Such a young mother would not be subject to the same judgement as the poorer performing typical adolescent mother. More importantly, the success of these anomalous adolescent mothers does not call into question the categorisation of all adolescent mothers. They are discounted as "the minority" and "not the norm". They can be conveniently constructed as atypical rare examples of the successful adolescent mother. This draws upon statistical norm based understandings of the population to define appropriate behaviour.

Within the individual difference approach, the individuals were often constructed as *responsible* for their own outcomes. The following extract shows how individual mothers differ in the extent to which they will alter their lives to accommodate the needs of the new baby. In this extract the differences are viewed as under the control of the young mother.

> They want to be, they want to carry on meeting with their friends and you know doing the same sort of things that they used to do. And a lot of them very very easily give that up, but there's a lot that don't, a lot will say oh no, you know, baby, I have to do this for the baby, they're really trying to get all the sort of knowledge and things that they can for the baby. But there's a lot of others that start to sort of, it's not really a resentment, it's just they miss what they were doing and they want to be able to do those same sorts of things (Nurse 3).

Here the differences are determined by whether the young woman is prepared to give up her previous social life for the baby. A difficulty in giving up their social lives is initially likened to resentment towards the baby. Those who have difficulty with the adjustment to a reduced social life are viewed negatively compared to those who are "really trying to get all the sort of knowledge and thing that they can for the baby". The use of the 'Individual Differences' resources constructs individual responsibility for outcomes. The young mothers can choose to take responsibility and make sacrifices. If

they do not then they are not trying to do all they can for their baby. This is also reflected in the following extract from a midwife who suggests that young mothers differ in the extent to which they are organised and take responsibility for their pregnancy.

> There seem to be quite distinct types, those who are taking, who are more engaged with the fact that they're pregnant and taking responsibility, and planning with that, and others who it's a thing that's happening to them (Midwife 1).

The individuals in this extract can be organised into "distinct types" and some types are constructed much more positively than others. One type is "engaged" with their pregnancy, "taking responsibility" and "planning". The other distinct type is much less positively viewed, as they are viewing the pregnancy as "a thing that's happening to them". Those that are engaged with the pregnancy and taking responsibility are constructed as active and in control of their lives. In this way, they can be seen as more closely resembling the older mothers of the previous section who take responsibility for pregnancy and are planning for the baby. Here the distinct types of adolescent mothers are those more or less like the 'good' mother that is typified by the older mother. Those adolescent mothers who are viewed as more successful are viewed as taking control and trying harder to achieve positive outcomes for themselves and their children. Individuals are responsible for their positioning as better or worse adolescent mothers.

The following extracts also show the separation of adolescent mothers into different types. This was a common understanding of 'Individual Differences', that these differences were not strictly individual, but reflected underlying types of people. In the following extract from a doctor adolescent mothers are separated into two different types of mother; those that are "very caring" and those that are "cold and indifferent".

> It very much depends on the individual. I think some are very caring and really look after them well and take pride in that, um, for some of them it's the first time they've got somebody really to love and who loves them back some of the time. Others can be quite cold and indifferent, I've seen that, and very often in that situation it's the mother, you know, it's the grandmother of the baby who takes over and does the caring. Some teenagers just switch off and can't find it in

> themselves to do the physical caring or even to love the baby, that does happen, yeah, and that creates a lot of risk for that baby (Doctor 5).

The following extract also separates adolescent mothers into two distinct types:

> They're very good at telling you what you want to hear, but you actually need to know what is going on. Some of the little ratbags, you're never going to know, but some of them, they're worth working with because there's potential there for all sorts of wonderful things (Midwife 6).

In this case the two types are "little ratbags" who tell you "what you want to hear" and those who are "worth working with" as there is the "potential there for all sorts of wonderful things". This was a common device used to understand 'Individual Differences' as reflecting types of adolescent mothers. These types varied depending on the speaker, they were engaged and responsible versus apathetic, caring versus indifferent, ratbags versus wonderful. This separation of adolescent mothers into two types serves to polarise the adolescent mother into two mutually exclusive and exhaustive possibilities. It suggests that there is no middle ground between the "ratbag" and those who are "wonderful". These labels are also applied deterministically. Some *are* "ratbags", and deliberately tell you what you want to hear. Others have potential that can be capitalised on with the work of the health professional.

Health professionals drew upon 'Individual Differences' resources to characterise some young mothers as having done better because they continued to maintain their career plans in spite of the baby. One nurse described the differences for those mothers who continued further education compared to those give up everything for the baby.

> I've heard of young mums that have come in here not from low socio economic or difficult backgrounds, they have done better, they have done better all the way along the line. I mean even they just have baby, yes and have the same difficulties yes, but they're thinking about well, I was going to go to Massey [University], how could I do that now and they actually will work it out how they can do it. Whereas a lot of these other girls who haven't had jobs and haven't done haven't succeeded at school, they aren't even thinking anything like Massey or anything, but someone who you know has got pregnant from high school, would be say, 7th form, but have

> been doing really really well, they'll still manage to plan their life around that baby a bit more. Whereas the other ones seem to give up everything for the baby. They don't love them any more than the other ones but they give up everything for the baby, but then realise that hey, you've got to have a life yourself. And that's often where it all comes unstuck, in that they revolve all round the baby but they don't do, you know can't keep doing the same things they wanted to do themselves but they still need to have some sort of outlet (Nurse 3).

In the above extract, the mothers who do really well are separated from the poorer performing mothers, but the criteria here for success are quite different than from the same speaker in a previous extract (p. 181). In a previous extract the better adolescent mother is the one who gives up everything for the baby and tries to "to get all the sort of knowledge and things that they can for the baby" (Nurse 3). Within the extract above, however, the successful mother must not give up everything for the baby, she must realise that she must "have a life yourself". But this life should not be the social life of the typical adolescent mother. The "sort of outlet" that is appropriate for the adolescent mother to make a life for herself is an educational outlet such as attending university. In this extract giving up everything for the baby is not viewed as a sign of love or commitment to the baby "they don't love them any more than the other ones", but as a sign of life revolving around the baby because they have no other more suitable outlet. This ill-advised focus on the baby to the exclusion of all else may have dire consequences and cause the whole relationship to become "unstuck". This extract constructs adolescent mothers as responsible for their outcomes by taking control of their lives and providing a suitable outlet for themselves through further education.

Within these extracts the use of 'Individual Differences' discursive resources make available a position for an adolescent mother to be constructed as a 'good' adolescent mother. However, this position must be very carefully managed. To take up a position as a 'good' mother, the adolescent mother must rely on her place within an 'Individual Differences' resource – that is, she must be the exception to the general rule that adolescent mothers are poor mothers. In addition, 'good' motherhood for the adolescent mother cannot be achieved by merely doing what older mothers do, as the criteria for a 'good' adolescent mother are subtly different than for a 'good' older mother. A 'good' adolescent mother must be financially secure, either educated or

planning to resume her original pre pregnancy plans for education. She must be intelligent and able to cope. She must give up her social life but not give up everything for the baby, as that will cause resentment later. She must take responsibility and plan for the pregnancy and baby, but not take unrealistic joy in the impending arrival of her baby. Her position as a 'good' mother is then possible under the 'Individual Differences' discursive resources available to construct adolescent mothers, but requires a careful balancing act and attention to the similarities and difference in the construction of the older and adolescent mother.

Individualism

Health professionals deploy 'Individual Differences' resources as a dividing practice. These resources are used to separate out those adolescent mothers who are able to perform motherhood as dictated by mainstream psychology; those who are able to respond appropriately to their babies, to engage with their pregnancy, and are able to benefit from the effort and education provided by the health professional. This also serves to blame the individual for failing to live up to these criteria. In this way, successful adolescent mothers draw attention to the possibility of success, and so deflect attention from social explanations for disadvantage. If some adolescent mothers are capable of achieving 'good' motherhood, then those who are incapable must be individually to blame for their failure. This again directs attention to individual intervention to correct the problematic mothering of some adolescent mothers. In addition, these health professionals already account for the failure of these interventions for some adolescent mothers due to the adolescents' individual shortcomings. Some adolescent mothers are indifferent, apathetic, "ratbags", and so are to blame for failing to benefit from professional intervention.

The 'Individual Differences' resource is based on a traditional conception of personality. Burr (1995) describes traditional psychology's understanding of personality as individually different, stable, coherent and important in explaining behaviour. This understanding sees individuals as having a particular essentialist nature (Burr, 1998), which varies across individuals, and these differences can be seen as

directing behaviour. This view of personality suggests that once your personality is formed, your programming is fixed for the future. Personality traits can be seen as performative, however. The stable and unified subject of middle class psychology may not be the subjectivity that many adolescent mothers experience. They are then positioned as problematic subjects who differ from more acceptable adolescent mothers who are able to perform the personality of mainstream psychology. This view of the individual focuses on individual deficit and the development of intervention programmes to change individual behaviour to improve individual outcomes. These approaches ignore the social context of the behaviour investigated. As Riggs (2005) suggests, the construction of behaviours as 'individual' enables them to be separated from the context in which they are performed. This deployment of the notion of personality traits encourages better self-management, and suggests that improved outcomes for the individual are the result of individual work.

