Complex social factors affecting pregnancy and childbirth in teenagers: a case study

Josie Reynolds, Laura Abbott

ORIGINAL

Thorough examination of a case study involving complex social issues and analysis of the evidence identifies the factors affecting the planning and management of individualised maternity care for Sarah, a 13 year old girl expecting her first baby. The midwives' role in evaluating the impact of the psychological, social and physical influences on teenage pregnancy and childbearing is explored. This article demonstrates the challenges posed to the midwife in delivering optimised care to a teenage client, throughout the antenatal, intrapartum and postpartum periods. Social exclusion, poor education, poor antenatal care, lacking a strong family support network, allied/developing additional complex issues in symbiosis (more frequently mental health issues and substance and/or alcohol misuse), and postpartum physical and psychological recovery will be explored.

Sarah* presented her pregnancy to maternity services at the age of 13, at 20 weeks' gestation. She was living at home with her mother, step-father and step-brother in Town A, of County B. Town A has the highest under 18 and under-16 conception rate according to the Office for National Statistics (ONS) (2016) a higher rate than the country, as a whole. Many authors theorise this epidemic is directly related to social deprivation (Imamura *et al* 2007, ONS 2016). Demography of Town A illustrates highest trends in unemployment poor education and social disadvantage (Health & Social Care Information Centre (HSCIC) 2013). Rates of homelessness and poverty are also higher than national averages (Public Health England (PHE) 2014). Both Sarah's mother and step-father were unemployed and surviving on social benefits. Sarah was enrolled in a local state school, but with poor attendance, particularly during her pregnancy. Sarah and her family were already known to social services; a second, and older, step-brother had been convicted of, and was serving a prison sentence for, the sexual molestation of Sarah two years ago. Sarah admitted to regularly using alcohol and cannabis since the trauma of this incident. Sarah's boyfriend, 15 year old Jack and father of the baby, wished to be involved in the pregnancy and thereafter. Sarah desperately wished to keep her baby and idealised that she would be able to care for the newborn once home.

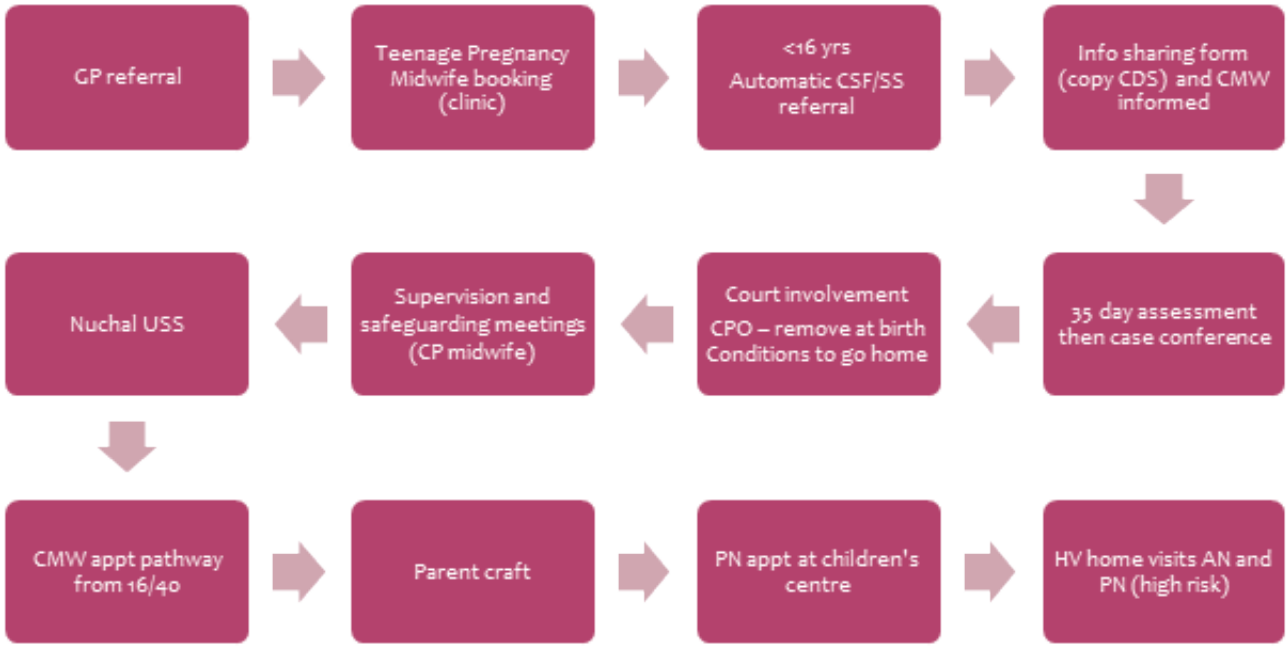
Trust C employs a safeguarding midwife, whose role is diverse and multi-faceted, overseeing all cases with complex social issues; however there is no complex social issues team operating within the Trust, and care of these specialised cases is shared between community midwives, and all health care professionals who interact with, or are involved in, the client's clinical care.

