

**ORIGINAL RESEARCH:  
EMPIRICAL RESEARCH - QUALITATIVE**

# Repeat pregnancies in teenage mothers: An exploratory study

Amy Bucknall RN, BSc, MSc<sup>1,2</sup>  | Debra Bick RM, BA, MMedSci, PhD, Professor<sup>3</sup>

<sup>1</sup>King's College London School of Medical Education, London, UK

<sup>2</sup>Faculty of Nursing, Guys and St Thomas NHS Trust, London, UK

<sup>3</sup>University of Warwick, Coventry, UK

**Correspondence**

Amy Bucknall, King's College London School of Medical Education, London SE1 9RT, UK.  
Email: a.e.bucknall@gmail.com

**Funding information**

No funding was obtained for the study and was self-funded as part of an MSc.

**Abstract**

**Aim:** To explore young mothers' experience of rapid repeat pregnancy.

**Background:** Despite a reduction in teenage pregnancies in England over the last two decades, the number of repeat pregnancies remains high, accounting for around 25% of teenage pregnancies. There is a lack of qualitative evidence of teenage perspectives making planning appropriate interventions challenging.

**Design:** Exploratory design.

**Methods:** Six young women were purposively sampled from a Family Nurse Partnership programme in the South London. Semi-structured interviews conducted in spring 2017 elicited experiences of repeat pregnancy.

**Findings:** Each repeat pregnancy was unplanned and accounted for by participants' rejection of Long Acting Reversible Contraceptives and inconsistent use of non- Long Acting Reversible Contraceptives. Misinformation about Long Acting Reversible Contraceptives contributed to their rejection and staff delivery of contraceptive advice was influential. Motherhood was initially prioritised over other life goals to make sense of second pregnancy. Discharge from the Family Nurse Partnership may lead to fractured service contacts. Peer support and health professional contact through social media were proposed as "stepping stones" out of the service.

**Conclusions:** Practice developments working in partnership with young mothers to reduce the risk of a repeat teenage pregnancy are highlighted. Further research is recommended.

**Impact:** Understanding the experiences of teenage mothers who are at risk of rapid repeat pregnancy can assist nurses to provide preventative care and support. Structured advice through social media platforms can provide "stepping stones" that bridge gaps in provision as young mothers transition through services. Further research and development into the role of social media and contraceptive counselling are necessary.

**KEYWORDS**

adolescent, contraception, family nurse partnership, health visiting, nurse patient relationships, repeat pregnancy, school nursing, sexual health, social media, teenage pregnancy

## 1 | INTRODUCTION

Teenage pregnancies are a global problem commonly driven by poverty and lack of education and employment opportunities (United Nations Population Fund, 2015). Some teenage pregnancies are planned and provide girls from poor neighbourhoods with a path toward a better life (Kreager, Matsueda, & Erosheva, 2010). However, most are unplanned and childbirth complications remain the leading cause of death among 15 to 19 year-olds globally (World Health Organization, 2018). In the United Kingdom (UK), under-18-year-old conceptions were at a record level of 46 per 1,000 women in 1999 (Department of Health [DH], 2010). The rate has since reduced by more than half to 18.9 conceptions per 1,000 women, although the proportion of repeat pregnancies remains high, accounting for between 12–25% of the total (Public Health England [PHE], 2018). Rapid repeat teen pregnancy, defined as a second birth within 2 years of a first birth, increases the risk of premature birth, low birth weight and child mortality (Conroy, 2016). Parental education and employment opportunities are also adversely affected (PHE, 2016). Relatively little is known of a teenage mother's experience of a rapid repeat pregnancy which magnifies the challenge of planning effective services for a vulnerable group.

## 2 | BACKGROUND

The reduction in UK teenage pregnancies has been attributed to changes in teenagers' social interactions through digital media, thereby spending less time in physical contact with one another (British Pregnancy Advisory Service, 2018). The contribution of the then UK Labour Government's 10-year Teenage Pregnancy Strategy has also been acknowledged (Skinner & Marino, 2016; Social Exclusion Unit, 1999). Coordinated support for young parents was an important part of the strategy and from 2007 this was delivered through the Family Nurse Partnership (FNP) Programme (PHE, 2016). FNP is an evidence-based programme developed in the United States of America (US) to address high rates of teenage pregnancy and associated disadvantage. The programme is delivered by specially trained nurses who make regular home visits to teenage parents over a contact period of two to three years. FNP programmes are highly structured personalised interventions based on peoples' strengths and needs.

