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**YOUNG MOTHERS' INFANT-CARE SLEEP PRACTICES AND FACTORS WHICH
INFLUENCE THEIR PRACTICE CHOICE**

A THESIS PRESENTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE
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Abstract

New Zealand has one of the highest Sudden Unexpected Death in Infancy (SUDI) rates in the industrialised world. Young Maternal Age (YMA) has been posited as a strong risk factor for SUDI. Little is known of the decision-making processes of young mothers which may contribute to the higher levels of risk. This study enquired into the experiences of young mothers with regard to their infant care sleeping practices. Through the use of Thematic Analysis (TA) it researched as to whether there were patterns in these mothers' talk of their experiences, and then sought to understand the ways they constructed their practice choices, in order to provide explanation and understanding of the complex social environments in which these mothers must survive and how these may contribute to the overall statistics. Eleven young mothers were interviewed in semi-structured interviews. Five themes arose from the data: Needs of the Baby; Needs of the Mother; Baby's Wishes; Mother's Instinct or a Natural Ability; and, Non-compliance – Incognizant or Purposeful Action. Through analysis of the themes, it became clear that the social milieu of which these mothers are a part, has tended to influence their practice choices. However, one surprising discovery was how little their decision-making appeared to differ from that of other western parenting groups. What has been borne of the societal influences and attitudes toward this group is the unexpectedly comforting find that these mothers, despite their age, are resilient, resourceful, insightful young women who, like others, want nothing but the best for their infants. Implications of this work for practice, policy and research are discussed, and future recommendations made which make use of the resourcefulness of young mothers such as those in the present study. This group deserves the right to society's respect, acceptance and, above all, support, which will enable them to be the valued, contributing members of society that they so rightfully deserve to be – as mothers, as women, and as an equal!

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Chapter One, Introduction

Sudden Unexpected Death in Infancy (SUDI) – A New Zealand History

New Zealand has the highest Sudden Unexpected Death in Infancy (SUDI) rate among industrialised nations (Health Quality and Safety Commission, 2012). This has been the case since at least the early 1980s (Mitchell, 2009). As such, SUDI is not so much a diagnosis as it is a blanket term used to cover Sudden Infant Death Syndrome (SIDS - SUDI deaths that remain unexplained) and explained SUDI. Historically, the advocacy of safer sleeping practices of infants in New Zealand came about after a realisation, as recently as some 30 years ago, that the numbers of SUDI may actually be preventable or at least somewhat reduced. In 1991 the New Zealand Cot Death Prevention Programme was launched and this saw an almost immediate and significant reduction in infant deaths (Mitchell, 2009). SUDI deaths have reduced from approximately 250 per year to around 60 per year since the programme's launch (Johnston, 2013). It is estimated that approximately 3000 New Zealanders' lives were saved between 1990 and 2008 because of this initiative (Mitchell & Blair, 2012).

To address the recent history of the changes in SUDI rates in New Zealand, Cowan (2010) discusses a number of change periods which occurred over this time, and firstly refers to the "Rapid Change" period, which was between 1984 and 1994. This was a period when SIDS rates were high, at 5 deaths per 1000 live births, and there was heightened community and professional concern and anxiety about how to protect babies from SIDS when there was no confirmed way to do so. In 1987 material promoting the side or supine (back) sleeping

position over prone (front) position, as well as other advice such as a clear face and avoiding smoking, was distributed. Then, as mentioned earlier, in 1991 the New Zealand Cot Death Prevention Programme was launched promoting mainly supine positioning. However, side positioning was still also an option, and at this point death rates were seen to plummet until around 1993/94 when the rate of decrease slowed significantly (p. 89).

From 1994 to 2004, a period Cowan (2010) calls “Gradual Change”, a number of other risk factors began to emerge, and now included the initially-advised ‘safer’ side sleeping position. The position for optimum safety was now considered to be the supine position only. This, of course, created much confusion and was greeted with distrust and a reluctance to change again (p. 89). Further, confusion over the relationship of SIDS with smoking saw changing messages, as too did information about the importance of breastfeeding. The change to supine position in particular came with a new set of concerns and challenges, such as the possibility of babies choking if they spilled/vomited (aspiration), or getting a flat head (plagiocephaly) (p. 89). This was all taking place during a time when others were promoting a controversial relationship between SIDS and toxic gases, which the media was all too happy to champion, but which was later disproved as a risk factor (Mitchell, 2009).

The process of “Slow Change” (2004 to 2010), as Cowan (2010) continues, saw deaths plateau at approximately 1.2 per 1000 live births. These statistics have remained at this level since. However, while SIDS rates were at their lowest ever, the rates of accidental suffocation had risen and this led to a focus on the

behaviours of smoking and bed-sharing (p. 90). These are discussed in more detail further on. However, the relationship between these two factors and SUDI was recognised as the most plausible explanation at that time. This was due to better information surrounding the circumstances of the deaths, which revealed that maternal smoking and the accidental rolling on top of babies while sleeping, or babies becoming wedged into places where they were unable to get access to air, such as on a couch, became more transparent (Mitchell, 2009).

In summary, while overall there have been significant improvements in the New Zealand statistics over the past 30 or so years, which in turn reflects changes in practice, it would seem that this has now come to a somewhat grinding halt. Health promotion efforts over this time, about changing from sleeping baby in the prone position, avoiding smoking, and keeping the space around baby's face clear of bedding and toys for example, certainly had an impact upon the changing statistics. However, these rates have remained at a plateaued level since, and given that this is a preventable form of death, there is still heightened concern to eliminate the rates and remove New Zealand from the top of the industrialised world's statistical table.

The Risk Factors of Sleeping Environment and Sleep Position For SUDI

It is unfortunate, but as New Zealand, and the rest of the world, have experienced more SUDI cases in recent times, this has necessarily been the main way more has been learned, and thus knowledge and advice have both gradually become more accurate and appropriate. On the majority of risk factors now known, such as maternal smoking, alcohol consumption, breastfeeding, infant

sleep environment (including bed-sharing and/or co-sleeping), and infant sleep position, a considerable amount of research has been conducted. The former three are for discussion elsewhere. However, the latter two will receive further consideration here.

Sleeping Environment. Perhaps the one risk factor that has been more contentious of late is related to the issues around the infant sleeping environment, in particular bed-sharing. Arguments have been made both for and against the practice of bed-sharing. For example, while the American Academy of Pediatrics (2005, 2011) advocates ‘zero’ bed-sharing, and Carlberg, Shapiro-Mendoza and Goodman (2012) consider accidental suffocation and strangulation in bed (ASSB) a major maternal and infant characteristic responsible for most infant unintentional injuries causing death, others (for example, Glasgow, Thompson & Ingram, 2006; McKenna & McDade, 2005; and, Nelson & Taylor, 2001) believe it is not as simple as having a ‘one-size-fits-all’ approach to such a personal issue. Many factors considered by these authors which necessarily come into play here are those such as culture, lifestyle/living conditions, whether a mother breastfeeds and so on, and that the choices to bed-share are both varied and more complex than first thought. Hence, they advocate that approaches should be more person and/or context-specific and less “simplistic, scientifically inaccurate and misleading” (McKenna & McDade, 2005). Further, Ball and Volpe (2013), comment that, “clinical and academic discussion of infant sleep location has had a volatile history due to the personal and cultural value (or lack of value) attributed to bed-sharing” (p. 89). McKenna and Volpe (2007) found that many factors work in relation to each other, often

in unique contexts, and these determine the choices parents make as to where babies sleep and why. They acknowledge that baby sleep patterns and locations will change in the first 12 months of life and that, “nighttime sleeping arrangements almost always reflect the nature of family values and the quality of social relationships at any given time” (p. 360).

The immediate sleeping environment can also contribute to a higher risk of SUDI, particularly if the infant is placed on or is surrounded by pillows, or lies on soft bedding, is surrounded by loose linen and toys, or is supported by sleep-positioners, for example. These concerns are discussed further here.

The risks associated with soft bedding, the use of pillows and having loose bed-linen and/or toys are such that they pose a threat to a baby if that baby should move or change position while sleeping. A soft mattress, as opposed to a firm one, may tend to allow the baby’s body weight to sink into it, thus should baby move it may inadvertently turn either its head, or entire body, prone and become stuck in the ‘crevice’, threatening suffocation if he or she cannot extricate themselves from the position they are in (see American Academy of Pediatrics, 2005). Loose bed-linen has the potential to envelop a baby as it moves, possibly tightening around it and holding it in a position where it cannot breathe clearly, or it may cover the baby completely forming an enclosed space where oxygen eventually is unable to enter and carbon-dioxide is unable to escape (ConsumerReports.org, 2012), creating the condition known as rebreathing. Likewise, and for similar reasons to the risk attached to pillows and loose linen, it is recommended that soft toys also be kept out of the baby’s bed

or crib (American Academy of Pediatrics, 2005) to avoid creating further suffocation risk. In addition, sleep-positioners have been known to cause suffocation in instances where babies have wriggled downward in their sleep and the face has become covered by the positioner itself (Centers for Disease Control and Prevention, 2012). Additionally, the U.S. Consumer Product Safety Commission (2010) found that should a baby roll to the prone position during sleep, the sleep-positioner may hold baby in that position making it difficult to roll back to a side or supine position, risking being forced face down and suffocating (p. 1).

Sleep Position. As discussed earlier, the sleeping position of infants has witnessed major changes in recent times due to the recognition that prone positioning was deemed a significant contributor to the SUDI statistics from the early 1990s. According to Hutchison, Stewart and Mitchell (2007), “in 1985 46% of New Zealand infants slept in the prone position; by 1990 this had dropped to 32.9%...from 1993 on, the prevalence of prone positioning in New Zealand dropped to around 2.5-3% and this appears to have remained unchanged” (pp. 245-246). However, these authors also witnessed a marked increase in the side and side-plus-back positioning rates in New Zealand (32% and 15% respectively), as compared with the United States. They found that the reasons for such rates revolved around parents’ concerns over plagiocephaly or aspiration of vomit if baby is always positioned supine, or that baby just slept better on his or her side (p. 246).

The relationship between prone position and rates of SUDI was noted as early as 1965 but, as discussed earlier, changes recommending the supine position did not appear until the 1990s (Chung-Park, 2012, p.235). Despite this change, and the fact that SUDI rates declined markedly from then, this author also found that, in the United States, rates of side-sleeping positioning had increased, citing parents' main concerns related to supine positioning as, "the possibility of an increased incidence of aspiration or choking" (p. 235) and "infant comfort" (p. 235). As has been previously discussed, the risks associated with side positioning involve the threat of babies rolling over to prone and being unable to create a clear breathing space by either rolling back to their side or into supine, or turning their head while still prone to allow the freer flow of the necessary gases, thus avoiding re-breathing and possible asphyxiation. None-the-less, the consistency in concerns expressed by parents about positioning their babies supine must not be treated lightly as they appear very real fears and therefore merit further attention.

Parental concerns over the threat of aspiration or choking, and of plagiocephaly, have more recently been addressed and the literature has found that, generally, these concerns are largely able to be allayed through better education and alternative, safer options for counteracting the effects of these concerns. For example, with regard to plagiocephaly, it is now suggested that regularly placing baby prone during awake time (see Jones, 2004), or gently alternating the head to one side or the other while baby is sleeping supine (see Hutchison et al., 2007), will reduce, if not avoid altogether, the risk of a misshapen head.

Where risk of aspiration or choking is concerned, evidence suggests that supine positioning as a causal factor in SUDI due to aspiration is minimal at best. Byard and Beal (2000) reviewed 196 cases of infant and early childhood death and concluded that in only three cases could it be suggested that death could be attributed to “significant gastric aspiration”. These three cases, however, were found in the prone position with faces buried in vomitus at the time. The remaining cases were in supine position and none of their deaths were attributed to gastric aspiration. Additionally, Krous, Masoumi, Haas, Chadwick, Stanley and Thach (2007) concluded that the risk of gastric aspiration is not increased by supine positioning. These authors further discussed the fact that although fear of aspiration resulting in death is among the numerous reasons why supine positioning of infants is not taken up, there has been no demonstrated support for this fear in the many past academic studies investigating its validity (p. 244). Regardless, these authors also discussed the auto-resuscitation mechanism that occurs when the brainstem centres initiate an automatic reflex response to the threat of hypoxemia (insufficient oxygen in the blood), which results in unconsciousness. Despite the fact that there are numerous reasons why a hypoxemic event can occur in infants, they went on to state that, “the vast majority of these infants auto-resuscitate” (p. 244). This ‘auto-resuscitation’ is an automatic response to the threat of suffocation or choking or an object becoming stuck or touching the back of the throat.

Why prone positioning holds the highest risk has had much attention over recent times. In a study of infants at three months of age, Galland, Bolton, Taylor, Sayers and Williams (2000), found that when these infants were placed

prone, their ventilatory sensitivity to the threat of asphyxiation was somewhat reduced as compared to being placed supine (p. 426). These authors explained that this is due to the prone position forcing the baby to exert “greater inspiratory effort to achieve normal response from lung mechanoreceptors” (p. 427). Further, Ishikawa, Isono, Aiba, Tanaka and Nishino (2002) found that prone positioning increased the occurrence of collapsibility in the upper airway of infants and small children when compared to supine positioning (p. 761). However, these authors have not yet been able to identify the exact mechanisms through which this phenomenon occurs. Jeffery, Megevand, and Page (1999) found that a decrease in the protective responses of swallowing and arousal occurred more frequently when infants were placed in the prone position (p. 266). What this evidence shows is that there are very real physiological, evidence-based explanations why prone positioning poses greater risk for SUDI.

That said, the prone position has also been found to have benefits, particularly for newborn babies (up to four weeks of age) and to those born pre-term. Galland et al. (2000), although unclear on the exact reasons, found that the reduced ventilatory sensitivity which was apparent in three-month-old babies placed prone was not the same for newborns or preterm babies when placed in the same position. These authors discussed how, in fact, this position “generally improves lung function and respiratory drive” in this particular group but that, “beyond the newborn period there is no advantage to ventilation in healthy infants sleeping prone” (p. 427). These authors suspect the lower weight of newborn and pre-term infants may play a role in that there is less

pressure limiting effective lung expansion, thus less force is needed in the mechanisms required for breathing itself (p. 426). However, they also consider how the babies in these two groups tend to lie when in the prone position. They observed that the newborn and pre-term babies tended to lie with the knees tucked up under the abdomen suggesting that there is less abdominal pressure between the lungs and the sleeping surface, whereas three-month-old babies tended to lie flatter, or not with tucked-under knees, thus increasing the pressure upon the breathing mechanism (pp. 426-427).

Young Maternal Age (YMA) – the Under-examined Risk Factor

One particularly less-investigated risk factor is that of Young Maternal Age (YMA). Generally, YMA has been treated as any woman who becomes a mother up to 25 years of age. Statistics report that, in more recent times at least, YMA has been a relatively stable factor contributing to SUDI rates. In New Zealand, for example, the rate of SIDS deaths for mothers up to 25 years of age for the period 2008 and 2009 was 1.95 per 1000 live births as compared with the rate for all mothers for the same period of 0.7 per 1000 live births. Higher still was the rate for mothers <20 years which was 2.5 per 1000 live births (Ministry of Health, 2012, p. 53). This same report concluded that, "SIDS rates were highest for young mothers...and mothers from the most deprived areas" (p. viii). For the purposes of this dissertation the term *Young Mother* refers to mothers up to and including 20 years of age.