National Institute for Health and Care Excellence guidelines

The National Institute for Health and Care Excellence (NICE) (2010) provides a model of care provision for women accessing maternity services, highlighting that those with complex social issues will have additional needs. Teenage pregnancy, in particular, has been identified as one of four exemplars (along with substance and/or alcohol misuse, domestic abuse, and women from the migrant, asylum seeker or refugee population) requiring specific recommendations, particularly due to differences in barriers to care. *The Teenage pregnancy strategy: beyond 2010* (Department of Health (DH) and Department for Children, Schools and Families (CSF) 2010) warns that the number of women with complex medical and social issues will continue to rise. The *Midwifery 2020 delivering expectations* report (Chief Nursing Officers of England, Northern Ireland, Scotland and Wales 2010) confirms that the increase in social diversity presents clinical challenges in maternity care. Midwives working as lead professionals, within a multidisciplinary team, are encouraged to improve outcomes for women and babies, particularly for those with complex needs who have multiple risk factors and increased vulnerability (NICE 2010).

NICE (2008) has outlined guidance for generic and standard antenatal care of the pregnant woman. A pathway detailing the pregnant teenager's journey through antenatal, intrapartum and puerperium periods can be seen in the flowchart below. The specialist role of Teenage Pregnancy Midwife is considered essential in the provision of a tailor-made service for young mothers under the age of

Teenage pregnancy care pathway



Chlamydia testing <25yrs (+partner) @ booking. NB free milk vouchers <16yrs or if on benefits

20 (Allen 2003). In her specialist role, the teenage pregnancy midwife at Trust C books approximately 70 caseload teenage pregnancies (Reynolds 2014), and oversees antenatal care thereafter, including clinics and home visits.

Nursing & Midwifery Council rules

The NMC make a clear statement to all registered professionals, that midwives are expected to understand their leading role in safeguarding children, recognise potential for harm, and to refer those who are at risk, working with multi-agency teams and to take reasonable steps to protect from abuse or potential harm (NMC 2014). This responsibility to the social welfare of the client is also reiterated in the *Midwives' rules and standards* (NMC 2012), acknowledging that deviation from the norm, and from the midwives' scope of practice, should be referred, and specialist services, such as social services must assist in care for the individual.

Midwifery role and responsibility

It is the immediate and imperative responsibility of the midwife to refer any teenage pregnancy (under 16 years) to the CSF department. This is usually done by telephone, along with alerting the lead safeguarding or child protection midwife. Social services are involved with each teenage pregnancy case from the outset, and health visitors may be recruited for support antenatally, not just in the postpartum period.

Information sharing

An information sharing form is completed, detailing a clinical and social history, a synopsis of the case and any actions to be taken, which is kept in a locked cabinet on delivery suite. Information for clients with complex social issues is updated to the Information Sharing database and is available to all members of staff within the Trust. The need for referral to CSF is always discussed with senior staff and members of the safeguarding children team, and all referrals are reviewed and followed up daily. In this instance Sarah was already on the Child Protection Register in view of previous sexual abuse and substance misuse.

It is often the case that where one complex issue is in force, several others may be apparent. Thus, overlapping of complex social issues demonstrates the complexity of the case and the necessity for multidisciplinary mixed-skill team working. Researchers report that pregnant teenagers are three times more likely to smoke (NICE 2008) and Sarah, too, required referral to smoking cessation. Sarah's history of sexual abuse, early ons*et al*cohol and nicotine use, and substance misuse were typical of a child struggling with many psychological issues — signals to the team to refer to appropriate specialists.