CHAPTER XII.
ETHNICITY

Within the health professional interviews, an 'Ethnicity' discourse was also drawn upon to categorise individuals as described in the health professional literature. A variety of terms were used ("race" "ethnicity", "culture"), as well as specific group labels such as "Māori", "European", "Pakeha", "Pacific Islander", "Indian". These labels were drawn upon to categorise individuals into types that would explain aspects of their behaviour and health outcomes.

An initial response to the introduction of questions or comments related to ethnicity was suspicion and hesitancy. Many health professionals seemed reluctant to be drawn into the area, which was often viewed as "non PC" [politically correct] (Doctor 1) and fraught with danger. This hesitancy is shown in the following extract as the speaker begins to draw upon the explanatory category of ethnicity, but does so very reluctantly:

> Mary: Is that different for the families where younger motherhood is more common?
>
> Educator: No, no, um, you mean in some, perhaps um, some um, ethnicities where its a common practice?

Here the speaker interpreted my use of "families" as code for ethnic differences and wants to clarify this meaning before continuing to answer the question (which following this extract and a further clarification is abandoned with a non committal "Mmm" from the Educator). However, the introduction of an 'Ethnicity' discourse is troubling for the speaker and she hesitates, first denying that early motherhood is more common in some families, and then reluctantly introducing the notion that "some, perhaps um, some um, ethnicities". The following extract also attests to the apparent difficulty for the speaker to introduce an ethnic discourse to explain patterns of early childbearing.

> There's an interesting trend though that you, we would get, I'd be on shaky ground because I don't actually have the statistics and it is just an impression, I am aware

> of some statistics to back it up though and I mean looking at New Zealand's teenage pregnancy rate which is quite severe in the sense of international comparison, I'm sure you're thoroughly aware of all of this, but, and there is a disproportionate number in certain social, economic and ethnic groups who appear in those statistics. That there would certainly be a disproportionate Māori number that we see (Doctor 1).

The speaker above also wishes to introduce ethnicity as an explanatory category but repeatedly defers the introduction of this problematic category. Finally, after a rather circuitous route, the point is made, that there is a "a disproportionate Māori number" of early pregnancies. On the way to this statement the doctor states that he is on "shaky ground", fears that this "is just an impression" as he cannot report "the statistics" although he is aware that statistics supporting his statement are available. Even as the final point unfolds, the disproportionate number is first described as "in certain social, economic and ethnic groups". The "ethnic groups" appear to be a final tag on to the explanation of differential rates of childbearing, yet the summary sentence makes it clear that the disproportionate rate of early childbearing in Māori is the point of this circuitous statement: "That there would certainly be a disproportionate Māori number that we see." Any mention of ethnicity must apparently be handled with such extreme caution as the speakers greatly fear offending and the appearance of being "non PC" (Doctor 1).

One use of cultural category that was seldom drawn upon was that of race as physical appearance. This does warrant a mention, however, as it is often what is meant when ethnic categories are attributed to others. An individual assessment of the defining physical characteristics of members of an ethnic group often determines who qualifies and who is excluded from this categorisation in practice. In these interviews, two speakers explicitly drew upon the category of ethnicity as appearance. The defining aspect of physical characteristics is shown in the following extract:

> One of the young girls she [the midwife] had whose parents are Māori but they actually happen to be professional, paid for her, that girl, to go to an obstetrician privately and got that particular midwife. And they are both, both the father and mother are Māori so you can imagine their daughter's very Māori to look at (Nurse 1).

This use of the category 'Māori' in this instance draws upon very racial understanding. Parents transmit racial characteristics to their children, and consequently, depending on the extent of parental racial make-up it is possible to appear "very Māori to look at". This speaker draws on the racial aspect of being Māori in this case to explain how it would not be possible for the midwife not to realise that the patient was Māori, as she appeared to have Māori physical characteristics despite lacking the typical Māori characteristic of poverty. Another interviewee also referred to the categorisation of young women as "young Māori mothers" by others:

> Um, visual for a lot of people you know, they look at this person and they see that it is a young mother um, maybe a young Māori mother, maybe a young um, European mother who doesn't dress the way that we would expect [them]...to dress when they're a parent (Educator).

In this extract others make the attribution of ethnicity according to the young woman's physical appearance, and this categorisation becomes an important part of the judgement placed upon her for how she dresses. Not only is she a young mother who dresses inappropriately according to a shared understanding of how mothers should dress, but she is also at all times a representative of her ethnicity. As such, she will be evaluated as a "young Māori mother" or a "young European mother". This categorisation is an important aspect of the visual categorisation of the adolescent mother.

This way of speaking about the attribution of racial or ethnic categories, although rare among those interviewed, is implicit in many of the statements regarding ethnicity. In practice, determining who is Māori is likely to be more a matter of physical characteristics than the methods of self-classification that are suggested in the professional literature. Health professionals will most commonly draw upon an ethnic discourse to explain the behaviour of individuals or groups not by asking whether they are Māori, but by assessing their physical characteristics. And judgement by others as those "young Māori mothers" will similarly be made according to visual physical characteristics. Ethnicity is more commonly a position that is assigned by others, rather than a position that is taken up. This positioning is determined by physical criteria.

Another way that the ethnicity discourse was invoked was the use of ethnicity as an available explanatory variable that could be drawn upon to account for any differences between individuals or populations. It was often included by health professionals in the list of determinants of health outcomes for wider populations groups as listed by a nurse here:

> Well the determinants of health are like education, poverty, culture, you know, all the list. What was the question again? (Nurse 4).

Here the speaker is reciting a list of health determinants that can be applied to any setting and as an answer to any question, and within this list, ethnicity is a possible determinant. In addition to viewing ethnicity as a specific determinant of health care outcomes, the use of the ethnicity discourse can be tried on to fit any possible argument as shown here:

> We see quite a lot of that, um, young mums getting really fed up with children at that stage and passing them on. I don't know whether that's particular to our practice, it being a Māori population that we deal with, or whether that's more widespread. It's probably more widespread. Its quite a universal phenomenon I think that 2 year olds are not quite as loveable as 2 day olds (Doctor 5).

Here the doctor draws upon the ethnic composition of the general practice as an explanation for the difficulty of raising a child as they progress into toddlerhood. The explanation is tried, and discarded, but in doing so the doctor shows that the ethnicity discourse is a widely available explanation for a variety of outcomes, and as such provides the lens through which the practice's clients are viewed. 'Ethnicity' remains as an explanatory category that is widely available for health professionals to draw upon to explain differences between individuals and groups.

Although 'Ethnicity' was introduced with such hesitancy, it was still deployed by the health professionals in interviews. Within these interviews an 'Ethnicity' discourse is used to describe the 'other', and was exclusively drawn upon to position others. None of the health professionals positioned themselves in relation to this discourse. Therefore

the work accomplished by an ethnicity discourse was in relation to an 'other' who was typically a member of a 'coloured' culture, most commonly Māori. The notion of the 'other' is an important concept within a discourse of ethnicity. Although an ethnic discourse brings an almost infinite number of labels that can be applied to individuals in practice, the rhetorical work that is accomplished with these specific labels is the categorisation of people into 'us' and 'them'. The 'other' is the position available to position members of any group whose values and understandings of the world are not implicit within dominant sense making. Although it is possible to be positioned as 'Māori', 'Pacific Islander', 'Turkish' within an 'Ethnicity' discourse, what this means in practice is a position as different from the mainstream. The mainstream ethnic understandings are the background of these categorisations, and consequently do not require explanation. The dominant cultural identity goes unexamined, and only the ethnicity of the 'other' is examined in health research.

Cultural explanations for different health practices or values were often explicitly positive, but were compared with taken for granted European cultural practices and values. The theme of culture and ethnicity as "them" was widespread throughout the interviews. The following extract shows how "we" the health professionals should respect "them" who have different cultural practices such as early motherhood:

> Just some cultures that it's perfectly okay for them to have a baby at 15 or 16. Accepted norm and we should, you know, that's them and we respect that, yeah (Midwife 5).

The 'other' were not always described in explicitly positive terms however, as in this extract where the "Māori girls" are described very negatively as having no idea what they are doing in having babies early:

> Probably the majority of the teenage mums are Māori girls. They don't actually know what the hell they're doing (Midwife 6).

The separation of 'we' the health professionals from 'they' the Māori is particularly illustrated in the following extract from a doctor who worked for an Iwi health provider.

> The philosophy of this place when we initially started was that we shouldn't encourage or refer the mothers, young mother or young prospective mothers for termination of pregnancy. But we the doctors spoke to them and said that you know it wasn't fair not to offer the option, so we do now offer an option, but encourage them to discuss it with their families (Doctor 4).

Here "we the doctors" with a value of individual reproductive choice: "wasn't fair not to offer the option" are set against "them" who have set up the health service with a particular philosophy. In this extract, there are two "them"; those managing the health service and the clients. Both are set in contrast to the health professionals and their values. A concession is made to Māori values with the encouragement that young pregnant women discuss the pregnancy with wider family members, but individual reproductive choice is viewed as a primary requirement for the health service.