YMA cannot be a direct cause in and of itself, but it could be proposed that it may coalesce with other factors such as a lack of experience, knowledge,

maturity and/or support, as to why these younger mothers form part of the overall statistical calculation. As is discussed further on, young mothers also form part of the more vulnerable groups in society with regard to having a lack of access to appropriate and necessary resources, having lower incomes, interrupted or shortened education, and are likely to be of single marital status, with the added stress of societal stigmatisation. Fleming, Blair, Platt, Tripp, Smith and The CESDI SUDI Research Group (2003) listed the background epidemiological characteristics of SIDS infants and families which are strongly related to social class. This list included YMA and single parenthood (p.272). Further, Blair and Fleming (2002), in their epidemiological study of SIDS infants, described an even more comprehensive list of characteristics which placed YMA at the top, single marital status next, and states that, "SIDS families are generally poorer compared to the rest of the community and this gap appears to be widening" (p. 52).

It has further been found that YMA, among other factors, is a demographic factor that can influence, or is considered a predictor of, the prone and/or side sleeping positioning of infants, and for bed-sharing. For example, in the United States, single marital status and YMA (Taylor & Davis, 1996), and caregivers on lower incomes (Zachry & Kitzmann, 2010), have all been found to be predictors of infants being slept in the prone position. In Cardiff, United Kingdom, side-sleeping position was found to be more prevalent among mothers from the more deprived areas (Shrivastava, Davis & Davies, 1997). Further, bed-sharing was found to be notably more routine with mothers <18 years of age in Willinger, Ko, Hoffman, Kessler and Corwin's National Infant Sleep Position Study (2003). Yet,

the explanations behind why these factors have such an influence upon the statistics have had relatively little attention with respect to understanding *how* they can have an impact.

Stigmatisation of young mothers appears to have maintained its place in society over time. For example, Koniak-Griffin, Logsdon, Hines-Martin and Turner (2006) investigated contemporary mothering in a diverse society and discussed how for young mothers in particular mothering is still considered “deviant” by society because they do not meet the idealised expectation of what a “good mother” is – a view which has its roots in 19th-century middle-class Western standards (p. 672). Further, through a Social Constructionist epistemology, Breheny (2006) posits that the reasons for western society’s non-acceptance of these mothers into ‘mainstream’ can be attributed to the ways we categorise the world around us. The construct of young motherhood as a ‘social problem’ has become ingrained so deeply that not only has society categorised these women in such a way, but the mothers themselves, through the nature of the structures of power, have tended to do the same through the use of defensive or rebellious terms and/or behaviours in an attempt to justify their place (p.43). To further exacerbate this process, because of such categorisation, the choices young mothers make, and the phenomena which influence those choices, then become overly scrutinised should such ‘deviant’ behaviours result in tragic, or less than socially-acceptable outcomes, such as SUDI.

The historical and cultural significance of this categorisation practice, despite still clinging to its nature of sustaining the alienation of some members of

society, has in itself changed. Not so long ago, young, expectant mothers were whisked away before society had any chance to realise that something was 'awry'. These women would give birth, their babies adopted out, and then they would return to society some time later to resume their normal functional place (Else, 2012). For those not fortunate to be removed temporarily from society while this 'process' occurred, the risk of not only themselves being shunned by society but also their families, was significant. Today, however, while there is no more 'whisking away' and the majority of young mothers and/or their families choose to raise their babies themselves, that 'shunning' as it were, is still ever-present, particularly for the mother herself. The stigmatisation of her family is perhaps not as severe as it once was, but the negative attitudes toward the mothers themselves still remain. Should a young mother further experience a tragic outcome whilst raising her infant, this may serve to augment the problematisation of this group, and then possibly deflect further to the scrutiny of her family, forcing her to continue to assume the categorisations of deviant and a 'bad' mother.

On the other hand, there is a growing body of literature which demonstrates new-found strength and resilience in young women who become mothers at an early age, despite the stigmatisation. Lesser, Koniak-Griffin, and Anderson (1999), found some young mothers' experiences of motherhood helped improve their previously self-destructive lives through "straighten(ing) up" and "calm(ing) down", leaving the gang and stopping drug use (p. 140). Similarly, Hunt, Joe-Laidler and MacKenzie (2005), upon doing research with multi-ethnic gang girls, found that having their babies acted as a transition from gang girl to woman and

mother, and behaving more responsibly (p. 362). These authors also determined that the young women began to regulate their risky behaviours in order to protect their child's well-being and, at the same time, plan for the future so as to have improved quality of life for themselves and their children (p. 360).

As has been demonstrated thus far, a significant body of knowledge exists about the risk levels associated with YMA and SUDI. But, as mentioned earlier, generally YMA in and of itself is not a risk factor until it is paired with other behaviours considered SUDI risks, such as bed-sharing and prone or side sleeping position. This suggests, then, that perhaps YMA could be considered a risk factor because other issues around it may increase the risk of making unknowingly-erroneous judgments due to immaturity, naivety, and lack of experience or understanding of the long-term consequences of one's actions - not dissimilar to behaviour typical of adolescents in western society, perhaps. Investigating how or why YMA is a risk factor, even in combination with these other concerns, perhaps should be afforded more import than it has received in the past, particularly if the health industry is to attempt to turn the statistics on their head.

While YMA as a risk factor for SUDI is significant in the statistics, and statistics are necessary to assist change, they are, nonetheless, inherently just that - statistics. They are (most often) the result of quantitative enquiry and calculation with little regard for individual experience, meaning and context. Within statistics are calculations which help build a picture for humankind to

compare where they fit in numerically, but they give no heed to how or why people have ended up in those calculations in the first instance. Statistics help determine the categories people must fit into to function and be accepted within the norms of society. But, the outliers are largely ignored - outliers such as 'deviant' young mothers, for example. The long-term health outcomes of being labelled an outlier or 'deviant' are perhaps best examined through a brief glance at the determinants of health. In doing so it may then be possible to begin to understand this issue, broadening the picture to include systemically-created determinants of health, and may help to elucidate the historical and cultural relationships between YMA and the choices of infant-care sleeping practices.

Determinants of Health and How YMA may Impact SUDI. Wilkinson and Marmot (2003) wrote of the social determinants of health. Social gradient, stress, early life, social exclusion, social support, and addiction, among others, are purported by these authors to have a profound effect on an individual's long-term health outcomes. Disparities in health are reflected in the fact that, "poorer people live shorter lives and are more often ill than the rich" (p. 32). For the young mothers in society, the impact of such awareness has had, and can continue to have, consequences not only for themselves but also for their infants. How then do determinants of health contribute to this overall issue?

Social Gradient. The further down the social ladder, the greater the risk of serious illness or premature death (Wilkinson & Marmot, 2003, p. 10). For young mothers, as will be expanded upon in *Social Exclusion*, western society has

tended to discriminate and stigmatise not only this group, but unmarried mothers also (Kirchengast, Mayer & Voight, 2007). As a consequence, they are inclined to be placed lower down the social gradient with other vulnerable groups in society due to the moral judgments and values of western society being 'violated' (Thursby, 2007, p. 5), having lower educational attainment and, most often, living in poorer socio-economic conditions. Access to necessary resources for those at the lower end of the social gradient, including health services and support, is limited. Thus, access to appropriate support and information about safe-sleeping best practice will be compromised.

Stress. "Feeling worried, anxious and unable to cope are damaging to health and may lead to premature death...social and psychological circumstances can cause long-term stress" (Wilkinson & Marmot, 2003, p.12). Aside from the accelerated transition from adolescent to adult into which they have been thrust, this in combination with other likely present stressors such as worrying about coping, possible loss of social and emotional connections, and anxiety about caring for another dependent human being, may well have an impact upon a young mother's decision-making ability when it comes to her practices of infant-care sleeping.

Early Life. "Foundations of adult health are laid in early childhood and before birth. Slow growth and poor emotional support raise the lifetime risk of poor... health" (Wilkinson & Marmot, 2003, p.14). Adverse conditions during pregnancy – maternal stress, possible maternal smoking, drug and alcohol misuse, poor nutrition, insufficient exercise and inadequate prenatal care – all contribute to less than optimal fetal development, which is a risk for health in later life. If, for

whatever reasons, a young mother is unable to support positive infant experience(s) then this early life deficit in infant care has longer-term and far-reaching consequences for the infant's future health also. Besides the adverse conditions a young mother may experience during her pregnancy, the effects of a continuation of many of these conditions once her baby is born will impact significantly on the care she provides. Combine this with less than optimal fetal development, and it can put her baby at higher risk of SUDI depending upon her care decisions.

Social Exclusion. Relative poverty is about being much poorer than most in society, i.e. living on less than 60% of national median income, being denied access to decent housing, education, transport and other factors vital to full participation in life. Being excluded from the life of society and treated as less than equal leads to worse health and greater risk of premature death (Wilkinson & Marmot, 2003, p. 16). The stresses of living in poverty are particularly harmful during pregnancy. Social exclusion also results from racism, discrimination, stigmatisation, hostility and unemployment. Such processes are socially and psychologically damaging for both mother and infant, and when labelled 'deviant', she and her infant are destined to be affected long-term by such fixed attitudes and lack of feeling a valued contributor to society. Being socially excluded may prevent a young mother from accessing appropriate and necessary resources, which means she may not be aware of safe sleeping recommendations for her baby, as well as being unable to provide adequate environmental conditions in order to keep her baby safe.

Social Support. Friendship, good social relations and strong supportive networks improve health at home, work and in the community. People who get less social and emotional support from others are more likely to experience less wellbeing, more depression, a greater risk of pregnancy complications and higher levels of disability from chronic diseases (Wilkinson & Marmot, 2003, p. 22). Often young mothers notice a change in their social relationships after giving birth. Their lives irreversibly change direction but the lives of those they have socialised with, particularly friends who may still be in high school, have not. Often a 'natural' rift can occur. Relationships with family may also be at risk, especially if news of the pregnancy was not well-received in the first instance. Additionally, bad social relationships can lead to poor mental and physical health. Inequality is also corrosive of good social relations and, as discussed previously, for many young mothers this inequality is borne of societal stigmatisation and a lack of access to necessary resources. A young mother may be forced to make decisions about infant-care sleeping without having access to appropriate knowledge, which may well have come from or through good social contact and support.

Addiction. Use of tobacco, alcohol and drugs is influenced by the wider social setting. All are closely associated with markers of social and economic disadvantage (Wilkinson & Marmot, 2003, p. 24). Aside from the fact that young mothers' social settings prior to pregnancy or birth may be the same as many adolescents who experiment with these addictive substances, they may also have had the added risk of being surrounded by family with addictions. Bringing

an infant into addictive environments risks their immediate health, particularly where sleeping is concerned.

Bearing these explanations in mind, it is barely surprising that young maternal age is considered a risk factor for SUDI and certainly fits within the bounds of how these mothers', and their babies', health outcomes are likely to be determined. On the face of it, it would seem that the odds are stacked against most, if not all, women who become mothers at a young age. In the New Zealand context, the ever-widening gap of inequality certainly influences the way young mothers experience health and society, and therefore they may make certain decisions at any given time depending on the resources available to them, risking possible tragic outcomes. A further, detailed discussion on this follows. But, they may also make decisions that do not result in such outcomes. Regardless, this explanation only helps to partially elucidate how these women have historically, socially and/or culturally come to be positioned where they are. What is less clear is what is happening within their own, personal worlds - their experiences, the choices they make, and what it is that has influenced such choices as infant-care sleeping practices.

Factors Influencing Parental Choices of Infant-care Sleeping

The practices of parents with regard to how they choose to sleep their infants (babies up to 12 months of age), are many and varied and can be affected by any number of factors. Culture, religious beliefs, medical advice, media, family and friends, and tradition are just some of the influences which dictate how and where an infant is slept. Said practices may also vary depending upon economic

status, environmental/living conditions, access to necessary resources and appropriate information, and parental age, to name a few additional elements. Recommended health advice advocates babies are slept in their own bed, on their back with their face clear of loose bedding, toys and clothing (Change For Our Children, 2010). Although the majority of countries around the world are a mix of ethnicities and cultures nowadays, not all parents or caregivers may follow this advice. The traditional infant-sleeping practices of many vary significantly, and may be deemed acceptable in one culture, but considered unsafe in another. While all of the above factors are too numerous to consider within the bounds of this dissertation, the intention of this section is to discuss those issues known to be more relevant in their influence within the current New Zealand environment.

New Zealand is officially recognised as bicultural and within it are both western and Māori views, among others. When considering infant-care sleep practices, McManus, Abel, McCreanor and Tipene-Leach (2010) comment how the practice of co-sleeping/bed-sharing, for example, is “a culturally-valued common practice amongst Maori” (p. 647). This observation could be extended to encapsulate many cultures (for example, see Mindell, Sadeh, Wiegand, How, & Goh, 2010; Nelson & Taylor, 2001; and Thoman, 2006). Hence, this poses an added complication in reconciling traditional, culturally-valued practices with current health recommendations for keeping babies safe. Thus, as Cowan (2010) states, “when a valued behaviour is in conflict with what is safe for a baby, barriers of understanding [need to be] overcome, and enablers found” (p. 91). Many parents in New Zealand nowadays, regardless of ethnicity or culture,

often choose to adopt practices outside those recommended for reasons specific to themselves. That is, culture is merely one factor which can contribute to parental decisions about their infant-care, but is by no means the only factor. Ball and Volpe (2013) support this claim with their findings that bed-sharing, for example, is a behaviour which, “has been surveyed in many Western countries, revealing a population prevalence of 40-50% of infants ever bed-sharing”, and they concluded that this practice is also, “therefore part of mainstream infant-care around the world” (p. 87). The point here is that the lines of practice are becoming more blurred and while ethnicities such as Māori practise for culturally-valued or traditional reasons, many others do not, merely choosing instead to practise in a similar way out of preference.

In the New Zealand context, the gap of health inequality is widening (Barnett, Pearce & Moon, 2005), and with it is the realisation that this has a seemingly direct relationship with the static and unmoving state of this country’s SUDI statistics. It is well documented (for example, Howden-Chapman, Blakely, Blaiklock, & Kiro, 2000; Pearce, Dorling, Wheeler, Barnett, & Rigby, 2006; Wilkinson & Marmot, 2003) that the wider the inequality gap, the more severely those at the most vulnerable end of the scale will be affected, particularly from a health perspective. Given what is known about the families of SUDI babies and their socio-economic status - that is, that they are at the lower end - and categorised with the more vulnerable groups in society (see Fleming et al., 2003; Blair and Fleming, 2002), ready access to vital best practice information and the accessing of health information in general, is not as easy to come by as it is for those who may be better resourced. There is a significant difference in the

simultaneous practice of SUDI risk behaviours such as bed-sharing and the use of specific sleep positions, for example, among the most vulnerable in society, and others, and this is discussed in more detail further on. Within New Zealand, the most vulnerable societal groups more likely to adopt risky infant-care sleep practices include those of young maternal age (Highet & Goldwater, 2013), those living in “average-to-more-deprived areas” (NZ Child and Youth Epidemiology Service, 2011), and/or those of Maori or Pacific ethnicity (Cowan, 2010).

There is a difference between awareness of best practice and actual practice. Access to appropriate resources is also a determining factor in what is practised in reality. Zachry and Kitzmann (2010) discovered that income is a significant predictor of awareness also. These authors found that income tended to dictate how mothers received information, with higher-income mothers having print material as their main source, and lower-income mothers having hospital staff as their main source (p. 1). Further, Tipene-Leach, Hutchison, Tangiora, Rea, White, Stewart and Mitchell (2010) discussed how those on lower incomes have long since had reduced access to healthcare (p. 88), which includes access to appropriate resources and information. Further, the Families Commission Research Fund (2009) in New Zealand found that there are poorer levels of engagement in ante- and post-natal care among those living in the most deprived areas and who have the greatest need (p.87), and that, in general, there is a lack of knowledge of entitlements to care among young women (p. 85) in particular.