Randomised controlled trials (RCT's) in the US have reported significant benefits compared to standard or no service controls, including fewer closely-spaced subsequent pregnancies (Olds et al., 1997, 2002). The first RCT of FNP provision in England involving 18 services found the programme to be less effective than anticipated, reporting no reduction in the rate of rapid repeat pregnancies (Robling, Sanders, & Owen-Jones, 2015). The availability of health services for young mothers in the UK, free at the point of delivery and more comprehensive than standard services available in the US, was noted as a possible reason for the lack of programme benefits. Robling et al. (2015) proposed that longer-term follow-up may be necessary to capture benefits. However,

the study included no qualitative exploration of the young mothers' experiences.

### 2.1 | Literature review

To inform the present study CINAHL, EMBASE, OVID- MEDLINE, Cochrane Library and OVID- Maternity & Infant Care databases were searched over a 10-year period (Jan 1st 2007–Dec 31st 2017) using the terms "teen\*" alongside "subsequent pregnan\*" and "repeat pregnan\*". The 10-year period searched incorporates key policy and practice initiatives aimed at reducing teenage conception rates. Inclusion and exclusion criteria were applied to an initial yield of 110 hits to select papers that dealt with repeat teenage pregnancy and/or professionals who supported that client group, were conducted in healthcare settings, published in English and from high income countries as classified by the World Bank Group (2017). Study protocols and papers that focused on obstetric management were omitted. The process resulted in 15 papers including quantitative, qualitative and mixed methodologies, a majority of which were from the US ( $n = 12$ ), the three other papers being from Australia (1) and the UK (2).

Long acting reversible contraception (LARC) including the contraceptive implant, intrauterine device (IUD) and Depo-Provera injections are the most effective ways of avoiding repeat pregnancies among teenagers (Charles et al., 2016; Conroy, 2016). LARC's can protect against pregnancy for between 3 months and up to 5 years. They do not rely on women using contraceptives daily or at the time of intercourse. In England, LARC uptake is poor among teenagers; only 30%–31% of those using contraception were using LARCs (Health & Social Care Information Centre [HSCIC], 2016). Lack of knowledge among teen parents around LARC safety, effectiveness and reversibility were thought to contribute to the low uptake (Conroy, 2016; Society for Adolescent Health & Medicine [SAHM], 2017). Additionally, adolescent mothers proactively search for health information through social networking sites (Nolan, Hendricks, Ferguson, & Towell, 2017; Wartella, Rideout, Zupancic, Beaudoin-Ryan, & Lauricella, 2015). Misinformation, including "horror stories" about LARC use, can be easily gleaned from these sources (Kelsey, 2017). In contrast, non-LARC contraception including condoms, spermicides and the pill, have been associated with a pregnancy rate in teens equivalent to that among women who use no contraception (Baldwin & Edelman, 2013; Lewis, Doherty, & M, 2010). Reasons include the challenge of remembering to use contraception and the forward planning that non-LARCs require.

Other factors are important regardless of the type of contraception. Whitaker et al. (2014) found that teenagers who expressed control over their future lives were less likely to become pregnant than those who lacked ambition. Educational achievement has been associated with protection against repeat pregnancies, whilst young mothers with limited educational attainment, or with breaks in their education, were at greater risk (Haamid & Wiemann, 2010; Herrman, 2007). The achievement and praise afforded new mothers were thought to be important motivators for these women.

Evidence identified in the literature provided some insight into the phenomenon of repeat teen pregnancy in terms of associated characteristics, however most of the identified studies were based on non-UK samples and there was little qualitative evidence that presented the perspectives of young people themselves. Their voices are rarely heard, the reasons for their contraceptive choices have not been explored, and specific circumstances more likely to impact on the likelihood of a rapid repeat pregnancy are not fully understood.