Case conference

At the outset of Sarah's pregnancy, a case conference was called in order to discuss the risk of neglect and/or abuse to the unborn baby (NICE 2014). Following a thirty-five day assessment, and under section 47 of the *Children Act 1989*, a plan was put in place to safeguard and promote the welfare of the unborn child, it was also entered on to the Child Protection Register. A plan was put in place to access a Court Protection Order (CPO) at the time of delivery of the neonate that would see its removal from the family at birth, based on the best interests of both mother and child determined by the multidisciplinary team. Throughout Sarah's pregnancy, regular safeguarding and supervisory meetings were held to ensure

dissemination of information, progress and plans, ensuring unity and teamworking.

Barriers to accessing care

Barriers to accessing care and to the provision of optimal care may include, in particular for teenage service users, unfamiliarity with services, attitudes of health care practitioners and an ability or inability to build rapport or instil trust, practical or financial problems in attending antenatally, lack of continuity of health care professional, an overwhelming involvement from multiple agencies and a fear of potential social services involvement and a misunderstanding or misinterpretation of what consequences that may bring. There is a perceived and very real fear of societal disapproval (Musick *et al* 1993) and the stigma associated with teenage pregnancy (Mason *et al* 2001). This painful awareness of ostracism from the greater community, gives rise to disengagement with maternity services (NICE 2014), and potentially school services too, late booking, poor attendance and reluctance to truly bond and hence work with the health care professional. The psychological impact of the social exclusion teenage pregnancy may induce must be monitored by the midwife (Whitehead 2001) as stress and lack of social support are hypothesised to negatively influence pregnancy outcomes (Istvan 1986). Social exclusion serves only to precipitate and catalyse further anti-social behaviours, again driving these vulnerable children in to undesirable and desperate situations (Social Exclusion Unit 1999).

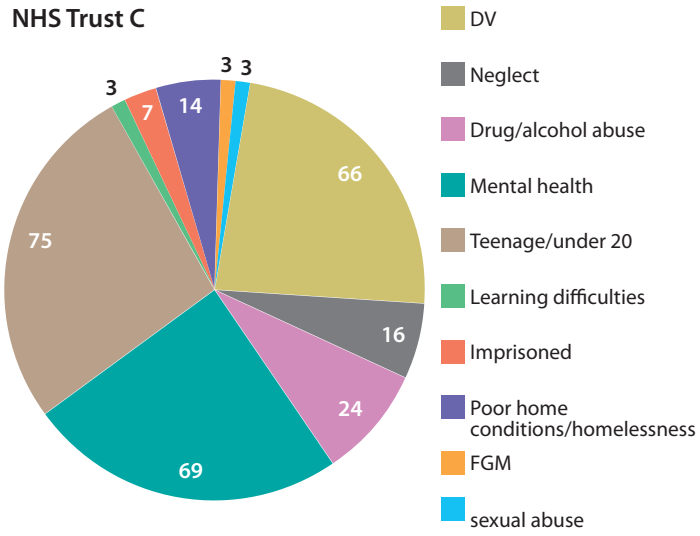
The pregnant teenager

The pregnant teenager is further at risk in distancing herself from maternity services; Heuston *et al* (2008) deduced that the younger the pregnant teenager, and the less education they have received, the greater likelihood of delayed access to maternity care. Delayed presentation to services (including concealed pregnancies) is ill-advised by health care professionals (Rogers *et al* 1996). Postponed midwifery involvement leads to poor antenatal care and possibly crucial omissions (Paranjothy *et al* 2009). Missed screenings may lead to undiagnosed abnormalities such as placenta praevia or growth retardation. Lack of counselling and education can mean potentially missed anti-D immunoglobin administration to Rhesus negative mothers, possible nutrient deficiency or anaemia in the mother and or an inability to tackle other harmful habits such as smoking and substance and/or alcohol misuse, sexual health problems and or sexually transmitted infections (STIs) and domestic violence.

Missed opportunities

As Sarah only booked with the midwife at 20 weeks' gestation, she completely missed opportunities for combined screening tests, and had not been screened for infectious diseases. Sarah was counselled about the choice of termination; however at this late stage decided to continue with the pregnancy. For the midwife there are ethical issues to consider, and reason to doubt competence and ability to consent when the client is under 16 (NMC 2008). Blood tests for screening and blood group were taken at the initial meeting, ultrasound dating and anomaly scans arranged and antenatal well-being advice given. Counsel was given and discussion was open regarding the referral to social services and the CSF department.