A further contributing factor lies in the number of name changes this health issue has undergone over the past 30-odd years. Besides the fast turnaround in information accuracy and dissemination over a similar period of time, the name has changed from *Cot Death* to *SIDS* and now it is known as SUDI. While it is accepted that as more is learned about this issue a more appropriate term should perhaps be awarded to it, what seems to have been ignored is the effect these changes in name alone have had upon people's perceptions and understandings of the issue in general. For example, the writer had some experience with past (unpublished) work that was completed for a New Zealand DHB investigating safe sleeping best practice awareness among professionals, and others, who most came into contact with parents of new babies. Fifty six interviews were conducted. One of the more outstanding themes from this work was a constant concern over understanding the name changes and why they occurred, and the fact that parents continually expressed their confusion to this group over what was relevant and correct. This translated into widespread confusion over what actually was meant to be best practice and it, again, represented an instability, and hence mistrust, in what the medical/professional community has been advising, as parents and professionals alike have become confused over what the 'latest' best practice (aside from title) should be. In a qualitative study on beliefs and perceptions about SIDS, Moon, Oden, Joyner and Ajao (2010) found that confusion over risk factors in general was, "reinforced by the perception that there has been frequent change in the recommendations" (p. 94), which only served to increase scepticism and diminish importance placed on adhering to safe sleeping recommendations. In

the New Zealand environment in particular, where SUDI statistics are so high, this is an important factor.

It has long since been assumed that one of the strongest influencing factors in a new mother's child-rearing decision-making is their mother or extended family and/or close friends. Certainly there is evidence to support this assumption. For example, Wilson (2008) found nine influencing factors in the decisions on infant care and in this author's study all groups of participants, "felt that family and friends had a major influence on new parents" (p. 168). Elder (2000), in a review conducted for the Consumer Products Safety Commission in the United States, also found that parents' information about safe sleeping of their babies came from the baby's grandparents and that they followed family tradition (p. 2). Fa'alau, Finau, Parks and Abel (2003) also found that mothers tended to repeat the family practices of their mothers and grandmothers (p. 160). For young mothers, though, while family, or more specifically their mother, may have significant input, Paskiewicz (2001) found often that issues around childcare arose where a significant cause of conflict between mother and daughter also occurred (p.7). Further, this author discussed how the strength of the relationship between the two depended on how each felt about assuming their new roles as mother and grandmother, and this in turn impacted upon the levels of conflict (p.7). One issue with regard to advice/support from the baby's grandparents is the risk of the use of outdated practices. Wilson (2008) comments that "if a child was born prior to 1991, parents and grandparents were more likely to use the prone position or a combination of prone and side sleeping position when putting infants to sleep" (p. 166). The risk here is that

these carers often practise the techniques they practised when putting their children to sleep many years previous and are not familiar with the dangers of such practices and what current best practice is.

The numerous health professionals a mother comes into contact with, both before and after the birth of her baby, are in a position where they can have a profound effect upon what a mother practises with regard to infant sleeping. However, in her study on SUDI and parental infant care, Wilson (2008) found that much confusion existed among many health professionals, including GPs, as to what is current best practice (pp. 164-5). Further, this author also discusses that even though nursing staff were aware of best practice, some still practised placing babies in either the side or prone position (Jeffrey, 2004, as cited in Wilson, 2008, pp. 165-6). In her own experience, working on behalf of a New Zealand DHB investigating safe sleeping best practice awareness among health professionals, the writer found a marked level of confusion, as well as outdated advice. It was also found that within maternity wards themselves there was great variation in the staff practices and the advice given to parents. This same enquiry also extended to secondary care givers, such as child-care facilities, and found these to be the most urgent in need of updated training and information as most tended to either practise what parents did when baby was at home, and it was frequently mentioned here that prone or side position was very common, or use outdated, dangerous practices of their own volition such as prone or side sleep position, pillows, wedges, or soft bedding and so on. Further, the author was informed on a number of occasions that there is no specific guideline or

policy which addresses this issue within early childhood centre protocol. This is supported by the findings of The American Academy of Pediatrics (2005), which noted how, “approximately 20% of SIDS deaths occur while the infant is in the care of a nonparental caregiver”, and that, “licensed child care centers seldom have adequate regulations regarding safe sleep for infants” (p. 1249). Further, it was discussed that mothers will also be inclined to repeat the practices at home of the health professionals they see whilst in hospital, even when this includes practices in neo-natal units which are likely done out of medical necessity, and this may in turn increase the likelihood that they will place their baby in positions other than supine when at home (p. 1251). Mitchell (2009) also found this type of imitation to be the case, commenting that, “if a midwife/nurse places a baby on the back to sleep, then this sleeping position will be continued by the mother following discharge home” (p. 1716). This demonstrates how powerful the practices of professionals, when witnessed by parents, can be whether in line with recommendations or not.

Hutchison, Stewart and Mitchell (2006) conducted a study on the knowledge of SIDS risk factors and infant care practices among 200 mothers in Auckland, New Zealand. With regard to the most common sources of information, these authors found that 54% of mothers stated a midwife, followed by antenatal classes at 40% and that, “less frequently cited sources were friends [and/or] family” (p. 3). Ninety percent of this population was over the age of 25 years however, which begs the question as to whether these statistics would be the same for those under 25. As stated earlier, family and friends tend to be a major source for younger mothers. Nonetheless, with midwives and antenatal classes

at the top of this list, it behooves DHBs to urgently take up the responsibility of ensuring the accurate dissemination of such vital information.

Such inconsistencies, confusion and complacency, or tendency to ignore more recent advice, may likely create similar behaviours in the parents themselves. Further, in New Zealand, the Families Commission Research Fund recently produced a report which highlighted differences between District Health Boards in the levels of funding, and hence quality of information that is being delivered to parents (2009, p. 87). This will also likely impact the quality and consistency of best practice information delivery. And, although many parents may be aware of what is best practice, it does not necessarily mean that they practise it in reality. Wilson (2008) also found this to be the case (p. 166).

Mother's Instinct or Mother's Intuition is a little studied construct or phenomenon but is perhaps worthy of mention here. There is a tendency to relate this term to the functions of motherhood as 'coming naturally' and, generally, it is a self-attached label used by those who have found parts of, if not all, mothering 'easy' or believe they have not been influenced by the vast amount of information and/or advice which surrounds them. Although Wilson (2008) does not discuss it further, 'intuition' is mentioned as a reason why people may choose to care for their infants in ways deemed by themselves as the most appropriate (p. 172). Likewise, Tipene-Leach, Abel, Finau, Park and Lenna (2000) found that women talked of, "the tensions between taking on others' advice and trusting one's own instincts...in caring for [the] baby" (p. 31), in their investigation into Maori infant care practices in New Zealand, but these

authors did not elaborate further on the meaning of instinct to these mothers. In both the above-cited cases, however, the terms were intermingled among more general terms such as 'traditional practice', 'cultural requirements' or 'customary practices' for example. This tends to suggest that some scholars interpret the use of this term as being based within ingrained, traditional practices without a mother necessarily being consciously aware of what has been taught or learned prior to her own mothering experiences.

In today's society, one could be forgiven for assuming that electronic sources of information may play a bigger role than they once used to. Although little has been found which discusses how often mothers use the internet for advice in this area, two investigations into the accuracy and appropriateness of advice and images which appear on websites gave surprising and worrying results. Chung, Oden, Joyner, Sims and Moon (2012) found, when using the search engine 'Google', that, "the internet contains much information about infant sleep safety that is inconsistent with...recommendations" (p. 1080). Clarke and Cowan (2010) also investigated images of sleeping babies in their review of internet images with regard to adherence to the New Zealand safe sleep recommendations, and likewise found 60% of the images did not meet the New Zealand Ministry of Health recommendations (p. 4).

While the above discussion highlights many of the numerous means through which parents may be influenced in their choices of infant-care sleeping, for young mothers in particular, many of these influences may have their limitations. Relationships with family and friends may be strained, lack of

income creates a lack of access to appropriate resources which may include some health professionals, fear of stigmatisation may influence whether a young expectant mother takes up antenatal education and care, being a member of any particular DHB may dictate how much information is available as well as access to resources in the first instance, and access to information technology such as a computer or the internet may be limited by her personal and financial circumstances. While these limitations are not exclusive to young mothers, they are more likely a reality for the majority of this particularly vulnerable group, for reasons discussed earlier. Understanding if this is so necessitates a form of enquiry which delves deeper, beyond the statistical categorisations afforded this group to date, into the 'how' and 'why' of their experiences.

Aside from these issues, the apparent 'slowing down' in the statistics in many ways could be attributed to any number of factors such as: the possibility that they may reflect a parental 'turn' in a preference for such practices as bed-sharing and a change away from the recommended supine positioning; the possibility that the actual messages themselves may not be being delivered with the same level of consistency and intensity as they were two or three decades ago; or perhaps a level of complacency has crept in among those who should know or parents, in fact, are still receiving the messages but choose to ignore them for whatever reasons. These are just a few possibilities. Understanding the slowing down or plateau in the New Zealand statistics from a young mother's perspective in particular is necessary in order to effect long-term change for this group. While not all SUDI cases can be attributed to young mothers, neither can the statistics be ignored. Thus it is time to give young

mothers a voice and allow them the space to share their experiences in the hope of better understanding said statistics. This investigation seeks to achieve a better understanding of young mothers' experiences of sleeping their infants, the choices they make with regard to this topic, and the influences which led them to make such choices. The aim of such an enquiry is to gain a deeper understanding of the complex nature of decision-making for young mothers when it comes to the sleeping practices of their infants. The longer term goal of this enquiry is to help inform those who are in a position to support this vulnerable group in order to specifically tailor that support to the very particular needs of these mothers. The research questions are therefore:

- 1) What are the experiences of young mothers in infant-care sleep practice?
- 2) How do young mothers construct their practice choice?

Chapter Two, Methodology and Method

Giving Young Mothers A Voice - Social Constructionism

Exploring the infant-care sleep practice choices of young mothers through individuals' perspectives, the ways in which they validate those choices, and to understand influences upon them within their historical and socio-cultural context, generates verbal, as opposed to statistical, data. This necessarily orientates such enquiry toward a social constructionist epistemology, and thus a qualitative form of methodology. Colson et al., (2005) explain how qualitative study works to elucidate why individuals are motivated in certain ways when it comes to their decision-making and subsequent health behaviours. These authors explain that, "careful attention to the language people use to explain their understanding of health problems and the complex choices they make to address these problems can reveal unique and useful insights inaccessible by other means of inquiry" (p. 349). It is because of observations such as this that, in order to discover the ways in which young mothers make the choices they do about sleeping their infants, it is pertinent to use a Social Constructionist epistemology.

Traditionally, Psychology has investigated social phenomena such as attitudes, motivations, and emotions as stable phenomena, but, as discussed earlier, Social Constructionism necessarily chooses to look at the social processes people are engaged in and which affect the choices they make, in a way deeming such phenomena as less stable than traditionally thought. Gergen (1985) describes Social Constructionism as being, "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). This of course will vary depending upon when and where any one individual is historically and culturally, as well as socially, located. If the practices of young mothers, in the context of this dissertation, are to be understood in a way that reaches beyond traditional psychological investigation, then Social Constructionism provides the necessary vehicle through which to do so and in the process allows for each mother’s individual experiences as truth. In order to reach beyond the numerical calculations of traditional positivist psychology and its associated assumptions and to fully understand the meaning-making behind the choices of this unique population, it becomes necessary to use an approach which illuminates how their practices and experiences have been socially constructed.

If young motherhood and the practices of young mothers are considered deviant, or not conforming to expected social norms by society, and, if this is a socially-repetitive phenomenon which is difficult to extinguish, then one must question if in fact the choices of young mothers are really deviant or if long-standing social expectations, which are historically and culturally located, have merely categorised them as such. Understanding the social processes behind why young mothers make the choices they do, through the ways they describe or explain such choices and the influences upon them in order to account for the world in which they live, is a way to challenge those historically and culturally situated expectations and subsequent categorisations. Social Constructionism provides a significant step in this direction.

Further, if knowledge is historically and culturally specific, then it is also necessary to look beyond the choices and decisions individuals make and go deeper into the social, political and economic influences upon these decisions. For young mothers and their infant-care sleep practices, this has been considered earlier in relation to the determinants of health. For young mothers in general, their reality as members of the more vulnerable group in society is also very much historically and culturally related to issues of power. Arai (2009), shows the relationship between the spectrums of power and constructions and where along the meeting points of these constructions young mothers fall. Recently, this author notes, young mothers have moved across the construction spectrum from the negative categorisation of 'deviant' to the 'more' positive categorisation of 'dependent' (p. 113). Despite this, Arai notes further that young mothers are still, however, at the weak end of the power spectrum. The purpose of this author's discussion though is to highlight that the shift from being categorised as deviant to now dependent reflects how social constructions are not fixed, but goes on to qualify that despite this, young mothers are likely to always be politically powerless. So, while being somewhat flexible, social constructions still have their limits it seems and young mothers may never have the opportunity to change the relationship they have with power.

Further, current statistics serve to reinforce the dominant discourses which problematise young mothering. However, as discussed earlier, while helpful, statistics do not allow themselves to be understood or contextualised beyond what they represent. Because, as Arai (2009) points out, social constructions are not fixed, one way to begin to change the categorisation of young motherhood

as problematic, is to give young mothers themselves a voice. If, through opening up a space for their voices, young mothers have an opportunity to describe the choices they have made as to how they sleep their infants, and to describe the factors which influence those choices, only then can it be said that a true reflection of their experiences is a way to make inroads to affecting the current social constructions of their categorisation. It is vital to understand the realities for young mothers, how and why they come to make the decisions they do, in order to inform and alter social perceptions, and ultimately have a positive impact upon the statistics.

Burr (2003) discusses how Social Constructionism is founded on four basic assumptions, one of which has previously been discussed – that knowledge of our world is historically and culturally situated. Acknowledging this alongside the remaining three: taking a critical stance toward taken-for-granted knowledge; knowledge is sustained by social processes; and, knowledge and social action go together (pp. 2-5), may make it possible to better understand the experiences of young mothers in their infant-care sleep practices and further suggests the possibility that this special group may actually push the boundaries of the traditional social constructions of the ‘good’ mother if given the chance to be heard. In fact, a Social Constructionist approach promotes such an investigation because it encourages the challenging of dominant social constructions such as these. Further, it can also elucidate how young mothers construct themselves in such a way that they themselves feel they have some power.

In the New Zealand context there is a paucity of literature allowing the voices of young mothers to be heard. In fact, the writer has been unable to uncover any qualitative works which address the experiences of young mothers, their infant-care sleep practices, and the factors that influence their practice choices. Qualitative investigation aids the understanding of the motivations behind decision-making and their resulting health behaviours. This type of enquiry is conducive to elucidating people's understanding of health issues and the complex ways they choose to attend to such problems, through paying particular attention to the language they use to explain said understandings. Enquiring in such fashion allows unique and useful insights to be revealed, which are not available through other modes of enquiry (Colson et al., 2005). Therefore this study takes such a qualitative approach under the auspices of a Social Constructionist epistemology in the endeavour to uncover and elucidate the choices, and influences upon those choices, that young mothers make when practising infant-care sleeping.

Participants

Participants were recruited through a New Zealand educational institution for young parents (for the purposes of this study it shall be referred to as the Young Parents Educational Institution (YPEI)). First contact was made with the institution's Manager and Chief Executive Officer when a meeting was held to discuss the possibility of doing some research where young mothers, who were attending the institution, could have a chance to have their say on their own baby-sleeping practice choices.