### 3 | THE STUDY

#### 3.1 | Aim

To explore young mothers' experience of a repeat pregnancy within 24 months of giving birth to their first child. Specifically, to understand the reasons for their second pregnancy, the influence of any advice or information received, and their experience of support from health professionals.

#### 3.2 | Design

A qualitative study, with an exploratory design to capture participant experiences and views.

#### 3.3 | Setting and sample

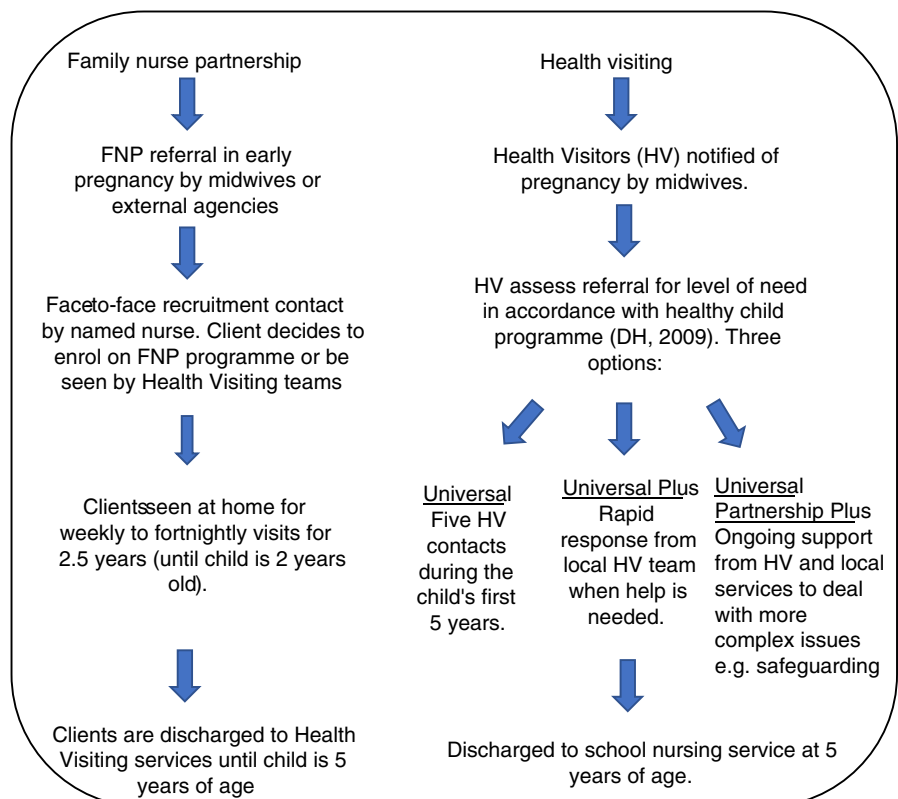
The study was conducted in a Family Nurse Partnership (FNP) that served an inner-city catchment area in the south of England. Seven

Family Nurses, one of whom is the first author (AB), each carried a caseload of 23 young mothers and their children. The American FNP model is strictly adhered to under licence to the Department of Health, which issues sub-licences to FNP delivery partners. Nurses receive training from American FNP specialists, deliver American developed content to clients, and have fidelity goals that are measured at each visit. For example, evidence-based delivery packs covering key topics such as breastfeeding and contraception, for which nurses report the percentage of content delivered.

First time young mothers aged 19 and under are eligible for the service and voluntarily enrol at their first antenatal contact with a midwife. FNP support is then provided by a nurse until their child is two years of age; a typical timespan is around 2.5 years. If a young mother declines FNP services, they will be routinely seen by a Health Visitor (HV), who typically works with children from birth to five years and their families to promote good health and prevent illness. Figure 1 presents differences in the content of FNP and HV referral and care pathways.

A purposive sample of participants was recruited by Family Nurses who identified potential mothers from their caseloads who met study inclusion criteria; aged 16 years or over, expecting or had given birth to another baby within 24 months of having their first child, and able to speak/read English. Young mothers on the first author's caseload were excluded from the sample.