This setting out of 'them' and 'us' and the primary value of European cultural values is also illustrated in the following extract. Here a midwife describes some other cultural settings that she has worked in that involved adolescent mothers.

> Different cultures, like Egyptian ones, arranged marriages and Indian ones, arranged marriages, predominantly sort of Muslim that are 16 and 17 ... but in those cases, what happens is, these ones came from very supportive background of course, very close knit families, so you've got the extended families who often, you know, poor young women, 16, yes it is planned, and she has some sort of idea (Midwife 2).

The description appears to be a positive one, the young women come from a "very supportive background" and live in "very close knit families", but the evaluation of this is very negative: "poor young women". The young Muslim women are to be pitied in spite of the support of their extended families. The young woman's attendance at health visits is later attributed to her desire to be "this dutiful wife you know" rather than any interest in or care for the baby. Even within this evaluation of the positive aspects of Egyptian and Indian cultures, the young pregnant woman is still to be pitied. European cultural practices are the unseen dominant against which the other, in this case Egyptian and Indian culture, is set.

Through this setting out of member of ethnic groups as the 'other', health professionals were often careful to overtly view the 'other' positively. The health professionals' comments often indicated a strong desire to appear accepting and non-judgemental of different cultural approaches to health. One midwife responded to the introduction of cultural differences in this way:

Mary:	You were saying, why do you imagine that for some families early motherhood is the norm? Why do you think that's the case?
Midwife 5:	I don't know, sometimes it's a cultural thing and that's fine.
Mary:	Cultural in what sense?
Midwife 5:	Oh I think, I suppose that it's just some cultures that it's perfectly okay for them to have a baby at 15 or 16. Accepted norm and we should, you know, that's them and we respect that, yeah.

The midwife here constructs acceptance of different cultural practices. Differences that can be ascribed as "a cultural thing" are automatically attributed with the status of being "fine". For this speaker there is no possibility of overt judgement of cultural differences and what is an accepted norm for others of a different culture should be respected by the mainstream that it indicated by the collective "we respect that". This separating out of the mainstream and the "cultural" is also achieved by the implicit judgement of what is perfectly okay for some cultures is not perfectly okay in the mainstream culture. The speaker explains that "some cultures that it's perfectly okay for them to have a baby at 15 or 16". Implied in this is that the cultural practice of early motherhood is not perfectly okay in other 'non-cultural' settings. What is perfectly okay in the minority is anomalous for the mainstream.

The categorisation of 'them' and 'us' was troubled by the introduction of cultural concepts into White ethnicity. When explaining about different cultural approaches to childrearing, different approaches in different White populations were only very reluctantly ascribed as 'cultural'. The following midwife explained about the different approach to childrearing among families she worked with in London:

Midwife 5: Oh I think, I suppose that its just some cultures that its perfectly okay for them to have a baby at 15 or 16. Accepted norm and we should you know, that's them and we respect that, yeah.

Mary: Okay. And even within that sort of idea of culture, was that the case particularly in that area of London as well?

Midwife 5: Oh, no, they were um, dare I say White East Enders, maybe it was perfectly alright for their culture, they're a rough group of people, think nothing of violence, um, but I must say I didn't like the way some of the younger kids you know, a 3 year olds, the first you know, few words out of them other than mum or dad was the f word, very violent um, in that aggressive manner, yeah, I found that quite disturbing. I suppose that's probably why I didn't want to bring up any children in that area. It wasn't the roughest place of the East End but it was certainly an eye opener of how you should I say drag your kids up because some of the ways that they spoke to their children and the expected norms came through from them, yeah, okay to hit because dad hits mum, its okay to swear because that's how they speak, um, yeah. I suppose it's their culture.

My suggestion that cultural differences were relevant in the midwife's work in London was immediately countered by the fact that they were White, and as such not subject to classification as having cultural differences. However, the classification as "White East Enders" still brings with it the hesitancy characteristic of the ethnicity discourse as the speaker prefaces this by saying "dare I say". Then, as the notion of culture is introduced to the practices of the rough White East Enders, she suggests that these practices may be viewed as cultural: "I suppose it's their culture". The way she speaks of their culture, however, is very different to the accepting and non-judgemental way she previously spoke of the cultural differences of the families for whom early motherhood was "fine". In the description of the White East Enders culture given above, things are not fine: they are "rough", "think nothing of violence", swear, and "drag" their children up. When the earlier attribution of all cultural differences as inherently fine is compared with the above description of the cultural differences of the White East Enders, it appears that cultural differences in cultures of colour are fine, but cultural differences in other White groups are far from fine. They are reluctantly attributed with the status of "cultural differences" as this implies a sanction of their behaviour, which is only reluctantly

given to White groups, as genuine cultural differences are seen as belonging only to non White groups. The use of 'Ethnicity' in this way reinforces the notion of culture as colour, and troubles the boundaries of 'them' and 'us'. The White East Enders are positioned as 'us', they *should* subscribe to White values and practices, and their failure to do so results in strong judgement on their childrearing practices. In contrast, other cultures and ethnicities are positioned as 'them', and as such their childrearing practices and values are not subject to the same criteria and judgement.

Cultural categories were also seen as a set of cultural values that *caused* certain behaviours. For example Māori cultural values were viewed as causing a rejection of abortion, as suggested by one doctor:

> The Māori feeling about terminations is that its not something that they feel should take place. (Doctor 4).

The Māori values are viewed as determining pregnancy decision making. This is further qualified however, as not all Māori cultural values are viewed as of equal strength. The speaker continues on to suggest that individuals can possess strong or weak Māori values:

> They've got some mothers you know, not the teenage mums, but their mothers feel that its really important to go on with the pregnancy because its not the Māori way of thinking to terminate a life and so they, they themselves feel, it depends on how much of the cultural values they have. If they have the strong cultural Māori values then they will continue with the pregnancy. Those who don't have such strong ties, or the ones who want to go on to educate themselves will say, well this isn't the time that I want to get pregnant and will consider termination of the pregnancy (Doctor 4).

In this extract weak values can be put aside and behaviour is seen as then determined by other factors such as life goals and economic imperatives. However, what is described as weak Māori values seems to mean no values in the context of the extract above "don't have such strong ties". But what is viewed as a lack of Māori values can be seen as the individual possessing mainstream European cultural values "want to go on to

educate themselves". Because cultural approaches are only attributed to groups of colour, possessing mainstream values towards abortion is seen as weak Māori values. The European cultural values that include the primacy of education and life course development are so completely taken for granted that they appear invisible.

The positions that are commonly available within the ethnicity discourse within New Zealand are 'Māori', 'Pacific Island', and 'European' (White). To take up a position (or more commonly be positioned based on defining physical criteria) is to be positioned within one of these racially defined categories. Each position has a number of different socially assigned characteristics, but collectively 'cultural' ethnic positions can be viewed as positioned as 'other', that is not mainstream White ethnicity whose values and aspirations are the unseen dominant values of the wider society. The result of this positioning within an 'Ethnicity' discourse is that the positioning of the other is treated with hesitancy. The 'other' is positioned as different and treated as potentially difficult and requiring caution. Members of this 'other' group are attributed with values that are different and potentially problematic. In addition, the positioning of the 'other' judges them by European standards and consequently these 'poor' Māori girls and 'poor' Indian wives are to be pitied. The position is determined in opposition to the European dominant. As a result, to take up or be positioned as an 'other' is to be positioned weakly as having values that do not accord with the mainstream. It is to be treated carefully and to be pitied.

Conclusion

The health professionals drew upon a discourse of ethnicity in these interviews to position members of other ethnicities as separate, as the 'other'. Mainstream European culture and cultural values were invisible in the explicit talk, but underpinned many of the statements made regarding abortion, adoption, and health care practices. European cultural practices are the unseen dominant against which the other, predominantly Māori culture, is set.

CHAPTER XIII.

A COMPARISON BETWEEN HEALTH PROFESSIONAL LITERATURE AND HEALTH PROFESSIONAL INTERVIEWS

The health professional literature and the interviews with the health professionals share a strong focus on the problem of adolescent motherhood. The discursive resources that are used to construct the problem of adolescent motherhood have similarities and differences. Not surprisingly, the health professional literature drew upon scientific discourses more strongly than during interviews with the health professionals. During the interviews, health professionals commonly drew upon resources from developmental psychology to understand adolescent mothers as having shared characteristics determined by their life stage. This level of development had important implications for their mothering. A further individualised approach was provided with the individual differences discursive resources. These were used to suggest that diversity was important in understanding the outcomes for any individual mothers, but ultimately supported the generalisations that were made about the category 'adolescent mother'.

Adolescence

Age and corresponding understandings of maturity were commonly drawn upon to construct adolescent motherhood. The importance of chronological age and the meaning of age for development and maturity underpinned the discussion of adolescents' suitability as mothers. The shifting norms towards later childbearing was viewed as implicitly more appropriate than early motherhood. In the interviews with health professionals, developmental psychology provided the basis for understanding adolescent characteristics and these characteristics were viewed as of primary importance. The health professional interviews elucidated the taken for granted characteristics of 'adolescence' that underpinned the discussion of adolescents as unsuitable mothers in the professional literature. This reflects the academic literature for health professionals that draws strongly and uncritically on understandings of

individual psychological development through adolescence (see Florsheim et al., 2003; James, 2000; Robinson, 1992; Roye, 1995). The stages of development are often used to explain the behaviour of individual adolescents, with particular attention given to the need for differentiation from adults through acts of rebellion (Bell, 1998). Failure to adhere to health advice is given as an example of this adolescent rebellion, rather than the inherent unsuitability of the advice within the wider social context of adolescents' lives.