In this meeting it was mentioned that the link for this study would be to add to what is already known about SUDI in the New Zealand context but more importantly, to understand the perspectives of young mothers and the experiences they have had or are having with regard to the choices they make or have made in sleeping their infants. At this point, it was explained by the institution management that the researcher should be very careful about any discussion mentioning SUDI when interviewing any participants because this particular group is highly vulnerable and easily distressed by anything which could be deemed a risk, or danger, or put into question what they do in relation to raising their babies. They requested that if at all possible, the researcher should avoid any mention of SUDI and only discuss it if participants raised it themselves. This was agreed to, at which point the researcher explained that she would only be interested in what they practised and why, and assured the management that it would be a non-judgmental experience for all participants. The aims of the study were then explained in full.

The criteria for inclusion were that participants were mothers between (and including) the ages of 16 and 20 years. After the YPEI expressed very enthusiastic support and provided a letter of authority to conduct the research, ethics approval was gained and then arrangements made to have an initial group introduction with the potential participants in the research. This was suggested by the YPEI management as they believed recruiting would be more successful and the potential participants more relaxed if they all heard about the study together and then had a chance to talk about it before deciding to take part.

At this meeting *Expression of Interest of Study Participation* forms and postage-paid envelopes were provided for the participants to return the forms within a set period if they were interested in participating. Twelve mothers returned their forms and contact was made with them privately to answer any questions and ascertain whether they preferred to have their interview at the YPEI in a private room, or in their home. They were also given the opportunity, should they so wish, to have a support/whanau (family) member with them. All were happy to be interviewed at the YPEI in a private room.

Of the 12 mothers who originally expressed an interest, 10 participants were interviewed. However, while the researcher was on the premises conducting interviews, a further two mothers expressed an interest. Interviews were also arranged with them, which one attended and the other did not. A total of 11 interviews were conducted for this study. In some cases the information was of a retrospective nature and in others it was present-day. The retrospective accounts were no older than two years maximum at the time of interview.

Participant anonymity was assured, therefore the initials used in this research are not their real initials.

Data Collection

After reading and discussing the study *Information Sheet*, signed consent was gained from each participant before proceeding with the interview. Two main questions formed the basis of this semi-structured enquiry and they were:

Could you please describe/explain the experiences you have had/are having, and the practices you like to follow, with the sleeping of your baby/ies?

Could you please describe/explain what has influenced your choice/s to practise such particular arrangements and why they are/have been important to you?

Smaller probing questions may also have been included if it became necessary to seek clarification of any responses (see Appendix A). The average interview time was approximately 11 min. Each interview was recorded on a digital voice recorder as well as the researcher making any extra field notes considered of relevance. Participants were offered the opportunity to add anything else they deemed relevant, or ask any other questions before the interview concluded. Each participant was then offered a \$20-00 baby store gift voucher at the conclusion of their interview in appreciation of the time they had given to the study.

Data Analysis

To answer the research questions, the data was subjected to Thematic Analysis (TA). TA is a widely used method in qualitative data analysis and, as its name suggests, its main focus is in identifying patterns of meaning across a dataset (Braun and Clarke, 2006). Uncovering the experiences of young mothers and their infant-care sleep practices is also about understanding the linguistic resources they use to define their choices, and the influences upon those choices. Finding patterns of meaning across the ways they choose to describe their experiences is a way to attempt to bring some sort of understanding of how they have positioned themselves in regard to the research questions.

Language is a form of social action and as such it, “produces and constructs our experience of each other and ourselves” (Burr, 2003, p. 62). The experiences of young mothers can be understood through the patterned meanings derived from the language they use to describe such experiences. Braun and Clarke (2006), advocates of TA being recognised as an analytic method in its own right rather than a tool to be utilised across a range of different methods (p.4), discuss how it is, “a method for identifying, analyzing, and reporting patterns (themes) within data...however, it also...interprets various aspects of the research topic” (p.6). Therefore, through a Social Constructionist epistemology, TA is the analytical method of choice in the present study. It has been chosen not only to aid the interpretation of certain aspects of the overall topic, but will analyse, identify, and represent the patterned meanings of the voices of this much under-represented group with regard to their infant-care sleep practices.

Each interview was transcribed verbatim by the researcher using Express Scribe NCH software, and then analysed for themes. Theme analysis consisted of repeated in-depth reading and note-taking of each transcript until no further new themes arose. Themes were identified by the regularity with which they arose, as this indicated to the researcher the value of importance placed upon them. Other themes were also identified that were considered by the researcher to be unexpected but nonetheless appeared on numerous occasions and deemed of interest and relevance to this enquiry. A number of themes emerged from the data and are, in many ways, interconnected.

Chapter Three, Results

A number of patterns emerged from the data; however, an overarching theme was the degree to which the participants did not practise sleeping their babies according to recommended health advice. Further, it became apparent that their levels of 'rule' awareness about such advice were significant in their variability. The first research question is therefore addressed by examining what these young mothers practised, what it was they knew about recommended health advice, and how they came to have such awareness.

In addressing the second research question, the manner in which the mothers constructed their practice choices served to work, in many ways, as a form of justification for such decisions, whether knowingly or not, in the face of recommended best practice advice. In many instances these appeared at face value to have been well-considered decisions. The patterns which emerged from the data resulted in five themes being identified which were labelled: Needs of the Baby; Needs of the Mother; Baby's Wishes; Mother's Instinct or a Natural Ability; and, Non-compliance – Incognizant or Deliberate Action. This question is answered by examining the patterns in the linguistic resources used to explain their actions.

Question 1: Young Mothers' Infant-care Sleep Practices and Apparent Non-compliance

Current best practice advice is that infants should be slept in their own sleeping space close to the parent/caregiver bed, placed in the supine position on a firm sleeping surface, with the sleeping space free of soft or loose bedding,

pillows and toys (Change For Our Children, 2010). The following highlights how this group practised infant-care sleeping, showing that very few mothers followed the recommended health advice.

Bed-sharing and Sleep Environment. Almost all mothers (nine) bed-shared with their babies by the time the babies were three months of age. Although a baby's vulnerable period for SUDI is up to 12 months of age, the highest risk occurs between one and four months. One mother felt forced to bed-share for the pragmatic reason that, after being "*kicked out*" of her mother's home when the baby was around two and a half months of age, the room she moved into at a friend's home was too small to cater for her baby's cot. She explains, "*so she (baby) had to sleep with me 'til she was one and a half*" (TG). Common examples of comments from the remaining eight mothers were those such as, "[baby] *just ended up sleeping with me*" or "*I just brought [baby] in bed with me*".

One mother's example of bed-sharing was illustrated in a sketch during the interview. LA drew her sketch not only of the two different types of breastfeeding pillow she used as sleeping surfaces for her baby at any one time, and how she placed her baby on them, but also where the pillow was placed when her baby was sleeping on it in relation to herself in the bed. In either case the pillows were shaped so that at any given time the baby's whole body could not be fully supported and level, but would sink or have one part higher than another. LA explained that when her baby was newborn he slept across a 'C-shaped' pillow, and when he began to move more (approximately a month later)

she changed to using an inverted 'V-shaped' tri-pillow. Practices similar to this, although modified to their specific contexts, were not uncommon among those in this group.

Sleep Position. Overall, 10 mothers slept their babies in non-supine positions at some point over their baby's first 12 months of life, and for lengthy periods of time. Three positions were discussed: supine (back), side, and prone (front).

One mother (SN) slept both her babies supine exclusively. Her first baby slept in this position in a bassinet from her first day, while the second baby slept in this position, surrounded by pillows and whilst bed-sharing with her. Another mother (BK) slept her baby exclusively in the prone position. Two others (TG and NT) slept their babies exclusively in the side position. TG used this practice for the first 3 months only and wedged her baby in by using a store-bought product to do so, then she changed to the supine position after three months. NT's baby was 'wedged' in the side position with the use of a rolled up blanket.

All other mothers tended to alternate between the various positions, with one mother (IA) choosing to alternate between all three positions for the first five weeks before eventually bed-sharing with her baby, when, at this point, baby was placed supine. At some point almost half the mothers chose to sleep their infants in the prone position and just over half chose side-sleeping.

Young Mothers' Best Practice Advice Awareness and Influences Upon that Awareness. In New Zealand the basic official advice for safe sleeping of infants is 'Face Up, Face Clear, Smoke Free' (Change For Our Children, 2010). In addition, it is further recommended that babies should be slept in their own sleeping

space on a firm sleep surface with no soft toys, pillows, sleep positioners, or loose bedding around them (Change For Our Children, 2010). The following data illustrates that despite their varying levels of awareness of the advice, these mothers often chose to ignore or 'adapt' it because of influences they considered to be too important to ignore, or that were of more value to their particular context. As a result of the interviews it was evident that all mothers in this study had some level of awareness of the current best practice advice. What also became apparent was that there was some confusion over just what is current advice, or advice from significant others tended to conflict, whether knowingly or not, with current advice. Regardless of their level of awareness of the 'rules', in reality these mothers' practices were founded on many different influencing factors such as advice from significant others, previous SUDI cases in the family, varying levels of health professional advice and advice from early childhood centres, and experiences of other parents. Only one mother referred to having seen and been affected by (albeit temporarily) any official advertising material.

SN, who has two children, was influenced with her first baby by an earlier family "*interrupted Cot Death*". This tended to dictate her following the 'rules' generally and, although both her babies were slept supine, it was only the first baby she slept in its own bed. Her second bed-shared with her, and was surrounded by pillows and she explained that this was, "*so that he couldn't roll over*", and although aware that bed-sharing is not recommended, she further explained that,

well, I haven't been so..um..I don't know what the word is, ah like, paranoid that he would, like, I..I would cause harm to him or..anything would happen to him because..my [first child's] been fine..like nothing ever happened to her (chuckles) like, you know. So he's (second baby) the opposite where he now sleeps in my bed like, he only sleeps in my bed, with me every night.

SN also attributed some of her knowledge to her experiences of looking after others' babies and children *"for a long time"*, and explained that, *"I always had kids around me, and..seeing the way their parents looked after them"* influenced the practices she chose for her own. In discussing other influences she further added, *"..and also, yeah, hearing about it from teachers (at the YPEI)...and friends that have kids"*.

BK was aware of the advice to sleep babies only in the supine position. However, she still chose to sleep her baby for some time in the prone position. Although she did not attend antenatal classes, BK's practice choice was, in part, influenced by those who cared for her baby in her baby's Daycare Centre despite this advice being incorrect, and by other young mothers at the YPEI who shared their experiences with her.

For NT and IA attending antenatal classes ended in quite different experiences. Although not receiving detailed best practice advice, NT had gleaned some information about how to wrap her baby, in preparation for sleeping, through her Antenatal classes but added that, *"I don't think she (the Antenatal Class Teacher) told us which way to lie them down"*. For IA, on the other hand, while she also attended antenatal classes, where safe sleeping best

practice was taught, she ultimately made the decision not to follow that advice. Further, she preferred to attribute much of her knowledge and practice to the fact that she played a large role in raising her two younger brothers, and to “*common sense*”.

Cultural mores and significant others played a role in NL’s decision not to follow recommended advice. NL placed cultural values and family tradition as the most important factors influencing her practice choice. Although her Plunket Nurse had advised her about current safe sleeping best practice this was over-ruled by such conventions. She explained that,

my plunket nurse, um she actually told me..you know, the whole um (pause) you know, kids, you know passing away while they’re sleeping with their parents and stuff, but um..it didn’t really..like, to me and my culture, because I’m an Islander, I love sleeping with my baby. And my parents used, you know, used to sleep with me and all.

Significant others, specifically close friends, ultimately influenced TO’s practice choices. Initially, she practised what she knew, which aligned with current advice, but later became confused by what she knew and what her friends had told her. She had begun sleeping her baby on his back but when advice from her close friend, and that of the friend’s mother, conflicted with this she changed to alternating between sides. She stated that, “*like, when he was a newborn he just slept on his back. And then I..but I di..they* (later explained ‘they’ refers to her friend and her mother) *always say move your ki..move your child, like, on their side...you alternate..they told me you alternate*”. A further

explanation which was offered later was when TO explained that she also slept her baby on his side, *“cos, like, I sleep on my side”*.

Despite ER admitting that she had learned *“heaps”* about what was best practice, she ultimately decided that it was safest to bed-share with her baby, trusting that her level of consciousness during sleep would be sufficient to ensure her baby’s safety. She discussed how,

I was just so, like, self-conscious that she could have cot-death or something...and I just thought...it was safer for her to be with me ‘cos, like, I could tell when she was waking up so I’d wake up. And I was conscious not to roll around and stuff. And I knew that if I’d, like, had a glass of wine with my mum...not to have her (baby) in bed with me. I’d have her in the little basket on my bed.

One mother (LA) talked of how she had initially been influenced by a poster on the wall in her room in the maternity suite when she had her baby, and could recall most of the message, ‘Face Up, Face Clear...’ but could not remember the last part ‘Smoke Free’. This had an impact and she stated that, *“I followed those for when my baby was a newborn”*. When her baby reached four months of age she changed him to the prone position, and the following extract shows her further awareness of the high risk involved with this positioning as she commented that, *“...they say that sleeping them on their stomach’s the worst position, blah blah blah, can...and blah blah blah..cause um suffocation and stuff like that”*. LA’s other influences also included the experience of an Aunty who had suffered through a *“Cot Death”* many years earlier, and also to what she termed a ‘mother’s instinct’.

Additionally, LA chose to sleep her baby upon breastfeeding pillows which meant that her baby's full body could not be supported due to the shape of the pillows. Thus, as she explained the positioning of the pillows under her baby she commented that, *"it nearly was, like, closed underneath him so he wasn't..he wasn't actually inside it. It was more on top of it, yeah, but with that drop"*. Further, alluding to safety awareness when discussing where in her bed the pillow would be placed when baby was on it, she stated, *"yeah, I would always put him here (pointing to the centre of the bed drawn in her sketch) in the middle..because..yeah"*. As mentioned earlier, a previous SUDI in her extended family was the trigger for ensuring her baby's safety while sleeping. And, although she had seen and read the safety messages in the maternity suite when she gave birth to her baby, neither of these factors was effective enough to alter the decisions she ultimately made.

Despite her apparent awareness that her practices were against recommended advice, the following mother tended to appear as though she was 'brushing off' her behavior and attributing it to more of an extrinsic cause. CN has two children and she practised differently with each. She bed-shared with the first from two weeks of age, but her second child has slept in his own bed from the beginning. This choice was influenced by her partner who insisted the children not share the same bed because, as she explained, it was, *"in case something bad happens"*. She had been made aware by health professionals about best practice, commenting that, *"Midwives and Plunket people say, you know, 'don't give your child pillows'"*, but nonetheless both babies were slept as newborns on a large European pillow as a 'safety precaution'. When her babies

were a little older and more mobile, she talked of changing from swaddling (wrapping) them to using a sleep-sack, where baby's arms are free but the rest of the body is encapsulated in a sack-like garment. When bed-sharing with her first baby, she explained that she would still, *"just put her to sleep like normal, apart from her head would just be on the pillow now. She'd still be sleeping in my bed...bad habit, I know, but..."* (making a 'cheeky' facial expression) *but nobody's perfect"*. Acknowledging that bed-sharing is a *"bad habit"* highlights CN's awareness of the 'rules' but there was no apparent recognition that sleeping her baby with her head raised above her body was also a risk. CN's further comment that *"nobody's perfect"*, and its accompanying facial expression, suggested perhaps that she knew she had taken a known risk to bed-share but nonetheless gotten away without any adverse or tragic outcomes.

Other influences have also been CN's mother, with whom she has a very close relationship, and her wider family in general. In response to discussing antenatal education, CN seemed to justify not using this education because her mother was able to help her through any issues that arose. She commented that, *"No, I didn't, no. I actually wanted to but um..'cos my mother..she's really understanding and, like, if I had a problem, like,..she'd tell me that..what to do, like, or what to eat or..."*. She also attributed a further influence to her previous experience of helping to raise her niece, from the age of 7 years.