Family Nurses offered potential participants an initial contact letter, which explained the study and obtained their contact details if they consented to be approached. The researcher then made contact by telephone to discuss the study. If they consented to interview, a



**FIGURE 1** Family Nurse Partnership (FNP) and health visiting referral and care pathways. [Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]

patient information letter was emailed to them or sent by post. Local FNP service data estimated that between five and ten women would meet the study inclusion criteria over a four-month recruitment period. In total, six women consented to be included in the research.

### 3.4 | Data collection

A semi-structured interview guide informed by the background literature review encouraged participants to reflect on their experiences of a repeat pregnancy (Box 1). Interviews were conducted with four women face-to-face and two by telephone. The interviews were audio recorded with the women's permission, took approximately 60 min, were transcribed verbatim by the first author and undertaken in Spring 2017.

### 3.5 | Ethical considerations

Ethical approval was granted through the Integrated Research Application System on 6 April 2017 (IRAS No. 217085). Written informed consent was obtained from all participants prior to interview.

### 3.6 | Data analysis

Data were analysed following Ritchie and Spencer's (1994) framework approach: familiarisation with the data, identification of a thematic framework, indexing themes of meaning, charting the themes into common groups and assigning higher order labels where

possible. A final stage of interpretation involved reviewing the charts to compare the perceptions, accounts or experiences of participants. Patterns, connections and explanations were sought which addressed the aim of the study.

### 3.7 | Rigour

An independent audit was used throughout the research process to appraise and promote rigour (Smith, Flowers, & Larkin, 2009). The first author (AB) presented data and documentation created from the start of the research process in a transparent way that provided an easily accessible audit trail. For example, research instrument construction, sampling strategy, annotated transcripts, tables of themes and analysis processes. These audit data were reviewed throughout the study by the second author (DB).

## 4 | FINDINGS

Women recruited had a range of ages, times since their first pregnancy, and pregnancy gestation or time since the birth of her second child when interviewed (Table 1). One of the six women had terminated her pregnancy before being recruited to the study and the first child of another mother was in local authority care. All the women's repeat pregnancies were unplanned.

Three super-ordinate themes emerged from women's responses: becoming pregnant, support from health professionals, and what women want from maternity services. Each reflected specific sub-themes and their associated codes (Table 2).

#### Box 1 Semi-structured interview guide

Theme	Questions
Experience of repeat pregnancy	Was pregnancy planned/ unplanned? How did you feel when you found out? What influenced your decision to have another baby? Who did you tell?
Professional support and education around contraception	Were you using contraception when you got pregnant? Had contraception been discussed with you after birth of first child? What were your thoughts on contraception? What prevented/ were barriers to using contraception?
Intimate relationships	Is the baby's father a new partner? Is the baby's father the same as their sibling? Is the father of the baby/ babies supportive?
Professional support postnatally	Did you find it easy to talk to professionals about a second baby? How do you think professionals felt about your decision? Did this affect the support? Did you feel supported to make decisions around your second pregnancy?
Support and education	Is there anything you would have found helpful? What materials, tools did professionals use to help (if any)?
Emotional impacts	How has having a second baby affected you emotionally? Have your future plans had to change? What would be helpful for you now from professionals?

**TABLE 1** Sample characteristics

Participant number	Age of woman at first conception	Age of child from first pregnancy	Age of woman at second conception	Outcome, gestation of second pregnancy	Ethnicity
1	18	Child aged 18 months.	19	Termination	Mixed race: White British and Black Caribbean
2	18	Child aged 2 years.	20	38 weeks pregnant.	Mixed race: White British and Black Caribbean
3	18	Child aged 3 years.	20	Live birth of child aged 9 months.	Mixed race: White British and Black Caribbean
4	17	Child aged 1 year	19	12 weeks pregnant.	Mixed race: White British and Black Caribbean
5	15	Child aged 2 years.	17	Live birth of child aged 5 months.	Latin American
6	19	Child aged 4 months.	20	2 months pregnant.	Mixed race: White British and Black Caribbean