Physical Health

The 'Developmental' discourse attributed adolescent mothers with good physical health. This focus on physical health makes sense given our cultural construction of youth and health, and also begins to explain the different focus in the interviews than in the professional literature. Within the professional literature there was a preoccupation with adolescent motherhood as a disease, and described under the 'Public Health' discourse. The 'Public Health' discourse consisted of disease metaphors and risk factors, and constructed adolescent motherhood as contagious. This discourse was much less evident in the health professional literature. The 'Public Health' discourse is not compatible with the physical health of adolescence as constructed within the Developmental' discourse, which was so heavily used by the health professionals in interviews. This use of the 'Developmental' discourse in interviews may be explained by the primacy of the age category within our society. Age is such a pervasive category for explaining differences between people that when confronted by a young woman in consultation, the overwhelming factor of importance becomes their age and this dominates the construction from the perspective of the health professional. Aspects such as disease rates, and health behaviour as presented by the 'Public Health' discourse are of secondary importance and are shaped by the initial framing of the interaction as one with an adolescent.

Motherhood

Health professionals also drew upon understandings of the 'good' mother that provided the ideal to which adolescent mothers were compared unfavourably. These understandings were not explicit in the professional literature, but the scientific discourses provided a position for the 'good' mother. The 'good' mother of science provided her offspring with superior genetic endowment and adequate nurturing. The 'good' mother was financially independent and adhered to family structure and health care practices as determined by the dominant ethnic group, New Zealand European. Motherhood outside of these bounds was understood as pathological and viewed as propagating disadvantage. The 'good' mother produced by the interviews with health professionals was the older mother, who understood and reflected dominant norms of childrearing behaviour such as speaking 'appropriately' to the child and providing developmentally 'appropriate' discipline. Both the health professional literature and the interviews constructed a particular type of motherhood as epitomising the 'good' mother. The 'good' mother adheres to a range of norms regarding family structure and independence from the welfare state. Within the interviews, attention to the 'good' mother and how the adolescent mother deviated from this ideal and idealised mother was more explicit. Older mothers were automatically attributed with 'good' mother status, whereas adolescent mothers needed to carefully manage their mothering and development to be understood as a 'good' mother. This required the adolescent mother to achieve financial independence from welfare, preferably by becoming dependent on a male provider, by her own self improvement through education, and by prioritising the health and development of her baby.

Ethnicity

Both the health professional interviews and the health professional literature drew upon an 'Ethnicity' discourse to construct adolescent motherhood. The 'Ethnicity' discourse was an important and pervasive discursive resource available to categorise adolescent mothers. This discourse was drawn upon differently in the interviews than in the professional literature. In the professional literature the method of assigning categories was considered explicitly, however, the assigning of categories was implicit within the

interviews. The most marked difference was the concern with the high rate of Māori pregnancy and the low rate of Māori abortion in the professional literature. In this literature, Māori ethnic group affiliation was one of a number of problem categories along with conduct disorder and low educational achievement and represented a way of indicating culture as problematic. Although some health professionals interviewed referred to the high number of Māori adolescents who become pregnant, the 'Ethnicity' discourse was drawn upon much more hesitantly in the interviews. When it was employed, it was often used to explicitly describe cultural differences positively. There was an understanding of ethnicity as a category that could be drawn upon to explain any differences between individuals, and these differences were not always positive, in spite of the explicit support of cultural differences. In the interviews, an 'Ethnicity' discourse was drawn upon to highlight difference and construct adolescent mothers as the 'other' whereas mainstream values remained unexamined.

'Naturalist' – An Example of Similarity

The discursive resources from the 'Naturalist', 'Public Health' and 'Economic' discourses were less prevalent in the interviews with health professionals. These discourses *were* drawn upon in the interviews, however, indicating that they are *available* to the health professionals to make sense of adolescent mothers, but are less salient than the focus on individual development that was prevalent in the interviews. The use of a 'Naturalist' discourse within the interviews with health professionals is discussed below to illustrate how health professionals make use of the discourses made available through the professional literature.

The 'Naturalist' discourse was an important device in the construction of adolescent mothers in the professional literature, but was not included in the analysis of the health professional interviews as it was much less commonly drawn upon in the interviews. This is not to suggest that it was not available to the health professionals to construct adolescent motherhood, however. More than one health professional provided explanations for outcomes that involved the "genes", and one midwife described groups of adolescent mother as having "this pack mentality" (Midwife 2). This explanation drew upon the animalistic understanding of the 'Naturalist' discourse that reduces

adolescent social behaviour to a pack of animals. One doctor explained different levels of coping ability as

> I can only really answer that in broad terms of nature, the genes, the way they're programmed to behave (Doctor 1).

A focus on the genes determining behaviour draws upon a physical explanation of psychological phenomena. Another doctor used a 'Naturalist' resource to describe the lack of fitness of adolescent mothers to parent in the following extract:

> So I think society needs to take a look at itself really clearly. Where do you see the most healthy people, the most healthy mentally, emotionally, physically, you see them in stable homes where there's enough money, and that means children have been brought in when they've been planned, when the parents, both of them, have earned enough money and they've been able to create a proper nest (...) I think that's the problem and I'm sure it's going to have knock on effects of children who are brought up without proper parental care and I mean from both father and mother in a stable union, are going to suffer the consequences, because it is not the optimum solution. It's like a three wheel motor car, yes it will work, but it's not a very safe way to travel. We need stable environment, stable family and it doesn't come from our present ethos where everything's about having a good time, you know its really what I think its about, I think the fundamental problems of teenage pregnancies don't lie in actual biological situations, it lies in the ethical situation. We'd better get that right and then the biology will correct itself (Doctor 2).

In this extract, the physical, emotional, and mental health of the population is viewed as determined by stable home environments and financial stability. This financial stability means that the parents are able to "create a proper nest", which draws on the animal metaphor for a comfortable home to rear their offspring. Here, both parents in a stable union can only provide "a proper nest". Without this financial and parental stability, the children will not be raised in an "optimum" situation. The use of the phrase "optimum solution" is itself from the field of genetic algorithms. Genetic algorithms involve the application of the laws of natural selection to the creation of information systems. The laws of natural selection reflect enough fitness to be able to survive and reproduce. However, the use of the "optimum solution" within the above extract, the ability to

survive and reproduce is not sufficient. The criterion for the optimum solution for this doctor is the nurturing of a child within a proper nest that involves the care of two parents. Here the optimum solution is determined by the inputs, rather than the output of sufficient fitness to survive and reproduce.

This example shows that health professionals draw upon discourses available in the professional literature. They are drawn upon flexibly to achieve particular outcomes. Here a 'Naturalist' discourse is drawn upon to characterise adolescent mothers as propagating disadvantage for themselves and their children by rejecting traditional family structures, which are necessary for optimal child outcomes. Although this is an individualistic understanding that positions adolescent mothers as more concerned with pleasure than responsibility, it calls on society to "take a look at itself" and so suggests that the individual pleasure seekers require societal surveillance to correct their lack of ethics.

Abortion – an example of difference

Abortion was discussed within both the health professional literature and by health professionals in interviews. The professional literature constructed abortion as an unproblematic individual decision, which would resolve the problem of adolescent motherhood, as described in 'Breaking the Cycle'. This is quite different from the interviews, which constructed abortion ideally as a joint decision for the whole family led by the young woman. In addition, many of the health professionals spoke of abortion as the worst possible outcome of any pregnancy. This provides a sharp contrast to the focus on pregnancy rates and abortion as a solution to unplanned adolescent pregnancy.

In the health professional literature, abortion was viewed as a negative health statistic that should be monitored and kept from rising. Within this literature, abortion is negative, but necessary to control the adolescent birth rate. It is a tool that is utilised to curb the increasing adolescent birth rate:

> An increase in the proportion of teenage pregnancies aborted since 1986 has prevented a more marked increase in the birth rate. (...)In the last decade only an increase in abortions has held the birth rate relatively stable (Dickson, et al., 2000).

The use of abortion to control unplanned fertility was not viewed as a moral or familial issue, but as a choice that should be as widely available as possible:

> Young Māori who become pregnant appear less likely to seek, or have access to, abortions. While the former is a matter of choice, it is important that any barriers are identified and removed for young Māori seeking abortions (Dickson, et al., 2000).

In sharp contrast, the health professional interviews constructed abortion as a tragedy, and the worst possible outcome for any pregnancy. This doctor spoke in direct opposition to the professional literature when he suggested that a child alive was always better than a child aborted:

> I think the tragedy is that that children are having children at far too young an age. I just think its very short sighted. On the other hand I'd much rather see a child alive than a child aborted and I'm clearly against the morning after pill, clearly against termination of pregnancy (Doctor 2).