Another mother influenced by significant others was ER, and although she also had some rule awareness, her mother had told her to bed-share and so she decided that ultimately this was safer than putting her baby in her own separate sleeping space. When discussing her varying practices she explained that,

the wrapping her was from antenatal, but the sleeping with her would probably be from my Mum because I was just so...self-conscious that she could have cot death or something...we'd learned heaps about it and the precautions to take.

ER also added that her practice of sleeping her baby in the side position was influenced by advice from staff at her baby's early childhood centre who had explained that this was the safest position.

One example which demonstrated how appropriate and accurate resources impact a mother's practices is seen in the case of MN. Although quite possibly unintentional in this case, this illustrated, when a coordinated effort to positively reinforce the messages occurs from those who are most in a mother's life over this time, how easy it is to influence the ways young mothers choose to practise. Safe sleeping best practice was repeatedly well-reinforced for her. She sometimes bed-shared, but only to settle her baby if he was upset or unwell. The remainder of the time her baby was slept in his own bed and on his back. A combined set of influences helped in her choice to practise in this way and they were that her Midwife had provided her with written information, her antenatal class constantly reinforced best practice, and her mother followed this up with similar advice as well. In describing this she stated that,

...mainly firstly from my Midwife. She'd, like, given me, like, all the booklets and pamphlets about sleeping and everything. And then I went to Antenatal classes and they were..constantly reinforcing the whole 'sleeping them on their back'..decision. But um, I think once I had him..um Mum was my main influence

For TG, a change of accommodation circumstances led to her having to bed-share with her baby from approximately three months of age. She further qualified her bed-sharing practice by remarking that, *“yeah, well, umm, she didn’t actually sleep in her cot for long. She was a in..in Mum’s bed girl (giggled)”*. There is a suggestion here that TG was aware of best practice advice but that her infant’s attachment to her overrode this and that she felt her daughter was happiest when close to her, even during sleep.

Before this, when her baby was in her own bed, rather than choose to sleep her on her back, TG alternated baby’s position from one side to the other each sleep using a sleep positioner. This was mainly due to a fear of her baby developing plagiocephaly. This fear was influenced by what other parents had experienced. She explained, *“so you just alternate and keep..keep it in shape...um..I’ve just seen a few babies who are..yeah..their parents have mentioned it”*. In general, TG showed an awareness of best practice. However a combination of necessity, through not having room for a cot, and what others had told her about plagiocephaly, led her to make choices which, for her, seemed best at the time but ultimately were of higher risk.

Question 2: Young Mothers’ Constructions of Their Practice Choices

As discussed earlier, the mothers in this study constructed their practice choices in five distinct patterns. In the majority of cases, the reasons they provided in order to validate their practices, appeared at face value to be well thought out, regardless of whether they were in line with current advice, and often resulted in many feeling they had exhausted their options and were left

with no option but to select the practices they eventually chose. This is evidenced in the first two themes of *Needs of the Baby* and *Needs of the Mother*. That said, the intermittently stoic nature of their expressions also told of an awareness of the stigmas that exist against the group they represented and a need to maintain a steadfastness in their decision-making. The construction of what the writer has termed *Baby's Wishes*, where the mothers have exchanged what may well be their own views as if they are actually those of their babies', served as a way to legitimise many of their practice choices. Further, to help validate how they fulfilled the role of the 'good mother', their actions were also justified through their constructions of a *Mother's Instinct or Natural Ability*. Finally, in *Non-compliance – Incognizant or Purposeful Action*, although the mothers' actions seemed most often to be non-compliant, the ways they constructed much of their talk suggested that their behaviours were either borne of incognizance or of purposeful actions.

Needs of the Baby. Until her baby was approximately four months old, LA followed the positioning advice she had seen on a poster in her maternity suite room and slept her baby supine. She then changed to prone positioning. At approximately one month old she chose to bed-share, however, believing that placing him on a breastfeeding pillow in her bed served two purposes – keeping baby safe, and allowing him to still be close to her. Her baby was first slept on a breast-feeding pillow for the first month (pillow was the shape of a 'C') and then moved onto sleeping on a triangular-shaped tri-pillow. She explained that,

my son actually, he had like um..he had some..problems with his um..'cos he had to go onto formula...and it just made his..his um..his stomach all different, so he was unsettled...and I had to end up putting him on his stomach to sleep. I never wanted to put him on his stomach..but it was the only way he would sleep..because I think he was uncomfortable...from the formula change. I dunno if he felt edgy..being distanced..and he wasn't sleeping for..long, but then I tried him in my bed in [sic.] his own [breastfeeding] pillow and um..he slept longer when he was close to me.

Here her explanation suggests she felt she had no other option but to sleep baby prone, despite the messages she had witnessed in the maternity suite. With regard to baby's position on the different pillows, rather than placing her baby fully on top, she placed him in such a way that his head was raised and resting on the centre part of the pillow while his body was lower down on the bed mattress. She explained that, *"I would push those (pointing to the wings/sides of the tri-pillow in her sketch) in towards his body...keep him snug (laughing) ...taking it step by step out of the womb"*. While this positioning is unsafe, particularly with baby's head raised above his body to sleep, it was more important to LA that her baby felt "snug" and secure as he would have done when in the womb. He slept in this way until approximately four months of age when she found it necessary to change him from breastfeeding to formula feeding. It was at this point she stopped using the pillows and began positioning her baby on his stomach while still bed-sharing. Ultimately though LA regrets the choice to bed-share, as she later explained that her baby, now a toddler, is a

very restless sleeper and she attributes this to her earlier choices to formula feed and sleep him on his stomach.

Plagiocephaly and aspiration of vomit were two strong fears for TG, and were enough reason not to follow the safe sleeping advice to sleep her baby in the supine position. In the first two to three months of her baby's life, TG slept her baby in the side position. She was the only mother to express a keen concern about plagiocephaly in particular, and it was vitally important for her to sleep her baby in the side position because of what she referred to as ensuring the *"perfect head shape"*. She comments that, *"when they are born they do kinda have the flat head if you keep them on their backs, so you just alternate [sides] and keep..keep it in shape"*. She then further attempted to support her choice by giving the impression there was a more medically-based reason for doing so. She explained that it was, *"just in case she spilled..she couldn't keep down any other formulas and that, and then so she would be quite sick quite often, so I had to keep her on her sides so she doesn't be sick in her sleep"*. This suggested she had chosen the side position due to medical advice by *having* to – which gives the perception of bolstering her justification significantly.

Three mothers (CN, BK and NT) chose to alternate sleeping positions for health-related reasons. CN would place her baby on his side when he was ill. She explained that, *"if he's sick, which he is at the moment, we stick him on his side so if he sneezes, it comes out"*. This young mother also initially slept both her babies on European pillows as a safety precaution. Once they became more mobile she further alluded to being safe by ensuring they could not move

through placing them with their head elevated on a pillow. She comments that, *“it (using a pillow) just made me feel like...she’s gonna stay there and stay still all through the night”*.

CN also discussed the use of a pacifier with her second baby and used the fact that the amount of breastfeeding she was having to give him became so draining that the pacifier would have to be used as a type of substitute. It served a particular purpose, therefore it was acceptable to use it, as she explained that,

he had this sucking actually going on constantly..’cos I was feeding him and I didn’t wanna bottle-feed him as much as what a bottle should..if I do something like give him a bottle he might get constipated, he might get sick..so I ended up getting him a pacifier and now he’s sweet..so I just give him a dummy after..when he’s ready to go to bed..stick him in his bed to self-settle.

Despite advice to sleep her baby supine, BK explained that the reason she slept her baby prone was because, *“...um when he was born his head was elongated and he didn’t...like the feeling of it (the bed)..on his head”* (BK) . The reference to the ‘elongation’ of the head, and this being the reason for her baby not settling in the supine position, also gives an impression of her baby having a special medical explanation which validated her decision to practise contrary to advice.

NT’s concern over her baby choking should he vomit while lying on his back was her reason for choosing to sleep him on his side. She comments that, *“I don’t think the back was good or something because they vomit, they choke”*.

In other cases, the choice to bed-share was made for the reason that the baby would not settle in their own bed. For example, NL backed her decision to bed-share by also referring to having *“tried everything”*, in an attempt to explain that her intentions in the initial stages were acceptable but that nothing worked to soothe her baby and thus she was left with no other choice because, *“he’ll wake up screaming at night, so yeah, mmm...so I just brought him in bed, yeah”*. And MN explained that, *“sometimes I would sleep him in my bed just when he was grizzly and irritable and he just wasn’t feeling himself probably, ‘cos it was only..me and him..so he was..really close to me”*.

In one case, the reasoning behind the following mother’s choice to bed-share with her second baby, was previous experience. She commented that, *“my [first baby] was fine..like..nothing ever happened to her”* (SN)

Two mothers (MN, ER) felt their babies were safest or had better sleep if they were placed on a separate pillow in the bed they shared. For example, although there is greater risk of suffocation when using pillows, MN seemed genuinely confident that her use of them was creating a safer environment for her baby’s sleeping space while bed-sharing with her. She commented that, *“yeah, and ‘cos I’d just make sure that there were like pillows galore surrounding..yeah, so I just had, like, this big barrier of pillows so he wouldn’t move”*. Likewise for ER, the justification to bed-share with her infant was related to perceived increased safety as she stated that, *“she ended up sleeping..in bed with me ‘cos I felt comfortable having her there, knowing that she was going to wake up and stuff, the next morning”*.

With a different perspective, IA was an open advocate of bed-sharing in order to reduce babies' perceived separation stress if they slept in their own space. She explained that, *"I think sleeping with your baby's good..it.it.well when you sleep properly, if you're not a heavy sleeper...just 'cos I reckon they (babies) get stressed like, real stressed and separation anxiety..."*. Because this young mother saw bed-sharing as a positive experience she also related how after being in the womb for such a long period of time that it does not seem appropriate to then separate a baby from the mother once they are born. When explaining how she came to the decision to bed-share herself, IA talks of how different options to keep her baby in her own sleeping space *"didn't work"* and so, from when her baby was around five weeks old she said she, *"pretty much just, um, breastfed her (baby) and she'd sleep with me...yeah"*.

Breastfeeding, over formula feeding, is strongly advocated in general by the health industry in New Zealand as having optimum health benefits, including lowering the risk of SUDI. However, in its wake, this advocacy can also sometimes have the effect of leaving mothers feeling guilty if, for whatever reason, they choose to feed their baby with milk formula instead. In justifying the change from breastfeeding to the bottle feeding of formula, TO stated that, *"...when you're, like, breastfeeding, he (baby) didn't sleep that much...I thought my milk..just went bad, as it does. As soon as I chuck him a bottle – longer sleeps..longer sleeps, easier to fall asleep..easier to fall asleep"*. TO's explanation of the benefits of formula feeding – longer sleeping and baby falling asleep sooner – suggested an attempt to counter the pressures which tend to weigh heavily on mothers to exclusively breastfeed. The added thought that her own

milk could have 'gone bad' also indicates a lack of appropriate education with regard to this misconception and how easy it is for such understandings to have wide-reaching consequences.

Finally, regarding the justification of placing her baby on his side to sleep, TO argued that, *"he'd sleep, like, on his side, like, 'cos I sleep on my side"*. Here, it appears TO aligns her baby's needs with those of adults in such a way that they are not, or should not, be any different.

Needs of the Mother. The main driver for most mothers to go against recommended advice was a fear of an adverse outcome or losing their baby, and a need to feel that through their practice choice they had ensured a better level of safety for their infant, and in the process, better peace of mind for themselves.

CN, who has had two children, bed-shared with her first baby. In the case of both babies, each was slept on a European pillow with other pillows chocked around it. Her current partner has insisted that the second be slept in its own bed since birth. However, her retrospective account of her practices with her first baby was that, *"it's my definition of being safe with my daughter"*. Prior to this CN had also talked about her 'paranoia' being a factor in her decision to bedshare. She became sick of getting up *"50 million times a night"*, and stated that,

I had to hear her..breathing and I had to feel her heartbeat so...the paranoia kicked in pretty much heaps and she ended up sleeping in my bed...It made

me feel more comfortable with being a parent to my child..it just made me feel safe.

CN's need for feeling safe outweighed any understandings she may have had about the safe-sleeping recommendations. However, her further justifying comment that, *"we only had each other, her father wasn't around but..it w..it was just me and her"* suggests that it would have been worse if her baby had slept in her own bed as she would have felt too isolated and alone, and because there was no father around to reduce the perceived levels of isolation in some way, CN's comment also suggested that she felt there was no choice but to bed-share in order to avoid this happening. When a baby is sleeping in the presence, or not, of another person such as a father there cannot truly be a feeling of isolation. However, CN's comment may also justify and explain that because the father is not around, she herself may in fact feel more abandoned or isolated, but is transferring this onto her baby, and in fact bed-sharing with her baby is making her feel more connected and helps her deal, subconsciously, with her own experiences/feelings. The following comment hints that this may indeed be the case as she stated later that, *"it was more of a, you know,..'cos it's more of a contact thing with me and my daughter..she's my shadow, like..."*.

For TO, her loss of 'bonding time' was particularly important and she justified this as being due to the medical intervention required at birth, stating that, *"...it was quite hard for me..very hard 'cos it was a c-section that I got knocked out and I couldn't see my son...so there was like three hours that I didn't have that bonding time"*. This mother's concern over losing bonding time stresses the

importance she placed upon this practice and how the lack of it in the first few hours of her baby's life has created a void for her which she may feel she will never regain.

NL felt compelled to justify her decision not to attend antenatal education and this suggested that not attending was perhaps another way of denying her pregnancy existed at all, at least in the initial stages. She stated that,

...it was a unplanned pregnancy...my parents didn't know, I found out at 20 weeks, aah..and um..(small chuckle) yeah, no, um I was just not into the whole idea of having a baby because of the whole traditional Islander stuff, so no, no antenatal, no..nothing, no classes whatsoever, so..yeah.

It appeared here that NL felt that if she took up such education then she was admitting to a future that was yet too sensitive to own.

IA's motivation for eventually deciding to sleep her baby supine after alternating between all three positions over the baby's first five weeks of life was fear. She stated that it was, "cos I was scared". The reason for IA's fear was unclear as she did not choose to elaborate during the interview. IA also chose to bed-share and this decision was about finding an option that worked best for the ease of breastfeeding:

I had a um..baby bed that lies on your bed...that didn't work. Um, bassinet, yeah she would go in the bassinet but that didn't work either, so I pretty much just um breastfed her and she slept with me...yeah.

ER had chosen to bed-share, partially because her mother had advised her to, but ultimately because she felt she would sleep better if her baby was next to

her. She explained that, *“I just thought, for me to have a good night’s sleep, it was safer”*.

While MN often had her son sleep on her in the prone position whilst bed-sharing, her fear of what may happen was enough reason for ultimately choosing the supine position and sleeping her baby in his own space the majority of the time. This mother had had the correct advice well-reinforced and she appeared to have a good understanding of the possible consequences of not following current advice. She stated,

so I’d just put him in his bassinet and lie him on his back...He’d only sleep on his tummy if he was on me...otherwise I’d never really tried him..to put him on his tummy ‘cos I was a bit scared as well.

NT attended Antenatal classes and passed a comment which implied an awareness of certain stigmas toward young mothers. She commented that, *“the lady was really nice, and ‘cos it was a teen...antenatal...yeah, so there was no judg..judging...yeah and she was really..really helpful”*. NT had obviously become sensitive to the ways some in society have judged young mothers, and may even have fallen victim to those herself. The fact that she felt comfortable in the antenatal education she chose suggests how important it may be for these mothers to receive appropriately-targeted support.