**TABLE 2** Super-ordinate themes, sub-themes, and main codes

Super-ordinate themes	Sub-themes	Main codes
Becoming pregnant	<ul style="list-style-type: none"> <li>Barriers to contraceptive use</li> <li>Learning from experience</li> </ul>	<ul style="list-style-type: none"> <li>LARC Side effects</li> <li>Desire for child to have a sibling</li> <li>Importance/value of motherhood</li> <li>Life events: new partner, sex life</li> <li>Recommence LARC after repeat pregnancy</li> <li>Importance of other life goals</li> </ul>
Support from health professionals	<ul style="list-style-type: none"> <li>Trust versus dependency</li> <li>Expectations and comparisons</li> <li>Style of interaction</li> </ul>	<ul style="list-style-type: none"> <li>Importance of long-term relationship with professionals</li> <li>Feeling "loss" of family nurse</li> <li>Relationship dynamics</li> <li>Perceptions of other professionals</li> <li>Disparity in services</li> <li>Service accessibility problems</li> <li>Feeling judged</li> <li>Pressure from a professional agenda</li> </ul>
What women want from maternity services	<ul style="list-style-type: none"> <li>Peer support</li> <li>Online support</li> </ul>	<ul style="list-style-type: none"> <li>Peer support to reduce chance of a repeat pregnancy</li> <li>Peer support for post repeat pregnancy</li> <li>Use of internet and technology for health advice</li> </ul>

#### 4.1 | Becoming pregnant

Each woman described their surprise and shock on learning the news of a subsequent pregnancy. They made sense of their circumstances by emphasising the place of family and the role of motherhood. For one, the chance that their first child would have a sibling gave meaning to her pregnancy. Another woman described the difficulties of trying to get on in life having missed lots of education. Her second pregnancy came as a "relief" and gave meaning to her life:

"OK, I've got something now, I've got a purpose. She is the person, she is my goal now. To make sure she turns out to be a good human being"

(Participant 6)

Two women had considered a termination of their pregnancy. In one instance the young woman had been prepared to undergo the procedure if her partner had not wanted the child. A termination was not pursued. In another, the child had been conceived in an unstable relationship in which the mother did not want to raise another child, and so

opted for a termination. She also said that her partner had “expected” her to have the termination.

The women's contraceptive histories provided some explanation for their unplanned pregnancies. In all but one case the women had used LARCs but had then removed them. Common concerns centred on a perceived risk that LARCs could become embedded in the body and cause other potential side effects. Several women reported LARC removal because they had experienced prolonged vaginal bleeding:

“I had an implant but then I took it out cuz I just kept bleeding all the time”

(Participant 3) “I had the implant and that just caused me to be on my period for basically a whole year”

(Participant 6)

There was a more general belief that LARCs were detrimental to a woman's health and well-being:

“I took my implant out recently ... because ... I just wanna clear my body and cleanse it out”

(Participant 1)

Partners also influenced the women's contraceptive choices. Participant 2 had met a new partner and the excitement of the relationship meant that contraception was “just the last thing on my mind”. Participant 6 had intended to have a coil fitted but had not found the time to attend services. Her partner's impatience and unwillingness to wear a condom led to unprotected sex. In both of these cases, the women fell pregnant.

A subsequent reliance on non-LARC contraception was problematic. Memory recall was a frequently cited challenge to consistent use of the contraceptive pill, but it was also clear that a much broader challenge was women's busy lifestyles. After the birth of their first child one woman described her routine as being “all over the place” (Participant 3) and another described trying to get her “life back on track” (Participant 6):

“some days you've got a lot of stuff to do ... some days you're gonna forget to take it [the pill], even if you have it sat right next to you ... you just look past it”

(Participant 3).

Non-LARC contraception was not a priority, meaning that contraceptive compliance was often forgotten about. When it was used it did not always protect against pregnancy. Two participants experienced a condom ripping during intercourse and in both cases, this led to their second pregnancy. One of the women was unaware that she could access emergency contraception and the other, although aware of emergency contraception, chose not to use it because she didn't think she was at risk of becoming pregnant. Her first child had been planned but it had taken eight months to become pregnant and so she assumed that she was not especially fertile.