Audit of the complex issue demographic in Trust 'C'



NB. No data collected from immigrant/refugee population groups

Risks to the teenage mother

The evidence highlights the risks to teenage mothers: obstructed labour, perineal injury, bladder or bowel incontinence (Khabir 2004), puerperal psychosis (Jolly *et al* 2000); and to neonates: prematurity (Chen *et al* 2007), congenital abnormality, low birth weight (Kliegman *et al* 1990), and a 60% increased mortality rate of those born to teenage mothers. Interestingly, research suggests subsequent pregnancies of teenagers have a threefold risk of prematurity and stillbirth (Smith & Pell 2001); further evidence to justify continued commissioning for sexual health and contraceptive initiatives for teens, especially postnatally. Studies have shown a decline in teenage pregnancy rates directly associated with contraceptive use and sexual education (Bennett & Assefi 2005). Dull & Blythe (1998) suggest we need to do more than provide hard-copy leafleting and suggest educational programmes in family planning clinics, school and community-based clinics and pregnancy prevention programmes with additional focus on STIs (Tripp & Viner 2005), although sex education in schools has always provoked controversy and debate (Pierre & Cox 1997). A randomised controlled trial (DiCenso *et al* 2002) deduced initiatives of this nature had little impact on teenage pregnancy rates, and Allen *et al* (2007) surmise parental or

guardian relationships are of most influence on teenage pregnancy. Indeed many claim a cyclical cross-generational pattern of behaviour (Whitehead 2009), and Ermish & Pevalin's (2003) study at the University of Essex entitled *Who has a child as a teenager?*, deduced girls whose mothers were a teen parent were twice as likely to become a teenage mother themselves as opposed to those with older parents. With regards to prevention of teenage pregnancy, the midwife is challenged by generations of learned behaviours. Sarah's mother was a teenage mother herself and all available services supported the entire family through their journey. Cultural and social influences like alcohol and substance misuse were also addressed with the midwife and social services, who in turn liaised with drug counsellors (Petersen & McBride 2002).

Labour and birth

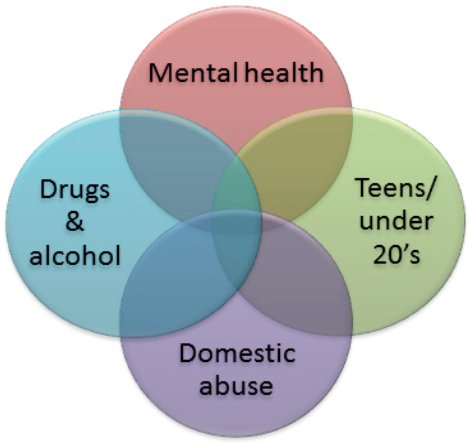
During the intrapartum period, Sarah was both medically well and obstetrically low-risk, and so laboured in the midwifery-led unit under the one-to-one care of a midwife, who was unknown to her. Sarah went into labour at 37 + 2 weeks' gestation, despite the greater risk of premature birth in teenagers (NICE 2008). Continuity of care has been cited as crucial in developing patient-professional rapport (Turner *et al* 1990) and absence of this may have impacted upon the experience of labour, for both the midwife and Sarah. Sensitivity was afforded to the family at a time where Sarah was psychologically, emotionally and physically vulnerable. Sarah was aware that at delivery a CPO would be applied for in order to legally remove the neonate, and the CSF department were informed by the case midwife at the onset of established labour. Fear and trepidation are common in particularly young teenagers upon ensuing labour, where the reality of the physical demands of labour and the psychological impact of becoming a mother is heightened (Bonell 2004).

Sarah progressed well through the first stage of labour; however she endured an extremely long second stage, with slow and difficult, yet not assisted, delivery after five hours of mobilisation and utilisation of birthing aids such as a birthing stool and a variety of positions. Sarah sustained extreme perineal bruising and severe oedema. Teenagers from under-developed countries can suffer intrapartum complications such as obstruction of labour (Mayor 2004) and it is hypothesised the immature pelvis of exceptionally young teenagers are not appropriate for birthing a full-term fetus normally (Kramer 1987). Conversely however, Petersen *et al* (2009), have shown that teenagers are more likely to have shorter labours and less likely to require assisted delivery or caesarean sections than older mothers. Physical recovery for Sarah was aided by personal hygiene and well-being education.