Baby’s Wishes. One unexpected and noticeable pattern that became apparent throughout the interviews was a tendency for many of the mothers to speak as if their infants had made their own choices, resulting in the mothers’ practice decisions. While some of the following statements may, in themselves,

seem unremarkable because, after all, many parents the world over may make similar claims, it is more the particular linguistic resource these mothers turned to which prompted this specific topic to be highlighted. The particular word choice had a potent and assertive conviction, often talking of their infants' wants, likes and feelings, giving an impression of a factual statement which was authoritative and unambiguous, and that there was no other reason that may possibly explain the behaviour/s which led to the final decision to practise as they chose. This appeared to serve the purpose of validating the decisions the mothers had made in their infant-sleeping practices by being a way they could state, as a fact, that their practice choice ultimately came down to their baby making a decision, as opposed to themselves. Further, rather than choosing words such as 'he/she *seemed* to be happiest when...' or 'he/she *seemed* to like it when...' for example, the ways these mothers expressed themselves gave a more definitive and clear-cut impression of who made the choices and why. The following statements are examples of the use of this particular linguistic resource by the group:

For NT, TO, BK and TG, aside from discussing their babies' perceived likes, wants and feelings, it was important to impress that their practices were also specific to their baby's own preferences of caregiving structure:

"he just wants to be cuddled all the time" and *"I just did what worked for him"* (NT);

"He didn't like being on his tummy though...nah, it's just not his thing" (TO);

"I did it by however he wanted it", "I always wrapped him so that he still felt little and that", "...and he didn't feel comfortable..he didn't like the feeling of

it..on his head, so that's why it was his tummy...his first night he slept on my chest because he didn't like the feeling on his head, yeah" and, *"I was like 'well, he doesn't sleep' and it's up to him"* (BK);

"She would go to bed when she was ready" (TG).

NL, LA and IA also made attempts to more deeply interpret the meaning behind their babies' preferences by referring to an anxiety at being separated, and further for LA, suggesting her infant also inherited her habits as an infant:

"he just didn't like it..he just liked cuddling with me", "he just didn't like his arms wrapped", and "he likes it with me,..to him it didn't feel right..to him it felt like I was leaving him" (NL);

"I dunno if he felt edgy..being distanced", "Yeah he loved it (sleeping on a breastfeeding pillow)", and "I was a restless sleeper when I was young...so, I don't know...he just picked it up" (LA);

"She really liked being on her side", and "they get stressed, real stressed and separation anxiety if they get taken away when they've been inside your tummy for so long and they're, like, separate from you" (IA).

SN, however, used a stronger choice of words to express the factual claim she was making:

"Um, he didn't like to be wrapped at all", and "he hated them (wearing a beanie hat) from the start" (SN).

Mother's Instinct or a Natural Ability. In various ways, the mothers used a particular language which appeared to serve the purpose of validating or justifying the decisions made and actions they had taken. Many of the ways in

which these took shape suggested a particular sensitivity to the need to be a 'good mother', and the stigmatisation of young motherhood that problematises them as never being able to fully attain such a categorisation. Many interview responses seemed also to act as defensive mechanisms. Through referring to having a 'natural ability' or 'mother's instinct', these mothers constructed a sense of being as competent and able as any other mother, and that, from their perspective, age should not be a factor when it comes to mothering. Often these references were accompanied by what the author would term a 'proud' intonation or stoic type of expression in their speech. This gave the added sense that being able to express their value as mothers was highly important.

For NL, a strong faith in her own ability to care for her first-born came across when she commented that, *"I knew..I knew that I was a good Mum"*.

On seven occasions, TO makes reference to having a natural ability and the words *"coming naturally"* repeated more than any other term – four times in one answer. It was important for her to stress that she was capable and independent. For example, she stated that, *"they (her parents) weren't much help though. I just did it all myself. 'Cos I'm a solo Mum and I did it all by myself"*, and when asked to describe the influences on how she practised sleeping her baby: *"Oh, that was all me, that was"*. When later asked if family had any influence on the choices she made in raising her baby, she strongly stated that, *"Oh NOT raising him, it was my choice, like, how to raise him"*.

SN has two children and her sleeping practice choices were different for each. For her, when asked to describe how she knew what she wanted to practise with

each of her babies when they were infants – despite each baby being managed differently – she also alluded to a natural awareness by answering, *“I think I just..yeah..I’ve just known”*. To further affirm that her mothering abilities should be considered acceptable, LA stated that, *“all the things that I did was instinctual, like, that ‘mother’s instinct’ I guess. Like, you just trying things and seeing what worked”*. Later, commenting on a lack of support, she again alluded to having some sort of natural ability by stating that,

support..yeah, but I didn’t mind ‘cos it was my responsibility anyway. So with or without support I had to do what I had to do for my child. That’s..that’s what mindset I was in and I still am in that...I always knew what I was gonna be like as a Mum.

And, although she describes herself as *“paranoid”* with her first baby, CN acknowledged that she had an element of ‘mother’s instinct’ with her second. She commented that, *“things are a lot different with my son, actually, ‘cos my motherly instinct is just already there so..I already know, like, how..how to do things with him”*. Further, when asked to describe the influences upon her practice choice she remarked that, *“my family plays a really big..a really big role...you know, in the way I’ve taught myse..well not really taught myself, because it come [sic.] naturally...”*.

When her baby was approximately three months of age TG was forced to leave her mother’s home, and circumstances meant that she needed to develop a sense of resilience and stoicism in her resolve in order to parent to the best of her ability and help her make the choices she did. When explaining why she

then had to bed-share with her baby she stated, *“cos there wasn't space or anything and I just had to do what I had to do, huh”*. Eventually she got her own place and proudly stated, *“...we have our own house...yep..just me and my daughter, yep...yeah (giggles), we got there”*. When later asked to describe how she knew to make the choices she had, she replied: *“To me it was kind of more common sense...yeah, um, nah, I kind of just did it...but we got there, yeah”*. And later, with a reminiscent tone she commented that, *“yeah, you have to be strong kind of..like, just keep doing it 'cos that's the only way it's going to work”*.

For IA, 'motherly instinct' and *“common sense”* were factors in her decisions for both her own baby and the two younger brothers she raised when she was younger herself. She commented that, *“um, just, I don't really..I had no one so, just motherly instincts really. And what was comfortable for me and baby, pretty much, yeah”* and, *“Um, I guess it was instinct...yep, pretty much common sense, I guess, yeah”*.

When asked to describe how she learned what was the 'right' thing to do, NT's response was concise as she stated, *“..yeah..like my Mum didn't tell me what to do or anything, so, I just..winged it...”*.

Non-compliance – Incognizant or Purposeful Action. This theme appeared almost as an aside, but none-the-less illustrated an obvious pattern of language use. It is important to mention here that, in general, none of the 11 mothers interviewed appeared to hold any resentment or anger with regard to their specific contexts, during their interviews. So, therefore at face value, this did not seem to be a factor in their ultimate choices. However, regardless of the

motivation, at times they spoke of certain of their behaviours or choices with either an air of discomfiture, pride or, what seemed at times rebelliousness. What made this more complex was that for some, this apparent 'defiant' talk was something that many, but not all, seemed unaware of in their supposed breaking of the suggested 'rules'.

Two mothers (MN and SN) showed an awareness that they may have been 'rule breaking', but not in such a way that it was intended as a deliberate act of defiance. Rather it appeared that they either believed they had good reason to do so, or partially attended to the rules by finding a 'happy medium' between what the rules suggested and what they wanted to do. Further, by their decision to omit talking of their choices earlier in the interview process when asked, they appeared to tag the following comments on as after-thoughts when asked at the end of the interview if there was anything else they would like to share.

MN's comments suggested a hesitation to mention her practice choice earlier when prompted, and further hint that she may have had an awareness that her choices did not follow general expectations, or that she may have been embarrassed or ashamed for fear of judgment. Therefore, her last comments were that, *"um..sometimes..I would sleep him in my bed, just when he was grizzly and irritable, and he just wasn't feeling himself..'cos his dad wasn't really in the picture..so he was really close to me"*. There seems to be an element of contradiction in this statement from the perspective that MN's baby did not spend a lot of time sharing her bed except when he was upset. But also using the fact that the baby's father was not a part of this family was an important issue for her and appears to be an attempt at gaining support for her choice through

appealing to the interviewer's more sympathetic side. Further, like many parents, the mention of bringing her infant to bed with her when he was upset was qualified by the use of the word 'just' to impress there were only select times when this happened.

SN had not mentioned earlier in the interview that she used to have toys in the cot with her first baby. Hence, when she mentioned this, she seemed to have a strong urgency to make sure she justified and fully explained this situation, showing further awareness of acting differently from what was expected. She commented that the toys were,

um..just teddies, just teddies. Um, not until she was about nine months did I ever put a toy..put a toy into her cot because I was worried about her grabbing things or smothering her or something like that. But, I put them at the end of the cot, anyways.. .

It appeared important for ER to stress the significance of where she bought a sleep-positioning device, colloquially referred to as a 'wedge', which is used to help secure a baby in a certain position while sleeping, and for what specific purpose she used it. This suggested that where she purchased it and why she used it made her actions acceptable. She commented that, "I had the..wedge..thing, that you can get from Farmers...just to support her". The wedge in this instance was used to secure her baby in a side-sleeping position, but ER's downplaying such use by using the words "just to support her" tends to suggest an awareness that positioners like these do not come highly recommended due to the risk of suffocation associated with their use.

Further, ER also chose to sleep her other infant in the prone position regularly, and justified her decision by commenting that, *“because, um, when he was born his head was elongated and he didn’t like the feeling of it (the bed) on his head. So that’s why it was his tummy”*. This gives the suggestion that ER had made this decision based on medical reasoning, which then implies that such a decision was acceptable. Through justification such as this, it is hard to argue otherwise, and serves the purpose of setting a scene where no other options could have been considered due to possible health risks. This type of passive defiance further serves to help this mother settle the conflict between her possible knowing and actual doing.

In support of her decision to bed-share LA used ‘they’ as a reference to authority and a way to give an impression that her decisions had been sanctioned without specifying who ‘they’ were. Further, her reference to an infant needing ‘closure’, which perhaps is a reference to ‘closeness’, because a bassinet had too much space, may also have been to appeal to the interviewer’s more maternal side for understanding and support. She commented that, *“he slept longer when he was close to me”* and *“cos in his bassinet there was no, um..closure, it was all space...and they do say that, um, like, every baby’s different, and every parent..different”*. Adding *“they do say...”*, somehow sanctions parents’ choices to practise outside of expected norms, without having to actually name where such advice comes from. This may also be a way that LA justifies her choices to herself, as much as to anyone else, in order to quell any anxiety she may have at choosing to practise outside of recommendations.

CN passed the comment that *"nobody's perfect"*, with an accompanying 'cheeky' facial expression, regarding bed-sharing with her baby. This suggested that she believed that sometimes people, including herself, cannot always be held responsible for their actions because they all have faults. Further, like LA earlier, this may also be an attempt to justify going against the expected norm to herself, as much as to others, in order to quell any underlying anxieties she may have had in making the choices she did, or to deflect any perceived judgments.

NL's comment about her practice choices came across with a deliberate air of defiance. She commented that she, *"didn't really care what they were saying..because I knew..that I could put my son to sleep, you know, and there was no hassle, nothing"*. NL's intonation and resolve changed markedly when she explained her decision not to follow expert advice, and this was particularly obvious when she stated she *"didn't really care"* and that she knew she was *"a good mum"*. A final cementing of her feelings was abruptly made with the end comment, *"and he's (baby) happy"*. By adding this last comment, she confirms that her decisions were ultimately acceptable, as her baby was content. Earlier comments also suggest that she believed she had exhausted all other options when initially trying to get her baby to sleep in his bassinet, not dissimilar to the way many parents in general feel, by stating that, *"I did everything"* and *"I tried everything"*.

One last attempt to qualify her ultimate choice to bed-share referred to NL's own ability to sleep lightly enough that she was constantly aware of her infant's presence in the bed with her, and so safety was not a concern. She commented

that, *“yeah, I don’t sleep heavy. Like, when he moves I wake up. I know when he moves. I know..exactly what he does”*.

Summary. To a large degree these young mothers were having to function in a highly complex social situation. In their own way each of these themes interacted with, and at times may have influenced, each other to result in these mothers seeming to have been walking a tightrope between understanding what was acceptable, being true to their own contextual situation at any given time, striving to parent to the best of their ability, and having an awareness that they existed in a world that chooses to construct them as a social problem. But, there is apparent contradiction also. While there is no doubt that, like most parents, they wanted to do best by their infants, they also appeared to carry the belief that their own situation was unique and thus called for unique health behaviour practices in infant-care sleeping. This suggested that, from their position, the influences these mothers identified had very little to do with adhering to current medical advice and, in fact, more likely served to supersede it. The two less expected themes of the construction of the ‘Mother’s Instinct’ and the ‘Baby’s Wishes’ were surprising in their regularity and the intensity with which they seemed to continually surface and resurface. In a way, these also served to validate the mothers’ ultimate practice decisions, but also in some ways acted to appease any conflict or contradiction between what they knew and what they actually did. Nonetheless, the reasons for their own individual practice choices varied considerably, and many, in their own context, appeared to have some validity relating to the way those contexts related to these mothers’ experiences at any given time.

Chapter Four, Discussion

This study sought to enquire and give voice to the infant-care sleep practices of young New Zealand mothers, and to investigate the factors which influenced their practice choice(s). Through a Social Constructionist epistemology, not only did the researcher enquire into these two phenomena, but also worked to elucidate the ways young mothers constructed their practice choices through the linguistic resources they made use of.

The two research questions addressed were: 1) What are the experiences of young mothers in infant-care sleep practice? and, 2) How do young mothers construct their practice choice? The results for question one – which show what the mothers do and what has influenced their choices – were more fully explained by the results of question two.

Question 1: Young Mothers' Infant-care Sleep Practices and Apparent Non-compliance

Very few mothers followed the current recommended health advice and it was found that the majority had bed-shared with their infant(s), used a variety of sleeping surfaces, positioners, or inappropriate bedding, and had, if not permanently then regularly, placed their baby(ies) in the prone or side-sleeping position for sleeping at some point in the first 12 months. The reasons behind such apparent non-compliance may, in part, be due to a complex web of issues which begin to become evident in the following subsection.

In the literature, and current health recommendations, the practice of bed-sharing with infants is generally advised against. Recent work has also found the risk of bed-sharing to be a major factor in cases of SUDI (American Academy of Pediatrics, 2005; Carlberg et al., 2012). Although most of the mothers in the present study were aware on varying levels of this risk, the majority none-the-less chose to practise in this way. Aside from one mother who was forced to bed-share with her baby due to housing circumstances, the remainder had other options which would have allowed their baby a safer sleeping space while still being close to them. Making such a choice may have been related to the assumption many mothers had about how an infant benefits, in some way, from sleeping close to another. Nevertheless, researchers (for example, Glasgow et al., 2006; and, McKenna & McDade, 2005) believe that a multitude of factors come into play in this complex decision-making process. The mothers in this study presented multiple reasons for choosing to bed-share, which tends to support the opinion that indeed, many factors contributed to their decision-making processes. Taking a 'one-size-fits-all' approach to addressing this issue is quite possibly too simplistic. In further support of these authors, and others (for example, Ball and Volpe, 2013; and, McKenna and Volpe, 2007), the present study has demonstrated that the choice to bed-share is highly personal and context-specific, as well as being dependent upon access to appropriate and effective resources.