Most of the women expressed a desire to learn from their experiences. Five reflected on the need to recommence contraception following the index pregnancy and some had reverted to using LARC's. A desire to get their lives back on track following the birth of their second baby had prompted these actions. One participant thought about the financial costs of more children and three of the participants expressed aspirations to attend college or university. On reflection they now felt an implant was probably the best way to reduce the risk of a further pregnancy, despite their earlier concerns:

“when I have the baby I'm gonna have the implant cuz I don't wanna be in the same situation again in like two or three years' time”

(Participant 4)

## 4.2 | Support from health professionals

Participants reported a tension between the importance of having trust in a Family Nurse, whilst recognising that over dependency on access to them could result. Trust was built through long-term relationships that nurtured a therapeutic alliance. These alliances were valued by the women, who considered that discussions around sexual health relied on a long-term relationship with a trusted health-care professional:

“Because ... if you trust someone ... like my (partner) trusts her too... we didn't used to talk about our sex life ... I think once you get comfortable ... you're more like alright, you can talk about it to them”

(Participant 6)

However, due to the strength of the relationship with their Family Nurse, there was also a sense of dependency that made discharge from the FNP service particularly difficult:

“I think what is hard as well is when you've been around someone. I was around (my nurse) for nearly three years and then that just stops. That is a difficult thing”

(Participant 2)

The women expected the same level of support from other healthcare professionals, including intensive one-to-one contact, and comparisons were made based on these expectations. The young person's midwifery team was valued because it offered home visits and could be a source of timely advice about any pregnancy concerns:

“...sometimes I'd get a couple of pains and I'd be unsure about them so I could just call or text and get an answer straight away, rather than waiting for the GP, to call them and make an appointment ... it was great”

(Participant 3)

Contact with health professionals during which the women felt rushed or where there was no attempt to build rapport were viewed less favourably. Health visiting services were noted in these respects:

"I don't think I would really trust them like confidently about my personal life .... But for example, with (Family Nurse) I would be able to talk about my relationship, about how I felt..."

(Participant 5)

Another woman described how "I had my guard up straight away" (Participant 2) before attending health visiting services because of negative reports about the profession she had read on social media from "a lot of mum's groups". Her own experience appeared to confirm them:

"They didn't attempt to build that rapport with me. They just asked questions ...quite rude at times"

(Participant 2)

The questions were very personal which made her feel judged by preconceived ideas about young mothers, questioning their suitability as parents and looking for problems rather than offering support to manage. In response this young mother withdrew from contact when she fell pregnant again:

"I haven't seen my health visitor though since being pregnant"

(Participant 2)

Another woman was reluctant to attend her GP if she needed to "...cuz it's a joke going to the doctors" (Participant 3). She reflected on regular home visits and telephone contacts from her FN compared to the healthcare that was now available to her. She would need to contact the GP practice, hope for an appointment along with everyone else and then attend a medical centre with her two young children, which was "full of ill people". For this woman, general practice was not an attractive alternative to the home-based contacts and support she had received from the FNP.

The way in which information about contraception was shared, or the style of interaction of a FN or midwife, also mattered. Three women felt pressured from their FN to consider an implant, which left them feeling that their own ability to decide was ignored. The women responded by asserting their independence even though one of them knew that had probably not been the best course of action:

"...my nurse kept on saying it but the type of person I am, I don't listen to no one - she knows how I am but I should have listened"

(Participant 1)

### 4.3 | What women want from maternity services

The benefits of peer support were emphasised by participants who felt that meeting another young person who had given birth to two or more children as a teenager, would have been more beneficial than professional advice alone. It was noted that this type of contact could have deterred their having a second child because:

"Speaking to someone else who has a second child that's around the same age as you ... you've got a lot to relate to ... so they might take advice and actually think about it properly"

(Participant 3)

The two women who had delivered their second child at the time of interview also emphasised the importance of peer support following birth and spoke about the value of interacting with other young mums with children. They felt that the everyday challenges of caring for two young children, including interactions between the children and parents, would be better understood by those in their peer group. The need was not so much for clinical information about healthcare and ongoing contraception, but for advice and guidance on the life skills necessary to manage two infants as a teenage parent. Participant 5 explained this point simply: "because they are experiencing it at that time ... so they would know more about what's going on and how to work things through".