Although both the health professional literature and the health professional interviews were in agreement on the tragedy of early parenthood, the solution was not the same. For most of the health professionals, abortion was the solution least favoured:

> If the woman comes alone and that's the choice she's made [termination](...) they've made up their mind before they come, but we try and find every possible solution other than termination (Doctor 5).

Adolescent pregnancy was described in very catastrophic terms as "the end of the young woman's options for life", but abortion was still referred to as a problematic solution to this terrible problem:

> I feel quite sad sometimes when it seems to be the end of the young woman's options for life. I think that's a waste. I don't think anybody likes referring them for termination of pregnancy. It's a horrible place to be in a woman's life to be pregnant and not want, and have the only option is to abort the pregnancy. It is a really awful place to be in a woman's life and it's hard for them. And you can, you can really see that it is (Doctor 3).

This different focus on abortion as the solution to adolescent pregnancy provides evidence that health professionals see both a broader social world, involving family and social structures of the adolescent mother, and a more individualised world that attends to the personal aspects of decision making. As McKinlay et al., (2004) highlight in their study on GPs response to health promotion, GPs work in a primary health care perspective that takes the individual as its focus. Health promotion and public health come from a population health perspective. The difference between the public health message from the wider health professional literature and the day to day clinical activities of GPs and other health professionals has wider implications. As McKinlay et al., (2004) suggest, the GPs draw upon a range of discursive resources to resist the health promotion models proposed in their own practices. In the present study, health professionals attend to different aspects of adolescent motherhood than that highlighted by the public health focus on the 'problem' of early motherhood. The disparity between these approaches may limit the relevance of the health professional literature to those it attempts to inform.

Conclusion

The health professional literature focused on the problems that adolescent motherhood creates for others: the poor health outcomes associated with adolescent motherhood, the financial cost of adolescent motherhood, and the long term deleterious effect of adolescent motherhood to the wider community. In comparison, the health professional interviews focussed on the problem of adolescent motherhood in the lives of the adolescents and their children. Their focus was more on the interruption of the life course development of the young women and on the negative child rearing practices of immature adolescent. These differences can be explained by the focus of the literature on the broader issues of adolescent motherhood, whereas the health professionals deal with each young mother in isolation and can sympathise with the individual issues of

each adolescent mother. The different focus in the interviews and the professional literature can be explained by the difference in a population health perspective versus a primary health perspective. A population health perspective focuses on rates of disease and health outcomes, whereas, a primary health perspective takes the individual health care consumer as its focus.

CHAPTER XIV.
DISCUSSION

The literature for health professionals and interviews with health professionals drew upon a number of discourses to construct adolescent motherhood. Within the literature for health professionals, four scientific discourses were described: a 'Naturalist' discourse that constructs parenting as a biological matter and draws upon eugenic arguments; a 'Public Health' discourse which constructs adolescent motherhood as a disease requiring surveillance; an 'Economic' discourse which understands adolescent motherhood as a financial cost to society and to the adolescent mothers; and an 'Ethnicity' discourse that separates people into categories to determine health behaviours and health outcomes. These discourses are also drawn upon to construct a 'cycle of disadvantage', which positions adolescent motherhood as the result of individual choice or family deviance. The health professional interviews focused on specific adolescent characteristics that preclude adolescents from being positioned as a 'good' mother. Although adolescent mothers were described as differing in their mothering ability, these resources ultimately supported the generalisations about adolescent mothers as deficient. An 'Ethnicity' discourse was also drawn upon to construct the 'other', while mainstream European cultural practices and values underpinning discussion of abortion and health care remain unexamined. There were similarities and differences in how adolescent mothers were constructed in the professional literature and in interviews. The professional literature drew strongly upon science to construct adolescent motherhood as deficient. The interviews attended to individual issues through stages of development and individual differences in mothering ability.

Although this analysis has focused on the negative implications of constructing adolescent mothers in these ways, some of the discourses construct adolescent mothers positively. For example, adolescent mothers' youth is related to good physical health and easy childbirth. It is possible for individual adolescent mothers to negotiate a position as a 'good' adolescent mother by defining themselves as an anomalous case in

the general construction of adolescent mothers as deficient. In addition, it is possible for European adolescent mothers to be positioned less negatively than Māori adolescent mothers, given the focus on ethnic explanations for early childbearing and disadvantage.

This analysis focused on the implications of these constructions for adolescent mothers and their children, rather than the positioning of health professionals within these discourses. These discourses do have implications for health professionals, and the discourses used reflect health professionals' positions within wider social structures. These constructions do not reflect individual attitudes that health professionals' hold regarding adolescent motherhood, but the ways that it is possible for health professionals to construct adolescent motherhood in the context of discourses of human development, motherhood, and the family. Health professionals do not construct adolescent mothers in the ways outlined in an attempt to oppress and marginalise them, but because these constructions make sense in the wider context of their lives, that generally include mainstream values and a lifetime of socioeconomic advantage. This analysis does not intend to undermine or diminish health professionals, but to draw attention to these dominant discourses and the implications they have for adolescent mothers, who have much less institutional power to resist them.

An assumption made in the health professional literature is that most adolescent mothers are of lower socioeconomic status, uneducated, and reside within a 'cycle of disadvantage'. This assumption has been highlighted in this present research as a device that makes invisible middle class, financially independent, educated young mothers. I have also used the assumption of disadvantaged adolescent mothers as a device to highlight the difference between the world of the health professional and the adolescent mother. The potential inconsistency between assuming adolescent mothers are lower class on one hand, and highlighting this assumption as erroneous when used by the health professionals, is important to address. Adolescent mothers are not a homogenous group, they differ in access to social resources, family support, and possess characteristics that may influence their ability to take up or resist subject positions. However, drawing attention to social class differences between health professionals and adolescent mothers is also important. Access to social resources has material effects of the lives of members of the lower classes. Privileged adolescent mothers benefit from the positions made available to the advantaged in wider discourses, and may also

benefit from being made invisible in any discussion of adolescent motherhood. Disadvantaged adolescent mothers have much more to gain from the disruption of dominant discourses that position them in constraining ways.

The discourses available for health professionals to construct adolescent motherhood rest on wider discursive resources that are supported by dominant understandings of appropriate individual development, family function, and social structures. These understandings frame what can be known about individuals and families who deviate from dominant cultural practices. The categories and structures of the world that are currently made possible provide a wider framework for interpreting these discourses. The framework of individualism, the family, and social class is the backdrop of the discourses analysed in the present research. This analysis draws attention to how these discourses are used to position individuals and families as responsible for disadvantage and to direct attention and intervention towards deficient members of society.

Individualism

A strand from the literature on adolescent motherhood, through the professional literature, and the health professional interviews is the role of the individual in society. 'Individualism' understands poor outcomes as the fault of the individual. People are primarily viewed as responsible for their own economic position; opportunities are available to all and those who do no take them up lack motivation or ability (Seccombe et al., 1998). The social scientific literature on adolescent motherhood draws attention to individual differences in mothering ability that explains parenting outcomes. The professional literature understands the individual as able to resist disadvantage through making individual choices to abstain from sexual activity or reliably apply reproductive technology to avoid early pregnancy. Health professionals also drew upon individual difference resources to explain the differing levels of parenting ability and outcomes for individual mothers and their children. The use of the individual as the appropriate social actor draws attention to individual prevention and intervention programmes as appropriate social actions. This deflects attention from any consideration of social structures in accounting for disadvantage. Individual success is viewed as the result of individual work, implying that lack of success is the result of lack of individual effort

(Riggs, 2005). As such, success is viewed as a personal achievement, rather than a result of different levels of support and opportunity.

A focus on the individual as the appropriate site of blame and consequently of intervention to alleviate disadvantage, is tempting when some individuals appear to do 'better' than others in what appears to be the same environment. However, it is valuable to consider how structural aspects such as poverty, ethnicity, and educational opportunities, impact on different adolescent mothers differently. Willig (1999) states that "the social environment cannot be reduced to an objective, external set of stimuli; instead it is the social conditions of life *as appropriated by the individual* that constitute his or her environment" (p.41). Individuals are not scripted by discourse; they are also active in resisting discursive positioning. Subjectivity depends upon an individual's location at the intersection of many discourses; and as such is plural rather than fixed and static. Individuals are also are capable of resistance. This discursive possibility of resistance should not be taken to mean that individuals are not genuinely constrained by social structural factors, but that each individual's subjectivity is fluid and dependent on available positions within many discourses.

The Family

The 'family' represents a major discourse within Western society such that "society has been familiarized" (Barrett & McIntosh, 1982, cited in Parker, 1992). The pervasive preoccupation with the family is prevalent here, as these discourses foreground the role of the family in explaining motherhood. These discourses construct the family in a variety of ways. Within an 'Economic' discourse, the family is viewed as a unit that produces an output. The quality of the output is used to determine the quality of family functioning, and the production of an adolescent mother indicates family dysfunction. A 'Naturalist' discourse understands the family as a breeding programme, and the 'Breaking the Cycle' discursive resource constructs family responsibility for poor outcomes and 'cycles of disadvantage'. Appropriate family formation is assessed as 'nuclear', financially independent, and emotionally supportive. The family is viewed as the primary vehicle for the transmission of values and behaviour in individuals, and individual failing is attributed to family factors. The family is also viewed as mediating

the individualism of the not yet autonomous adolescent, as they belong to families that can be held accountable for their functioning. The dominant worldview of individualism is applied to families (Peirson, 2005).