The young mothers expressed a more authoritative explanation for their choice of baby sleep position. That is, their explanations were backed with reasons which gave an impression that either their actions were based on

medical necessity of some kind, or that they had exhausted all other options. These types of explanations demonstrated an awareness, on varying levels, of recommended best practice but at the same time allowed a deviation from the expected behaviours because they were deemed valid reasons to do so. In their study, Hutchison et al., (2007) found that the main reasons parents expressed for not sleeping their infants supine exclusively, were risk of plagiocephaly, and/or aspiration of vomit (p. 246). These same concerns were also found in Chung-Park (2012). While risk of plagiocephaly was mentioned as a concern by only one mother in the present study, concern over the possibility of aspiration of vomit was the reason behind many mothers' decisions to avoid supine positioning. Numerous studies (for example, Byard & Beal, 2000; Hutchison et al., 2007; Jones, 2004; and, Krous et al., 2007) have been able to show that, in fact, risk of these concerns is minimal at best. In the case of plagiocephaly, there are very simple, effective steps to avoid, or significantly reduce, the risk of a misshapen head. Likewise, the risk of aspiration also could not be directly attributed to lying supine in any of these studies. In fact, there was higher risk of babies suffocating either in their own vomit, or from becoming stuck in a face-down position, when placed prone or in the side position respectively. It would seem from the mothers' concerns in this study that awareness of the reasons behind *why* there is a higher risk when placing their infants in the prone or side position is not present. Most, if not all, were aware on some level that these positions may no longer have been endorsed, however, because there appeared a lack of understanding *why*, the messages or advice seemed generally to have been ignored.

It appears that the explanations for the practices of this group differed little from other parenting groups. A number of studies have found that parents across a range of backgrounds and age-groups have chosen to practice in certain ways for reasons similar to the young mothers in this study, such as perceived safety, feeding, settling and comfort (see, Ball, Hooker & Kelly, 1999; Hauck, Signore, Fein & Tonse, 2008; and, Hooker, Ball & Kelly, 2001). Likewise, reasons for choosing particular sleep positions or the use of particular items in the sleep environment have also been found to be similar (see Colson et al., 2006; and, Hutchison et al., 2007). This suggests that the tendency to ignore or adapt particular recommendations is not specific to young mothers, but in fact seems consistent across parenting groups.

Many mothers were open about their fear of the risk of SUDI and it became evident that their practices were the best they could do to minimise this fear with the resources available to them. Many of their practices tended to demonstrate their resourcefulness and determination while attempting to create a safe space for their baby, but which also helped to subdue or allay their fears at the same time. While such practices were intended to minimise risk, they, according to the recommended advice, actually had the opposite effect of increasing their baby's risk of SUDI. Thus, these mothers' attempts to avoid SUDI actually highlight a severe lack of a thorough understanding of the risks and how to avoid or minimise them. Moon et al., (2010), found in their study on beliefs and perceptions around SUDI that a number of parents stated they would be more likely to follow recommended advice if they were given more detailed physiological information about how SUDI occurs (p. 95). There may well be a

similar finding among young mothers in the New Zealand context, but this is for consideration at another time.

Young Mothers' Best Practice Advice Awareness. The descriptions of these mothers showed there was significant variation in their awareness of what was recommended best practice. A few appeared to have a reasonably good up-to-date awareness but, for various reasons, seemed to either ignore or adapt the advice depending on individual circumstances. Only one mother was found to have full, up-to-date awareness and to follow the current advice verbatim. Many others were influenced by factors which held more important value to them, and these subsequently overrode any advice they may have known to be correct.

Fear was a motivating factor in the decision-making of many mothers, and this highlighted a glaring gap between knowledge and practice. Much of their knowledge came from significant others. While the mothers were aware of (the risk of) SUDI, this awareness appeared in some cases to have created an unjustifiably high level of anxiety. This may well have been reduced if these mothers had been fully informed and better educated to understand that they have the power to significantly reduce their baby's level of risk with very little effort. Further, relying on outdated information, often from significant others, poses a risk for these vulnerable families also. This highlights a need for more effective resources to be targeted at significant others, and emphasises the importance of providing appropriate support to this group also, especially if this is where many young mothers turn for their education and advice. This is

supported by Colson et al., (2005) who discuss how a vital factor in any effective intervention will be to include significant others when it comes to getting caregivers to follow recommendations for safer sleeping.

While practising autonomy in decision-making over the care of another as vulnerable as an infant should be acknowledged, it should also be recognised that young mothers are a group with higher needs when it comes to having access to appropriate resources. Further, the apparent behaviour of some in choosing to ignore professional advice may indicate a lack of ability within the professional community to engage effectively with this group, and that there is a need for more appropriate resources in order to reach and appeal to young mothers in general. Such access would enable mothers to make safe and informed decisions, rather than relying on the advice of others whose knowledge may be outdated or incorrect. Breheny (2006) discusses how young mothers may also be reluctant to engage with health professionals because they are acutely aware of how they are socially constructed by this community. This author states that, “[they] may well avoid situations in which they are inevitably seen as deficient” and that, “if young mothers are distrustful of health professionals, then they may be less likely to follow professional advice or even seek such advice” (p. 178). This may help explain why very few mothers in the present study referred to being influenced by, or even attending, antenatal education for example. Comments such as, “*I didn’t really care what they were saying*”, and making the decision to treat the second baby differently because “*nothing happened*” to the first baby, are further evidence that health professionals have lost respect and trust in this community and therefore their

messages are not effective. Additionally, there is a need to ensure that those professionals who care for the health of young mothers, and that of their infants, empower these women to have confidence that they are as important to the health community, and will receive the same levels of care without judgment, as every other mother. The health experiences of young mothers must change.

With the relatively short period in which not only numerous name-changes have occurred, but safety advice also, confusion among professionals may well have led many to impart incorrect knowledge to mothers and significant others. The results of this study revealed that this is also a factor requiring attention. For these mothers their perceptions and understanding of their advice indicated there is a lack of consistency, accuracy and effectiveness in the messages, if any, they have received. Although at an age where attempting to assert one's independence is expected, these mothers are also a group where accuracy, consistency and access to appropriate resources and support are more vital than for most, but seem sorely lacking. This is in addition to having to deal with an added health concern that many do not cope with well at such a vulnerable stage of life. While the mothers in this study showed resilience, determination and resourcefulness, this was borne of their own particular situation but highlighted how ineffective current messages have been. It may well be that health professionals and organisations are also in need of more effective professional development and support themselves before they feel confident in imparting such knowledge to young mothers. Moon et al., (2010) found that inconsistencies in the advice recommended by healthcare providers, and the

changing emphases in the recommendations themselves, were major reasons in the lack of adherence to that advice. Therefore, those professionals most charged with caring for this group should be included in the provision of appropriate support and education.

It was both interesting and concerning that only one mother made mention of any advertising material about safe sleeping. Regardless of her decision to later go against this advice, it seems that the one poster she saw in her maternity suite room had enough impact that she followed the advice for at least the infant's most vulnerable risk period. In the writer's past experience, visiting a large number of organisations on behalf of a New Zealand DHB, which included hospital maternity suites, it was discovered there were varying amounts of the recommended advertising material available. In general, there seemed to be a lack, rather than an over-abundance. Only some rooms had a poster, or in the case of one maternity suite, had typed up their own safety advice and placed it above where the infant cot was situated. There appeared to be no consistency in access to such material as not all rooms had the material visible, only one had any in their general public areas or pamphlet stands, and in the case of an antenatal education organisation, were using significantly outdated pamphlets and other information. If the experience of the one mother who did talk of reading the poster is any indication of its effectiveness, it may well be a very simple, cost-effective way to assist getting the messages across.

Advice through Childcare Centres also seems in urgent need of attention and policy around best practice, as a number of the mothers commented that their

advice came from these places, yet none of it was correct. At a bare minimum, Childcare Centres should have access to updated information and education given that young mothers, such as those in this study, all had their infants cared for in such institutions whilst trying to continue with their own education. Preferably, however, it would be more effective in the long run for policy to be in place that guided such organisations in order to significantly reduce the risks from the apparent levels of the present.

A further interesting observation was the absence of talk about the use of the internet as a way to gain advice and information about infant-care practices. It may be that it did not enter the mothers' minds at the time of the interview. However, it may just as likely be that due to their financial or living circumstances, access to information technology for such purposes is limited or unavailable altogether. It is more usual for the generation of which these participants are a part to engage in the use of information technology for advice and information-seeking than any generation before. Therefore, it is somewhat surprising that no mention of such use was made by any participant at any stage.

Summary. This question asked *What are the experiences of Young Mothers in infant-care sleep practice?* The present study demonstrated talk of almost full non-compliance with recommended advice. This, in turn, has highlighted a concerning lack of awareness pointing to an ineffective, if not severe, shortcoming of appropriate support and resources. The ways these mothers accessed any knowledge, whether correct or not, further highlight a lack of consistency in the messages, and an urgent need to educate not only young

mothers but their significant others, and all health professionals and organisations with which this group comes into contact. Better policy and education for secondary care organisations are also vital.

Question 2: Young Mothers' Constructions of Their Practice Choice

Five distinct themes arose from the data. These themes, *Needs of the Baby*, *Needs of the Mother*, *Baby's Wishes*, *Mother's Instinct or a Natural Ability*, and *Non-compliance – Incognizant or Purposeful Action*, generally tended to represent shared discourses and were often prominent because of the use of particular linguistic resources. It was found that many of the mothers' explanations for their practice choices followed a logic that may not be too dissimilar to that of other parents.

Needs of the Baby. The mothers often constructed the reasons for their practice choices as if their baby's needs were paramount. For example, many believed they had exhausted all their options in order to get their babies to sleep. Another common thread was about keeping their baby safe. Although it would, at face value, seem to contradict the purpose of the recommended advice, the mothers believed their practices were safer. Constructing their practice(s) in terms of putting the baby's needs first may be an indication of striving to fulfil the 'good mother' role. In the interview situation, the mothers were faced with having to describe their health behaviours to the researcher who was old enough to be their mother and may also have represented an authority figure. The mothers may have been trying to reduce any potentially negative judgments by using this particular linguistic resource.

A number of the mothers held the belief that by bed-sharing with their baby, they were ensuring the baby's safety. This is a commonly-held belief among parents in general (for example, see Colson et al., 2005; McKenna & Volpe, 2007; and, Moon et al., 2010), feeling that they do not sleep as deeply because they have a subconscious awareness of the baby being in the bed at all times and will easily wake if their baby requires attention. While, overall, SUDI events have decreased through recent decades, in some countries the numbers dying due to suffocation from sharing a sleeping surface with an adult have increased (see Carlberg et al., 2011; and, Shapiro-Mendoza, Kimball, Tomashek, Anderson & Blanding, 2009). While in some cases other factors may have come into play, the fact remains that this seems to be an unsafe practice. In New Zealand, safer options for bed-sharing are now available by way of the Pepi-Pod or Wahakura (Change For Our Children, 2010). These are designed to allow an infant to share the parental bed whilst in their own sleeping space. Some DHBs are making them available to more vulnerable families. One mother in the present study had mentioned the use of something similar to the Pepi-Pod. However, no others appeared aware of it as an option.

The use of pillows, soft bedding and sleep positioners among those in this group, while a very common practice, was justified mostly as a safety precaution which enabled the mothers to still have their babies close during sleep, without anxiety. Levels of awareness of the dangers of such practices varied but were over-ridden by the mothers' own perceptions and beliefs that what they were doing was safer than the recommended options. Ward (2014) also found this to be one of a number of explanations for mother-infant bed-sharing (abstract

only, article in press). And, although it is unclear whether this manner of reasoning would be common across all parenting groups, it nonetheless highlights the necessity for more accurate, consistent and appropriate education which is tailored to this particular group.

To justify their specific practice choice(s) some mothers implied that a particular decision was made for the baby's medical or health needs. The use of this particular type of linguistic resource gave a perception that a medical voice of authority had recommended such practice, or that their actions were professionally supported. This may have had the added effect of removing direct responsibility for their ultimate practice choice from the mother, and perhaps making it more acceptable.

Needs of the Mother. Fear of a tragic outcome was a major reason for the mothers not following recommended advice. In the case of their bed-sharing practice, this further enabled mothers to have a more rested sleep which served to neutralise their fears. The belief in their own ability to sleep with a subconscious awareness of their babies whilst bed-sharing, or that placing their baby in the prone or side-sleeping position would avoid the possibility of aspiration, came across strongly. Such apparent contradiction of what is purported as high-risk practice, and the actual behaviour with the perception of reducing risk, may be borne of a further failure in understanding the mechanisms behind why there is risk in the first place. Additionally, there also seemed a need to appeal to the researcher's empathetic side with regard to expressing their anxieties, and this in turn may have helped them feel they had

been able to validate their actions further. Through appealing to empathy, not only could this help validate the behaviour, but also the assumption that if the researcher was also a mother (and none of the participants knew this prior to their interviews) she could relate to those innate fears in some way.

There is a possibility that there is a relationship between a young mother's need to feel less isolated and an opportunity to forge a strong, connected relationship with another who they know cannot reject such a relationship. When younger women enter the journey of motherhood, they have been thrust into it from a world where self-identity, a need to belong, and the opinions of others are factors which are impacting on the normal passage through adolescent development. This is a time when an individual may feel isolated and disconnected, and relationships may be ever-evolving, creating a feeling of instability (Laurson & Hartl, 2013, p. 1265). While a young person is limited in controlling the trajectory of their relationships with other adolescents or adults, a young mother, on the other hand, is able to wield more control over the relationship she has with her infant. In being able to do so, such a relationship may act as a type of substitution for those relationships in which she has more limited control. Thus, bed-sharing with her infant is a way to satisfy the strong human desire for connectedness, which may be less assured with others during adolescent years. With her infant the relationship may feel safer or more assured in its endurance, whilst also acting as a comfort. This may help to further explain why this practice was so widespread in this group. This issue, however, is for further investigation elsewhere.

With regard to the varying influences upon their practice choices, antenatal education and culture were minor factors. A noticeable feature was how most mothers constructed their choice to take up, or not, antenatal education. Many, if not all, were aware that it was recommended but most chose not to attend, using the explanation that they had adequate support from elsewhere. While only one mother referred to an awareness that young mothers may feel judged in such classes, two acknowledged the benefit of attending classes specifically designed for young parents. With regard to culture, while this group hailed from a range of backgrounds, only one mother justified her infant-care decisions as being impacted in some way by her cultural heritage. This is not to say that for others in the group it was not an influence. However, through its absence of mention it is assumed that it has not played a vital role in their decision-making processes.

Baby's Wishes. This was, in many ways, an unexpected find. Aside from two, the mothers used a linguistic resource which appeared to voice the baby's own opinion and decision-making about how it was to be cared for during its sleep. For example, these mothers frequently referred to what their baby(ies) *wanted*, *liked* and/or *felt*, as though these had been verbally expressed by their infants. Additionally, there was a passive assertion to the way these sentiments were expressed, and combined with their very specific word choice, it gave an impression that, because their baby knew what it wanted, liked or felt, baby knew best. This may have served the somewhat inadvertent purpose of removing responsibility for their practice choice directly from the mother - a

particularly helpful tool if such practices should be brought into question. While not necessarily a deliberate act, the implication however, could then be focused upon the infant's decision-making ability, with the mother simply complying with that infant's wishes, as any 'good' mother may do. Through using such a tool to explain their actions, it would then be difficult to argue against it as one cannot argue with an infant. Further, if the commonly-held, social assumption that no-one understands an infant better than the mother or main caregiver themselves were upheld, then these mothers' interpretations of their infant's desires can only be accepted as correct.

There seems a paucity of work available on the use of a linguistic tool such as that found in this theme, yet in general it is likely that its use is widespread and certainly not specific to young mothers. However, because young mothers must endure the added issue of society's attitudes toward them and/or their situation, it is possible that it has become a practical way to help manage the impact of those stigmas. Further investigation into the practicality of such a tool could be helpful for understanding its implications for human interaction in the future.