In the absence of access to other young mothers in similar situations the participants proactively searched the internet and social media for advice. Mum's groups, baby apps and google searches were frequently cited as important sources of information. However, the participants recognised the varied quality of some of the online information they accessed. It was also difficult to know where to get a specific question answered since the sheer volume of potential data sources was difficult to navigate. Women also referred to gaps in online information from health professionals on parenting, sexual health and contraceptive advice, particularly following discharge by their FN. Whilst a range of information is already available online in the UK, such as the NHS Choices Teenage Pregnancy Support web pages, the women wanted online support through social media, by which they meant instant access to, and messaging with, a health professional:

"...it'd be nice to post on somewhere where there's a health professional"

(Participant 2)

## 5 | DISCUSSION

Findings from this study reflect previous publications that report the poor uptake of LARCs by teenagers (HSCIC, 2016; SAHM, 2017).

Without LARCs the young mothers' contraceptive choices were dependent on forward planning, remembering in the moment, partner co-operation and the reliability of a chosen method. The unplanned pregnancies that resulted from these challenges support Baldwin and Edelman's (2013) assertion that non-LARC contraception use among teenagers is associated with a pregnancy risk equivalent to that of women who use no contraception.

Charles et al. (2016) have highlighted the dichotomous choice that teenage girls face between motherhood and other life goals. This choice was restricted for the participants of this study by their substitution of LARCs with non-LARCs. However, their initial appraisals were subject to change. Different motivations were expressed after coming to terms with a second pregnancy including the pursuit of education and the re-use of LARCs to protect those aspirations. Cultivating these motivations may provide an important point of intervention for staff, promoting independent life choices and reducing the risk of rapid repeat pregnancies (Conroy, 2016).

This may be particularly important for the participants of this study who were ethnically representative of their local population in which a majority (66%) of young people under the age of 20 are from black and minority ethnic (BAME) backgrounds. The high proportion of participants with Caribbean ancestry is noteworthy since evidence indicates that teenage births among this group are higher than among other non-white ethnic groups in the UK (Office for National Statistics, 2015). This may be attributed to higher levels of socio-economic deprivation and lower levels of educational attainment, which can thwart a young woman's life chances and make them more vulnerable to repeat pregnancy (Herrman, 2007). This is supported by Demie and McLean (2015) who have noted that the educational underachievement of Black Caribbean heritage pupils has been a persistent issue in the UK since the 1950's. This underlines the importance of supporting young woman to identify and pursue life goals other than motherhood in services that aim to reduce teenage pregnancy.

LARCs had initially been rejected by participants for two main reasons. The first concerned misconceptions over their safety because of vaginal bleeding patterns and perceived detrimental effects on health and wellbeing. Conroy (2016) warned that until a key saturation point for LARC uptake is reached, young people will not hear positive messages about their use from family and peers. In place of positive messages, Kelsey (2017) points to the questionable quality of information available to young mothers through social media, something that participants acknowledged in this study. A nurse-led education programme delivered through YouTube, Snapchat or other digital platform would provide a cost-effective solution for teenage mothers struggling to access reliable information. It might usefully draw on National Institute for Health and Care Excellence Guideline 2014 ([NICE] 2014), which contains an appendix of topics to discuss with the users of LARCs, including effects on periods. Heavy and irregular bleeding are common and should be discussed when a LARC is fitted and during use to normalise side effects and promote adherence.

The other reason for rejecting LARCs concerned participants' interactions with health professionals. Two of the participants intentionally made a choice not to accept LARCs because they had felt pressured to accept them by FNs. How clinical staff discuss contraception with young mothers who may feel ambivalent about the choices they face between motherhood and other life goals is clearly an important issue (Charles et al., 2016; Merki-Feld & Gruber, 2014). Motivational approaches that work with ambivalence and encourage people to weigh up the pros and cons of any choice, and which help to nudge decisional balances in favour of positive life choices, may be more fruitful than simply reinforcing the importance of LARCs.