Disadvantaged families are often viewed as passive objects of research (Peirson, 2005), and this is shown in the health professional literature with calls to monitor and manage 'at risk' families. Disadvantaged families are assessed to quantify the extent to which they deviate in important ways from 'correctly' functioning families. Within the health professional literature, families are dissected into their constituent parts to determine levels of functioning. Families are also represented as static entities with particular traits, rather than as evolving though transitions which present opportunities and challenges (Peirson, 2005). Structural disadvantage is treated as it if were a property of the individual or family (Burman, 1994). Family research often attempts to intervene with families after problems have occurred and focuses on individual interventions. Poverty, unemployment, poor housing or lack of social cohesion is addressed, at best, on a case by case basis, rather than by resolving the cause. Interventions attempt to teach families to live with adversity rather than attempting to address disadvantage (Peirson, 2005).

Community psychology and community public health have drawn attention to the importance of social structures in mediating disadvantage in an attempt to deflect attention from individual deficient and individual interventions (Nelson & Prilleltensky, 2005). This present research indicates that health professionals draw upon psychological and medical understandings that continue to reflect individualistic conceptions of the person. This highlights the difficulty of introducing truly social notions of health and development into such individualised fields as psychology and medicine. Ultimately suggestions implicate individuals or families in producing disadvantage. At times the apparently socially located understanding of the family appears to stand in for a socially located individual. Interventions are targeted at the family in an attempt to address individual deficient in an apparently social way.

Social Class

Although social class is not explicitly identified in this literature, it is made available through an understanding of poverty, education, welfare acceptance, and ethnicity. These categories produce a hierarchy of class that determines social positioning. Welfare acceptance is often used as a proxy for class, because it justifies intervention in the lives of others for financial reasons. Understandings of social class pervade the professional literature on adolescent motherhood. These understandings are framed through the link of certain individuals and families with intergenerational patterns of disadvantage, with Māori and Pacific Island ethnicity as associated with poverty and lack, and with a focus on lack of education and unemployment. In this way, social class is enacted through a set of appropriate life course developments that certain individuals and families refuse to adhere to. The increasing age of first birth is highlighted as inherently appropriate, reflecting a middle class understanding of appropriate life course development (McRobbie, 1991). Lack of suitability for parenthood, poor health outcomes and long term welfare dependence are identified as part of the litany of disadvantage associated with adolescent motherhood. This is further developed with attention to the transmission of disadvantage and deviance in 'Breaking the Cycle'. In addition, the health professional interviews identified social factors as determining individual differences in parenting ability. The health professionals understanding of the 'good' mother was also constructed using middle class understandings of appropriate mothering behaviour.

The values, norms, and ideals of the middle class are unquestioningly seen as appropriate and middle class health professionals draw upon these understandings as the standard against which the deviant working classes are compared (Hays, 1996). Young working class women are often portrayed as such poor mothers that their children are better off in care than cared for by their own suspect mothers. The same is not said of the middle class mother. Full time mothering is constructed as ideal for women supported economically by a partner, but is viewed as insufficient for welfare dependant adolescent mothers (Kidger, 2004). Such mothers are expected to participate in education and employment to qualify as 'good' citizens. As such the difference between the appropriate response to motherhood depends partly on the mother's social class. If she is economically independent and educated, the ideal is full time care of her children.

If she is economically dependent on the state she should complete her education and find employment to support her children. Young women who have few options for education and employment are judged harshly for staying home to raise their children if they must remain on welfare to do so. In addition, young women also understand full time mothering as the ideal (Kidger, 2004; McRobbie, 1991; Phoenix, 1991). Their position as youth means that education and employment are the routes to good citizenship, yet this precludes them from achieving the ideals of motherhood that are constructed around understandings of marriage and economic independence of the traditional family. As such it is not possible for single working class women to achieve the ideals of adolescence and motherhood concurrently.

McRobbie states "who is to deny the poor and the unemployed the joys of parenthood, one of the few pleasures to which they have access?" (1991, p.231). Yet, this is precisely what the literature for health professionals suggests. Financial criteria are important determining criteria for suitability for parenthood, and as such poverty and unemployment become defining characteristics of the unsuitable parent. Luker (1991) describes how having a child may be one of the few avenues of satisfaction, fulfillment, and self esteem available to the poor, disadvantaged, and discouraged women who tend to become pregnant early. Yet, in this they are positioned as unsuitable parents and assumed to be long term welfare recipients. Policy encouragement to delay adolescent pregnancy is unlikely to improve the prospects for adolescent mothers and their children, as it fails to address the social context of the lives of these women.

Notions of social class have seemed to have been overturned with the apparent freeing of the universality of education. Herrnstein and Murray (1994) draw attention to the role of intelligence in creating increased mobility through the social strata. This, they argue, creates an underclass determined by cognitive lack rather than social position. This is presented as a reasonable way of ordering society that reflects real differences in both ability and employment outcomes. Within this understanding of social class, those who fall to the bottom deserve to be there. Herrnstein and Murray (1994) argue that natural movement upward for the most capable and downward for the least able is a superior ordering of the world. This hierarchy is based on a very individualistic understanding of social class. Social class is viewed as appropriately determining ability, and as such attempts to disrupt this mechanism are viewed as unnecessary and

unwise. These authors also highlight the role of familial genetic factors in transmitting disadvantage, and these low levels of ability as closely connected with poor economic chances and employment.

This understanding of cognitive lack and downward mobility is also reflected in the literature for health professionals. The least capable of parenting are identified through conduct disorder, lack of school achievement, and lack of training for employment. These disadvantaged individuals and families require management and monitoring to discourage their early and pathological childbearing practices. This is proposed to reduce the societal impact of reproduction of poverty, conduct disorder, and unemployment. Social class is drawn upon to identify deviant individuals and families, rather than as a way to understand and address the social context of disadvantage. It is used as a social classification system where individuals can be viewed as more or less problematic. This fails to address how membership of such categories translates into barriers to social participation.

A way to think about this research is to consider alternative discourses to those described and how they might have advantages and disadvantages for adolescent mothers. These could include viewing motherhood as a challenge requiring support and community involvement regardless of the mothers' age. In addition, viewing motherhood as of value regardless of the economic or social status of mothers would impact on the evaluation of adolescent mothers. In the health professional literature particularly, adolescent motherhood is viewed as transmitting long term social disadvantage, rather than as a valuable contribution young women make to society as mothers. Motherhood is only sanctioned through certain social conditions, such as financial independence and marriage, which may be unachievable for some mothers at any age. This requires addressing the understanding of economic participation as the primary way of contributing to society and valuing motherhood in its own right (Kidger, 2004).

Disadvantage associated with adolescent motherhood can be understood as mediated through social structures such as access to education, employment, and childcare facilities. The difficulty in combining early motherhood with successful adult life may determine levels of disadvantage. The trajectory of appropriate development proscribe

adolescent motherhood, however, different social support structures could support motherhood occurring at any point in the life course. This could enable motherhood to be successfully combined with education and employment in any order (Lawlor & Shaw, 2002b).

Health Care Interactions

The discourses available to health professionals to construct adolescent mothers predominantly understand adolescent motherhood through deficiency and lack. Adolescent mothers are viewed in the professional literature as poor candidates for motherhood, as economically dependent, as unable or unwilling to resist early sexuality, and as refusing to access abortion services. Within the health professional interviews, adolescent mothers were viewed primarily as 'adolescents' and their developmental stage precluded them from being positioned as a 'good' mother. Within the interview analysis, health professionals drew strongly on the notion of a 'good' mother defined by appropriate norms of middle class motherhood. This positioning of adolescent mothers as 'bad' mothers and the interpretation of their health care behaviours in light of their adolescence is likely to pervade health care interactions.

Much of the literature for health professionals highlights the importance of non-judgmental health care for adolescent mothers. However, this judgment does not reside within the health professional. It is the result of shared understandings of 'adolescence' and 'motherhood', the role of the individual in creating poor outcomes, and the role of the family in reproducing disadvantage. The present research highlights the difficulty of providing accessible and appropriate health care for adolescent mothers, when many of the underlying understandings of this age group are based around poor outcomes and lack. Such understandings frame what it is to *be* and what we can *know* about adolescent mothers. Any attempt to improve health care provision for adolescent mothers needs to take into account the wider discursive context of 'judgmental' health care provision. Research into the health care needs of adolescent mothers frames health professionals as individually to blame for their poor provision of service to adolescent mothers. Addressing individual health professionals' level of bias and knowledge of adolescence will not address the wider understandings that these discourses draw upon.

The academic literature for health professionals should take account of the broader social world in suggestions for practice, rather than attending to the individual health professional as the site of insufficient and inappropriate health care provision.