Perinatal mental health and the teenage pregnant woman

A referral for mental health to review Sarah was also made by the lead midwife, as Sarah exhibited several pre-disposing risk factors for postnatal depression (Cunnington 2001). Teenage mothers are three times more likely to suffer from postnatal depression than older mothers and have a higher risk of poor mental health for three years after giving birth (Teenage Pregnancy Independent Advisory Group 2010).

Venn diagrammatical representation of complex social issues and their potential to inter-link and co-exist



NB. Whilst collating the data on the Information Sharing database, some cases were unspecified, not all had date-of-birth details, and most importantly, many individuals had several complex social issues and so did not fit in to just one category, instead overlapping in to several. Statistics are affected by the rate of disclosure of a complex social issue.

Breastfeeding and the teenager

Teenage mothers are 50% less likely to breastfeed, speculated to be the result of reluctance to breastfeed in public due to embarrassment, peer pressure, viewing breasts as sexual and not functional parts of their body, lack of education regarding benefits and often lack of role-modelling and a positive example of breastfeeding from their own mothers (Petersen *et al* 2009). Sarah consented to breastfeed with encouragement, but only for the first feed. She did not attend antenatal breastfeeding classes. When asked why, Sarah explained logistically and financially it was difficult for her.

Postnatal care

The immediate postnatal period was emotionally charged, and Sarah required an exceptional amount of support to deal with the psychological ramifications of her baby being removed once the CPO was passed. This matter is complicated over weekend periods where CPOs cannot be granted, and this is challenging for the midwife, acknowledging a mother-child bond will only grow in strength, and make it all the more difficult for the young teen

to cope once discharged. Physical management of suppression of lactation was assisted by the GP in order to minimise the distress this may have caused. Contraceptive advice and implementation were also imperative in working towards a positive future for Sarah (Churchill *et al* 2000). Accessibility to sexual health 'one-stop-shops' (Rogstad *et al* 2002) and reducing the expense of contraception can only encourage reduction in teenage pregnancy and STIs (Darroch *et al* 2001). The health visitor plays an important role in ensuring re-integration in to the community, support with getting back into education and preventing relapse into drug abuse and/or the repetition of events (Chapman *et al* 1990).

Sexual health needs

Although marked improvements have been observed in recent years particularly since implementation of the Teenage Pregnancy Strategy, including schemes such as the Family Nurse Partnership (Barnes *et al* 2008), more could still be done towards prevention rather than just cure (Arai 2003). Jones *et al* (1985) claim that children diagnosed with psychiatric disorders showed a propensity toward teenage parenthood later on. Although education is key in reducing teenage pregnancy rates, becoming proactive in sexual health and contraception education at the earliest identification of those pre-disposed, or at risk due to surrounding complex issues (Dull & Blythe 1998), could reduce future teenage pregnancy rates.

Non-judgemental care

Like all pregnant women, teenage mothers must be assisted in making informed decisions about their care. They require nurturing and the support of a health care professional willing to think 'youthfully', be welcoming, non-judgemental, accessible, have strong links to a multitude of agencies (Bennett & Assefi 2005) and be willing to provide support with finances, housing and education. Sarah lacked continuity in her care, and this may have impeded the positive impact she may have enjoyed through the support of a named midwife (Turner *et al* 1990) and a complex social issues team.

Conclusion

Sarah was a young teenager who accessed maternity services when she was 20 weeks' pregnant. Having suffered trauma in her childhood, she was at risk of psychological distress as well as having a number of physical risk factors. Having continuity of care from a midwife may have given her greater support. However, the importance of a non-judgemental approach to care and multi-agency arrangements enhanced safety for Sarah and her baby. The importance of early sexual health education and support for the teenager's mental health, especially where she may have been a victim of abuse can encourage engagement and a trusting relationship with health professionals.

**Anonymity of the teenage client has been preserved, through the use of a false name, in accordance with The Code (Nursing & Midwifery Council (NMC) 2008).*

Josie Reynolds, Midwife at East and North Hertfordshire NHS Trust.
Laura Abbott, Senior Lecturer at the University of Hertfordshire.

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