Mother's Instinct or a Natural Ability. The resolve which accompanied this construct also made it somewhat unexpected. It appeared to hold high value for more than half of these mothers and it was important for them to refer to it, or to having a certain type of resilience, repeatedly in their interviews. For example, it was not uncommon for some mothers to refer to their parenting ability as *coming naturally* or that it was *common sense*. But by far the most

consistent reference was to having an *instinctual* ability. An interesting feature of their talk was the way they expressed this construct. That is, the researcher became immediately aware that when these mothers talked of this topic, they each did so with a purposeful, proud tone and stoic nature.

Due to the seemingly high value of this shared discourse, the explanations help to illustrate why these mothers seemed so resilient and determined in their resolve. Whether such a discourse served to prove that, regardless of how a person is categorised, mothering is the same, or whether the frequent use of such terms resulted in making them feel more confident in their parenting skills, is unclear. It may, however, indicate an awareness among these mothers that, for some, mothering is not a 'natural' phenomenon and that they prided themselves, through their self-diagnosis, on having an admirable quality such as a natural ability or instinct. Many of these mothers have, themselves, come from environments where they have learned to help raise other children, if not observed others raise their children. It is, therefore, also possible that they have unwittingly learned some of their skills through exposure to such environments. What they have determined as a natural ability or mother's instinct could possibly be what they have retained from such previous experiences, combined with their own ability to reason, akin to having 'common sense'. Literature on the phenomenon of a mother's instinct or a natural ability as it relates to young mothering is scarce, therefore it is difficult to determine if in fact such a phenomenon exists in its own right. What is clear, however, is that for these mothers it does exist in some capacity and it would seem to have an important

intrinsic value to the way they feel about themselves as mothers and, quite possibly, as women.

This has implications for both the young mothers and those who are there to support them, whether in a professional or a personal capacity. For the young mothers, if this construct is highly valued then its intrinsic value may well be a determining factor in the level of resilience they have toward society's attitudes. The writer found each of the mothers she met to be particularly upbeat and thinking positively, yet realistically, toward her future. Each appeared to exude a confidence which was unexpectedly comforting, and although they talked of having some vulnerabilities, these seemed, at face value, to be no more or less than would be experienced by either other adolescents or other mothers. It is possible also, that many of these young mothers have had a more challenging start to their lives than many, but despite this they seemed to have a down-to-earth approach to their lives and tended to continually promote a positive future. The choice alone to return to school would certainly support the view that they intended to direct their best efforts toward making those futures happen. This would be difficult to achieve without at least a certain amount of resilience. Those who are entrusted with their care should be encouraged to nurture the confidence which comes with employing the use of the construct of a natural ability or instinct. Doing so may likely enable these mothers, and others like them, to gain a sense of empowerment and control over their future direction.

Non-compliance – Incognizant or Purposeful Action. Whether a deliberate action or not, at no time did the researcher gain the impression that any of the mothers were non-compliant purely for ‘rule-breaking’s’ sake. That is, some genuinely appeared, through their talk, not to have knowledge of current best practice, but their intentions none-the-less, were to act to the best of their ability with the resources they had at their disposal. For others, their practice choices were purposely made – most often contravening current advice on some level – despite having some, if not most, of the knowledge. However, their reasons for doing so did not appear to be rebellious in nature. Rather, it seemed they had thought through, and made attempts, to conform at least to the levels to which they had knowledge. Ultimately, however, they made their practice choices upon the values and concerns which were most important to them at the time. Again, this is perhaps not too dissimilar to other parenting groups. Regardless of the level of incognizance, overall the health behaviours these mothers chose to practice appeared deliberate. Although the reasoning behind their choices may have contravened current advice, it seemed considered rather than impetuous.

Limitations

This was a qualitative study under the epistemological assumptions of Social Constructionism. The findings of qualitative studies are not intended to be generalisable to the wider population. More readily, the findings in the present study add to the voice and perspective of young mothers with the intention of elucidating those factors which influenced the infant-care sleep practices they

chose. Such findings represent the experiences of the participants in their decision-making processes which have ultimately dictated what the outcomes will be. While qualitative study is concerned with meaning rather than numbers, the qualitative analytical method of Thematic Analysis (TA) is concerned with identifying patterns within a data set. In the case of the present study, this is the participant interviews which highlighted the practices and influences that were important in the decision-making processes of young mothers as they related to their infant-care sleep practices. As such, the findings through using TA have added a richer description and a depth of understanding that has, until now, been absent from the literature, but are none-the-less not representative of the young mother population.

A disadvantage of using TA is its limitation of the depth of interpretation of the results. While assisting a richer description and deeper level of understanding it does not allow analysis to go much beyond this and therefore, as Braun and Clarke (2006) discuss, the researcher is, “unable to retain a sense of continuity and contradiction through any one individual account” (p. 27). In the case of the present study, however, this is a health issue never before researched within the specific context on which it is founded, and TA has provided a solid analytical springboard from which future enquiry can dive and branch out.

In the case of this qualitative study, its validity is the trustworthiness of the results. All data analysis and subsequent theme identification, while assisted in the initial stage by the software package Express Scribe NCH, were conducted by

the researcher herself. While the data were subjected to repeated analysis until identification of the patterns appeared exhausted, validity could possibly have been further enhanced by adopting the method of triangulation.

This study's sample was limited by the age range of the participants and their geographical location. The age range was between 16 and 20 years inclusive, and due to the need for anonymity and confidentiality, while the area cannot be identified, it suffices to say that all the participants were from the same New Zealand geographical location. The participants self-selected into the study after having first been introduced to it in a group meeting situation at the YPEI. The experiences of the young mothers were influenced by their age and geographical location. In limiting them by these two factors, and with 11 respondents, there is also a small possibility that data saturation may not have been achieved.

Further, through the process of an initial group introduction to the study, it may have been possible for the participants to discuss the topic together prior to their individual interviews. This, however, did not appear to the researcher to have had much, if any influence, as the participants' ways of responding were so unique and varied, they seemed personal, natural and individualised accounts.

Reflexivity on behalf of the researcher is a vital ingredient to the success or otherwise of a study such as this. The researcher herself has come from a particular social, historical and cultural place which may have been different from those of the participants. She is a middle-aged, married, educated New Zealand mother of European descent. As such the researcher made her best

efforts to keep this awareness at the forefront of her mind in order to ensure it impacted as little as possible upon the ways she interacted with participants and ultimately analysed and reported their data. There is acknowledgement, however, that to some degree this background may have had some influence.

Future Recommendations - Implications for Practice, Policy and Research

Young mothers have been defined as problematic by social, cultural and political biases. While there is a risk that data from this study may be used to further this standpoint, the voice of young mothers should not be absent. All of the participants chose to contribute to this study because they felt strongly about being heard, rather than being spoken on behalf of by those who likely have not experienced this particular facet of motherhood in the ways they have. Their own knowledge about their experiences and practices should be used to reconstruct understandings of young motherhood, and as it relates to infant-care sleep practices, in order to produce implications and effect change for health practice, policy and research.

For health practice, these findings contribute to providing health professionals and institutions with information that can lead to prevention with regard to SUDI, and/or intervention where identified. It is recommended, however, that because of the unique, exceptional characteristics of this group, it would behoove the industry to make a genuine and concerted effort to work with and among these mothers, rather than from above or from an authoritarian-like standpoint. Further, the apparent resourcefulness, resilience and determination demonstrated by the participants, are strengths that can be

tapped into and used to guide ways to tailor the delivery of future education and support to this distinct group. Young mothers have additional stressors that no other group of mothers has ever to deal with. If resources and education are to be effective, they must be tailored specifically to this group. Working with young mothers to understand their needs will have a more permanent and long-lasting effect upon outcomes. There may be a tendency to assume that, because of their age, their contribution would be limited at best. This would be a very short-sighted assumption. Through the completion of this study, it was the writer's experience that age seldom dictated these mothers' levels of insightfulness, motivation, wisdom or awareness of what they need. They are the best-informed, over any other group, of their specific needs and expectations and it would be careless, to say the least, not to make use of what they know.

Implications for the professionals who are charged with supporting these mothers revolve around how best to create an effective way to provide them with appropriate education and resources in the future. If having a 'mother's instinct' indeed holds significance for this group, then this could be translated into teaching them how to enhance or complement that ability to empower them to make informed and safe decisions in their infant-care practices, and be confident that they are right. This would require specifically-tailored programmes that promote self-confidence alongside the safety messages. Such programmes must be designed in a fashion that is non-judgmental, but relevant to this group and the values that it holds most important. Engaging young mothers, particularly in the development stage of such programmes, and

employing them as peer educators, are quite possibly vital links to getting the messages across accurately and most effectively in the future.

At the time of conducting the research for this project, there had been no further nationally-coordinated major campaigns promoting safe sleeping for infants since the 1991 New Zealand Cot Death Prevention Programme. Depending on funding, each DHB has more or less been left to its own devices with regard to how much it has been able to promote and to provide appropriate resources. However, there have been varying levels of engagement and an apparent lack in providing support, and consistent and accurate information, not only to parents themselves, but to the professionals and institutions who come into contact with those parents most. At a policy level this is in urgent need of attention. What largely seems to have been missed is the fact that each generation will continue to have babies and therefore the messages need to be constantly available to every new generation of parents. This study has demonstrated that relying on advice from previous generations, or assuming that the professionals and institutions these mothers come into contact with are up-to-date, without monitoring them in some way, poses a significant risk to infants. While the level of safe-sleeping awareness varied greatly among the mothers in this group, which in itself is a risk, most of the mothers chose to make their own decisions out of the belief that they were taking the safest course of action for their infant with the resources available to them. In the majority of instances this was misguided, but barely surprising if the messages they receive, or do not receive, are as confused and conflicted as

they currently appear to be. Policies which afford more clarity and consistency are vital to the way forward.

There are also officially-sanctioned resources and materials available for health boards, as well as others, to make use of, (for example, see *Change For Our Children*, 2010). While just one mother in this study recalled taking notice of one such resource, the remaining 10 did not, nor did they make reference to the official advice motto '*Face Up, Face Clear, Smoke Free*' which has been in place as part of the overall safe sleeping promotional concept for a number of years (*Change For Our Children*, 2010). This lack of awareness, and minimal guidance from authority, signals a lack of importance being placed on the value of education and support, not only for this particular group, but parents in general. It would seem that unless these issues are addressed, and policy tightened up, a decline in or even complete erasure of New Zealand's SUDI statistics is unlikely to occur. Lobbying, by those health professionals and institutions who are most in contact with this particular group, to see more coordinated, better-resourced and ongoing campaigns in place, may enable those in authority to understand why policy needs to change in order to change the statistics for the long haul.

Implications for research are that much more investigation such as this project is sorely needed in order to represent the voices in the midst of health issues. This project has added to the knowledge base, but is limited by its analytic mode. Use of more in-depth analytical methods such as Interpretative Phenomenological Analysis (IPA) or Discourse Analysis (DA) for example may

provide even richer data. Nonetheless, TA has created a new opening for deeper areas of investigation, which are desperately needed, to highlight where the deficits are and how society in general is, perhaps, letting this vulnerable group down. While sometimes slow to have an effect, the more research into the decision-making processes of young mothers there is, the sooner more tailored, effective approaches can begin to be developed. Further, repeating this type of study with a more diverse group which includes mothers from many and varied backgrounds, and also to include young mothers from different geographical locations, would lend itself to more robust data overall.

Significant others were shown to have a powerful impact upon many of the choices these mothers made. Further investigation into this important group, the value their knowledge holds and discovering the best ways to work with them to impact the SUDI statistics in the long term is recommended. Awareness creates change, and researchers are in a prime position to create that awareness. SUDI is a significant issue in New Zealand and unless factors which affect it are continually examined, it will remain so.

Chapter Five, Conclusion

The aim of this study was to explore from the voices of minority young mothers, the discursive constructions used to shape their choices of ways to sleep their infants. The focus was also on understanding the social context of the experiences which influenced their decision-making to practice as they chose. To problematise and categorise young mothering in the way society has done is neither helpful nor completely explanatory. This study brought the voices of young mothers to the fore. In their own ways, all the mothers in this study demonstrated how they are caught in the middle of a complex social environment which has failed to provide them with appropriate support and resources. Include the additional issues purely reserved for young mothers and the recipe for poor or devastating outcomes is a very real possibility, as past statistics have shown. Their personal accounts reflected the seemingly endless conflicts they faced in reconciling societal expectations of behavioural norms, what is acceptable best practice, and their realities. This is a clear example of how social and political attitudes systemically determine health outcomes.

Many factors interact and contribute to the makeup of SUDI statistics in any country, and being of young maternal age is but one. It would seem, however, that many of the explanations uncovered in the present study may have differed little from those of other mothers in general. In the case of young mothers in particular, society has tended to stigmatise their choices and this is very much based within specific social, historical and cultural locations. This, therefore, continues to place young mothers near the bottom of the social order for not

conforming, and serves to maintain the status quo. Further, and more importantly, it has forced them to use their own resourcefulness to work through the maze of confused and conflicting advice in order to make sense of the world of being a mother, and to hold at least a 'tolerated' position in society. Being a young mother and making choices about infant-care sleep practices are both, in themselves, complex issues that are deeply seated within the dominant discourses of their culture. Through the ways they constructed their practice choices, the young mothers in this study illustrated that they are acutely aware of such discourses. Generally, however, they responded in a way that showed they were not like the dominant discourses, but rather were akin to any other western parenting group. Nonetheless, these resourceful young women made decisions that were based on sets of complex issues particular to their own contexts, and which appeared by no means to be ill- or un-considered.

As discussed above, while they may not necessarily have the life skills and experiences of some other parents, young mothers' issues and concerns appear to be the same. Ultimately this makes them just like all parents. Therefore, they should not be positioned so that they must continually fight to be accepted as distinct, valuable individuals who are contributing actively to the social environment. For young mothers, unlike any other mothers, they have the added stress of continually working to balance the dominant social stigmas related to their age alongside the many other usual infant-care expectations associated with mothering in general. Thus, at the very least they deserve (and earn) the right to a change in current unhelpful societal attitudes and categorisations. More importantly, they deserve to be accepted, supported and

valued as contributing members of society. Appropriate political, societal and professional support, rightful access to adequate resources, and the valuing and accommodating of the important role significant others play in their support of these mothers, will help to disrupt the relationship between young maternal age and SUDI.

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APPENDIX

Interview Schedule of Questions

(Note: Due to the semi-structured nature of the interviews, this is a guide only. Outside of the two main questions listed below as '1' and '2', probing questions may be asked in order to seek clarification only)

- 1. Could you please describe/explain to me the experiences you have had/are having, and the practices you like to follow, with the sleeping of your baby?**

- 2. Can you please describe/explain to me what has influenced your choices to practice such particular sleeping arrangements and why they are important to you?**

Probing questions for possible clarification of the above may revolve around:

- Baby's sleeping environment, e.g. own bed or co-sharing, bedding, sleeping surface(s) (type of mattress/couch etc), daytime vs nighttime place of sleep, room temperature
- Beliefs about smoking around baby or during pregnancy
- Choice of positioning of baby in bed for sleeping, e.g. on back, side or tummy, or combination, use of positioners
- How participants choose to dress their baby for sleeping, e.g. beanie, number of layers
- Feeding of baby (bottle or breastfeed)
- Living arrangements, i.e. with whanau, friends, father of baby, or on own etc
- Influences upon practice choices: family/whanau; traditions; beliefs; media/internet; midwife/medical professionals etc
- Prenatal care access

Abbreviations

DA - Discourse Analysis

DHB - District Health Board

IPA - Interpretative Phenomenological Analysis

SIDS - Sudden Infant Death Syndrome

SUDI - Sudden Unexpected Death in Infancy

TA - Thematic Analysis

YMA - Young Maternal Age

YPEI - Young Parents Educational Institution