Reflexivity

The social location of the researcher is important in situating the research endeavour (Marecek, 2003). As such it is important to locate myself, the researcher and interviewer, in this project. Firstly, I am a non-adolescent mother. I was aged 25-30 years when I had my children, a time that is widely understood to be a socially and physically appropriate age for childbearing. I am married, well educated, Pakeha New Zealander, a member of the majority culture in New Zealand. In the context of this research on adolescent motherhood, I represent the 'good' mother, who is white, educated, middle class, married, heterosexual, and financially independent. From this social location I provide this critical analysis of adolescent motherhood, and from this position engaged the health professionals in the process of constructing their talk about adolescent mothers.

Interviews are often represented as reflecting a power imbalance between the interviewer and the interviewee (Cooper & Burnett, 2006). The interviewee is usually understood as subordinate and the interviewer, as the one asking the questions, as in a position of power. However, this relationship also depends upon a variety of other social positions. Within the context of this research, the interviewee was positioned as having professional knowledge of the health care needs of adolescent mothers while the interviewer was positioned as applying to receive that knowledge. This positioning was negotiated flexibly throughout the interview, however. Some participants strongly positioned themselves as knowledgeable; others positioned the interviewer as knowledgeable about research on adolescent motherhood. In addition, the participants often used the interview situation for a specific purpose. Some described the need for intact family structures, some for sexuality education, and others for the reform of the health care system. In this way, the interviewee was not passive, but contributed actively to the construction of the interview.

An ethical problem with the current research concerned the participants. Seventeen health professionals donated their time to this project on the understanding that the research was about the health care needs of adolescent mothers. Consequently, they were encouraged to view themselves as providing expert knowledge of the specific health care needs of adolescent mothers. The participants all consented to be interviewed as outlined in the method; however this project had an agenda that was not made explicit. It is unlikely that the health professionals conceptualised the project in the critical manner that it was designed from the outset. Although, the participants contributed to the production of this research, the project was not designed to serve their interests. The analysis was intended to deconstruct the ways that adolescent mothers are constructed and positioned within the health professional literature and by health professionals. As such, the adolescent mothers' interests were served over those of the health professionals. This was undertaken to reduce the power imbalance between adolescent mothers and health professionals that relies upon and constructs these discourses.

I have attended to the disparity between the health professionals' expectations and the outcomes of the analysis by providing a publicly available analysis of the interviews that includes those aspects that the participants actively and consciously drew attention to in their talk (Breheny & Stephens, 2006). The health professionals who participated in this research have a right to see the study they expected to be undertaken carried out. Consequently the issues that they raised in the interview situation will be analysed and published, and the results of the analysis will be returned to the health professionals.

The health professionals who participated in this research also have a right to see the results of the study presented here. In addition, providing a summary of the analysis may draw the health professionals' attention to the implications of these ways of understanding adolescent mothers. For these reasons the results of this analysis will be returned to the participants at the conclusion of the study. In presenting the results in this way, it is important to clarify the implications of the constructions without representing the health professionals as deliberately oppressing adolescent mothers, or conversely as unwittingly controlled by their language against their intentions. The

constructions revealed by the analysis do not reflect individual attitudes, but wider ways of accounting that draw upon discourses of development, motherhood and the family. Consequently a summary of the results will be made available to interested participants that consist of a combination of the thematic analysis and the critical discourse analysis presented in this thesis.

Interview schedule

The questions included in the interview schedule frame the interview in particular ways. It is not possible to construct a set of questions that would not draw attention to some ways of framing the object as opposed to alternatives ways. The interview schedule drew attention to adolescent mothers as a group, and also made sense to the health professionals by drawing attention to differences in health care and health outcomes. As discussed previously, the interview topic of the 'Health Care Needs of Teenage Mothers' (see Appendix B) provided the initial resources to view adolescent mothers as a category to which particular attributes and circumstances applied. As outlined in the 'Developmental' discourse, health professionals readily spoke to these categorisations. In apparent contrast to this, the 'Individual Differences' resources were drawn upon to suggest that the effects of age were not equally deterministic for all young women. In this way, the health professionals flexibly used the questions to reflect and resist the discursive possibilities suggested with the interview schedule. In addition, few of the questions were asked in the same way for all participants and most interviewees directed the interview. However, the context of the interview constrains what can be said and consequently produces certain kinds of knowledge. Questions regarding the capability and success of adolescent mothers and the similarity of mothering at any age may have resulted in different discourses being draw upon by the health professionals. This is not to say that the discourses presented here are any less valid, but to acknowledge that they are situated within the discursive possibilities of this particular interaction, and that these health professionals also have a range of other discourses available to construct adolescent mothers in alternative ways.

Reflexivity and analysis

The analysis does not emerge from the data, but is a constructive practice. The analysis provided is dependent on the researcher, and as such this is my analysis, rather than a definitive discourse analysis of this data (Delafield, 1999). The analysis presented here did not focus attention on the various rhetorical strategies used to blame and attribute responsibility, but drew attention to wider discursive resources. Attention was draw to these broader structures as they are typically taken for granted and position adolescent mothers in ways that appear invisible. Other readings would have produced different analyses that attended to different aspects of the transcripts. In addition, the purpose of the analysis was to be critical of the potentially damaging constructions of adolescent mothers provided by the health professional literature and by health professionals in interviews. This analysis explicitly draws attention to constructions that position adolescent mothers negatively and consequently constructs a particular version of the relationship between adolescent mothers and health professionals. Other readings could have been produced which would have highlighted alternative versions of this relationship. In doing so, it attempts to provide a starting point for addressing the power imbalance between adolescent mothers and health professionals.

One aspect of reflexivity often described is feeding back the analysis to the participants for validation (Cooper & Burnett, 2006). Burr (1995) describes respondent validation as an essential hallmark of social constructionist work. This makes sense if the intent is to produce an account that accurately reflects the lived experience of the participants. However, if the account is not intended to reflect the sense making of the participants, the analysis is unlikely to be assisted by altering it to reflect these understandings. In this project the intention was not to reflect the participants' understandings of adolescent motherhood, but to dismantle it. In this case, returning the results of the analysis to the participants does not contribute to improving the analysis process, although as noted above the final results will be returned to the participants.

Future Research

Adolescent motherhood has produced an enormous amount of professional attention and research. Adolescent mothers have been researched to assess their parenting, health care practices, education, and employment status. More recently attention has turned to the capability of adolescents to achieve 'good' motherhood. The transformation of adolescent motherhood into a scientific problem has propagated endless investigation into adolescent motherhood (Arney & Bergen, 1984; MacLeod, 1999). Consequently, it would be productive to deflect attention from adolescent motherhood and investigate how professionals produce understandings of 'good' mothering and 'correct' family functioning within a particular social context. In addition, how failure to achieve 'good' mothering and family dysfunction is drawn upon as the hallmark of the disadvantaged.

Discourse Analytic Data

The literature for health professionals was analysed for the first stage of this project on the assumption that the discourses contained within this literature would impact on the health care that adolescent mothers receive from health professionals. The academic literature draws strongly on scientific constructions as shown in the analysis. This provides a framework for understanding the nature of the individual, the role of the family and the nature of adolescent motherhood. Although this literature does provide useful understandings of the construction of adolescent motherhood, it is limited in the ability to extrapolate to the health care relationship. In addition, an interview is very different from an encounter with a client. Interviews with health professionals provide information on how it is possible for health professionals to construct adolescent motherhood, but provide little information on how adolescent mothers are positioned in interactions with health professionals. Lupton (2003) states that encounters between health professionals and patients involve shifting subject positions taken up across the medical encounter. The patient and health professional select various discourses to serve particular purposes, and doctors particularly draw upon discourses to enact patient participation, responsibility, and surveillance (Lupton, 2003). It would be productive to investigate the ways health professionals' position adolescent mothers in a primary health setting. General practitioners use videotaping of consultations to assess effectiveness and to monitor quality of consultations. Assessing these consultations

may provide examples of how health professionals position adolescent mothers in ways that undermine or enhance their competence as parents. This would not be used to try and remedy the health professional or position them as failing to provide adequate health care, but to understand how discourses are used to position adolescent mothers, and also the ways adolescent mothers resist this discursive positioning.

Other Professionals

The relationship between health professionals and adolescent mothers is foregrounded in the present research; however, other professionals also interact with adolescent mothers and have an important role in constraining and enabling adolescent mothers. Many pregnant adolescents attend hospital and other pregnancy counseling services that are often provided by social workers, counselors, and psychologists. These professionals draw upon prevalent understandings of adolescent motherhood when dispensing advice about pregnancy resolution, and play a powerful role in shaping adolescent mothers' pregnancy resolution decisions. These professionals would be a useful starting point for understanding how constructions of adolescent motherhood impact on those adolescents faced with a decision to continue or terminate pregnancy. These counselors representation of adolescent motherhood may have an important impact on these decisions.

Family Research

This analysis points to the way that families are viewed by health professionals. This requires further analysis. As discussed, the health professionals have a strong warrant for describing and circumscribing what is normal, and this includes family formation. Current statistics of family formation in New Zealand point to the rise in stepfamilies and increases in defacto relationships (Dharmalingam, Pool, Sceats, & Mackay, 2004). Despite these changes, the discussion of families by these health professionals indicates that the appropriate family best able to rear children is still constructed as the nuclear family headed by two parents who are legally married and live in a household containing only them and their children. Alternative family structures were typically viewed as less than ideal. Families were also viewed as of prime importance in the transmission of values and appropriate behaviours, and dysfunctional family structures

were strongly implicated in the production of dysfunctional individuals. The meanings, implications and potential effects of these understandings by health professionals warrant more in depth analysis. This analysis could centre on the discourses used to construct the family, the social context of these understandings, and their effects on relations of health professionals with families.

Specifically, future research could investigate the construction of the family and how the family is viewed as mediating the impact of disadvantage on individual outcomes. The present analysis indicates that families are viewed as a homogeneous group of individuals. Understandings of individual psychology and individual intervention are applied to families. Addressing families rather than individuals appears to address social location of families and individuals. However, individualised psychological models may be applied to family groups in such a way that psychology treats families as acting a group of autonomous individuals. This focus on adapting families and individuals to more comfortably inhabit the social order needs to be addressed with more specific studies of how social structures impact on the lives of individuals, families, and communities. This will enable a more socially located understanding of health and health care provision.

Conclusion

Adolescent motherhood is presented as an important social issue for individuals, the community, and the state, and a range of discursive resources are used to justify intervention into the lives of adolescent mothers and their children. These discourses focus attention on adolescent motherhood as one example of the 'cycle of disadvantage'. These discourses draw attention to wider societal conceptions of the individual, and the family and their role in participating in dominant social structures such as paid work, health care, and raising children. The construction of adolescent motherhood in the social scientific and professional literature, and in interviews with health professionals has important implications. These constructions determine what can be said and what can be known about adolescent mothers. As such, these sources represent authoritative social voices in strong positions of warrant that powerfully shape the experience of mothering in adolescence. Although each adolescent mother's

subjective experience is different according to their position at the intersection of many discourses, this analysis has shown how it may be very difficult for adolescent mothers to negotiate a positive position within the discursive possibilities available to construct adolescent motherhood. In many instances, they are positioned negatively through aspects of familial disadvantage, ethnicity, and social class, which is impossible for them to escape. Rather than focusing on adolescent mothers' deficiency or health professionals' inadequate care, the present research draws attention to the need to address wider social structures that limit the possibilities available for adolescent mothers.

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APPENDICES

APPENDIX A

Journal Articles in Health Professional Literature Analysis

Condon, J. T. & Corkindale, C. J. (2002, April). Teenage pregnancy: Trends and consequences. *New Ethicals Journal*, 45-51.

Dickson, N., Sporle, A., Rimene, C., & Paul, C. (2000). Pregnancies among New Zealand teenagers: Trends, current status and international comparisons. *New Zealand Medical Journal, 113*, 241-245.

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The following summaries of Woodward, Horwood, et al. (2001) were also included in the analysis:

Teen pregnancy prevention needed. (2001, July 25). New Zealand GP, p.2.

Break cycle of teen pregnancies. (2001, July 13). New Zealand Doctor, Retrieved April 19, 2002, from http://www.nzdoctor.co.nz/fullstory/july_teenpreg.html.

Massey University
COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Psychology
Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 350 5673

APPENDIX B.

Information Sheet for Participants

Information Sheet

Health Care Needs of Teenage Mothers

My name is Mary Breheny and I am a PhD student in the School of Psychology, Massey University. I would like to talk to health professionals about their views on the health care needs of teenage mothers. This study supervised by Dr Christine Stephens and Dr Mandy Morgan from the School of Psychology at Massey University. You can contact the researchers at any time by writing to us at the address above, or by telephoning on **350 5799 extn 7678.**

What is the study about?
The aim of this study is to understand more about the health care needs of teenage mothers from the perspective of health professionals working with young mothers.

What will be expected if I participate?
You will meet with Mary Breheny at a place of your choice, at a time that suits you. You will discuss the health care needs of teenage mothers for as long as you wish to talk about the topic.

What will happen to the interview information?
What is said in the interviews will be tape recorded, with your agreement, and used to answer our research questions, and to plan further studies. The findings of this work will be reported to other health professionals through publication in medical/nursing journals. It will contribute to our understanding of young mothers' needs, and the development of future health care services. Every participant can also receive a copy of what they have said, and a summary of all the results at the end of the study. All reports from this study will be anonymous and no names will be used. The names will be completely confidential to the researchers, and will *not* be connected with the interview information at any time.

Am I eligible to take part?
If you wish to take part in the study you should be a midwife, nurse, or doctor and working with teenage mothers.

Summary of your rights
If you choose to participate in the study you have the right to:

- Contact the researchers at any time during the study
- Read and check a copy of your interview.
- Receive information about the results at the end of the study.
- Participate in the study anonymously and with confidence that your personal details are confidential
- Decline to take part or withdraw from the study at any time.
- Withdraw any piece of information that you have volunteered.
- Turn off the tape at any time during the interview.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/46, and the Manawatu Whanganui Ethics Committee, Ethics Register 16/02. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair, Massey University Regional Human Ethics Committee: Palmerston North, telephone 06 350 5249, email S.V.Rumball@massey.ac.nz.

Massey University
COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Psychology
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Palmerston North,
New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 350 5673

APPENDIX C.

Consent Form

Health Care Needs of Teenage Mothers

Consent Form

I have read the information sheet and had the details of the study explained to me. My questions have been answered to my satisfaction and I understand that I may ask further questions at any time.

I understand that I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researchers on the understanding that my name will not be connected with any information from interviews or discussions. The information will be used only for this research and publications arising from this research project.

I agree/do not agree to the interview/discussion being audio taped. I understand that I have the right to ask for the audio tape to be turned off at any time during the interview/discussion.

I agree to participate in this study under the conditions set out in the information sheet.

Signed: .....

Name .....

Date .....

APPENDIX D.

INTERVIEW SCHEDULE

This interview concerns your experience of providing health care for teenage mothers and your views on the needs of teenage mothers.

Introduction

Can you tell me about your professional experience with teenage mothers?

Special health needs

Do you believe that teenage mothers have special health care needs?
What are these special needs?
What is it about teenage mothers that create these needs?
Do teenage mothers have different social situations?
Do teenage mothers have special learning needs? Relevance for health care?
Do teenage mothers have particular family concerns? Relevance for health care?
Do teenage mothers have special needs for social support? Relevance for health care?
Do teenage mothers have particular medical issues? Relevance for health care?

Teenage mothers' infant care

Do teenage mothers care for their children differently from older mothers?
Why do they care in different ways?
What are the implications of this for health professionals?
How should health professionals approach these differences?
Does having a stable relationship make a difference to the care-giving?

Different approaches to health care

What do you do differently for teenage mothers than for older mothers?
Why do you take this different approach?
What are the advantages of these different practices?
What advice do you give teenage mothers?
Is this different from the advice given to older mothers?
Why is this different?

Professional issues

Are there any particular professional issues in providing care for teenage mothers?
What are these issues?
What is it like for *you* when providing health care for teenage mothers?

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School of Psychology
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New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 350 5673

APPENDIX E.

Cover Letter

17 March 2003

Health Care Needs of Teenage Mothers

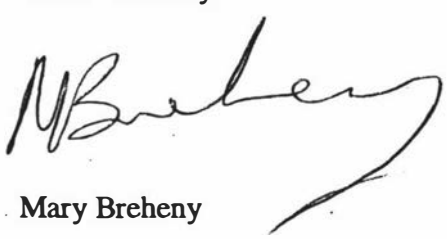
My name is Mary Breheny and I am a PhD student in the School of Psychology, Massey University. I am conducting a study on the health care needs of teenage mothers. As part of this study I would like to talk to health professionals about their views on the health care needs of teenage mothers.

I would like to invite you to participate in this study to discuss the particular health care needs of teenage mothers. It is not necessary for your work to be focussed on providing health services for teenage mothers to participate in this study. Interviews will be conducted at a place of your choice and a time convenient to you.

My study has received ethical approval from the Manawatu/Whanganui Ethics Committee, Massey University Human Ethics Committee, and Plunket Society Ethics Committee.

If you require any further information, please contact me by telephone on 06 350 5799 extn 7678 (work) or 06 329 7863 (home), or by email (M.R.Breheny@massey.ac.nz). Alternatively, you can complete the enclosed form indicating your interest in the research project and return the form in the freepost envelope provided. Thank you for your help.

Yours sincerely



Mary Breheny

APPENDIX F.

Response Sheet

Yes, I am interested in taking part or finding out more about the research.

Name _____

Contact phone number: work _____ home (optional) _____

Contact address _____

_____

- Would you like to be contacted to discuss the research further? Yes No
- Are you interested in participating in the research? Yes No

- How would you prefer to be contacted?

☐ Phone

☐ Mail

☐ Either

- If you wish to be contacted by phone, what day and time is it most suitable and convenient to phone you? _____

_____

- Any other comments _____

_____

_____

Please return in the free-post envelope provided. You do not need to attach a stamp.

APPENDIX G.

Publications

Breheny, M (2000). Health professionals' constructions of adolescent mothers: Using social constructionist approaches in health research. *Health Psychology Update, 10*(4), 33-37.