People pass through different motivational stages when making changes in their lives. For example, contemplating the need for change, deciding to act, maintaining any change and sometimes, relapsing to pre-change behaviours. Prochaska and DiClemente's (1986) cycle of change model depicts these stages and motivational interviewing (MI) is a counselling approach used to promote people's motivation and support them through a cycle of change. MI has now been trialled in American Nurse Partnership programmes. An 18% reduction in pregnancies and a 13% increase in LARC use was reported among 237 women who received the MI intervention relative to controls (Stevens, Lutz, Osuagwu, Rotz, & Goesling, 2017). In the present study, the use of MI after the birth of a first child may have offered some protection against a repeat pregnancy and provided opportunity for young mothers to explore other life goals and capitalise on their aspirations.

The service transition problems reported by participants in the current study are important findings. There was a sense of unease and a reluctance to attend health visitors and GPs. Fear of health visitors is a well-documented phenomenon among teenage parents (Mental Health Foundation [MHF], 2013; PHE, 2016). Young mums do not appreciate being asked about their private affairs, such as their parenting practices and the role of their baby's father, especially as some may fear that their baby may be removed (MHF, 2013). These concerns were evident in responses from this study's participants, at least one of whom had acquired her knowledge of health visitors through reading social media threads. This highlights the importance of health professionals connecting with young mums through digital sources and countering misinformation by making themselves and their professional knowledge available.

Participants in the current study emphasised the value of peer support in addition to professional services. This has been reported elsewhere by young mums leading to the development and evaluation of 12 peer support groups which reached 264 young mothers across four London boroughs (MHF, 2013). The groups developed parental confidence by reinforcing a sense of purpose, increased resilience through discussions with peers, improved mental health awareness through psychoeducation around risk factors, and encouraged mothers' hopes for their future through practical advice and information-sharing (MHF, 2018). Discharge from the FNP is a critical transition point and structured peer support can provide an important "stepping stone" to bridge any gaps in service provision.



## 5.1 | Limitations

There are potential biases in the sample since all six participants were recruited through a Family Nurse Partnership. Not all teen mothers will receive this service, some coming under the care of a midwife which is likely to lead to different experiences and outcomes relevant to care received. The small sample size and the local context of the care setting, though appropriate for exploratory designs of this type, also limits the generalisability of the findings to other populations of women based in other areas of the UK. It is important to acknowledge that the interviews were conducted by a Family Nurse who the participants may have recognised. Although this was unlikely, given that each FN had their own workload, it needs to be acknowledged as a possible limitation. This may have affected some women's responses, perhaps making it less likely that they would be critical of the FNP. However, familiarity with those undertaking the research may also have been advantageous, helping the young women feel at ease and able to engage with the subject matter in an open and honest way.

## 6 | CONCLUSION

The significant reduction in teenage pregnancies in the UK has been attributed to different factors including the use of social media, which can physically distance people from one another. Accounts from this study reveal a different truth. Its participants represent young mothers who account for between 12% and 25% of the total number of teenage pregnancies each year that are repeat pregnancies (PHE, 2018). Social media threads had distanced some of the participants from services and from the use of LARCs, their most effective barrier against a repeat pregnancy (Conroy, 2016). Participant stories demonstrate that "fake news" is not just a political phenomenon but a by-product of the digital age. Health professionals need to join them in that space which will require imagination. A creative social media clip on the safety, effectiveness, reversibility and side effects of LARCs, in partnership with young mums and based on NICE (2014) guidance, might be a useful place to start.

This study has also highlighted the ambivalence that a young woman can feel between her role as a mum and the pursuit of other aspirations in life. There are opportunities to nurture those aspirations before a young mother experiences a repeat pregnancy. Motivational approaches that explore the use of LARCs in ways that are perceived as non-coercive are important. So too are peer support groups that work in partnership with services, offering practical support to young mothers and encouraging their aspirations (MHF, 2018). Mechanisms of this type can offer protection against repeat pregnancies and peer support would provide an important "stepping stone" out of FNP services. Further research and development into the role of social media, peer support groups and motivational approaches to contraceptive counselling are necessary to identify interventions that work in partnership with young mothers to prevent rapid repeat pregnancies.

## ACKNOWLEDGEMENTS

I would like to acknowledge the generosity of the young women who allowed me to hear their stories and spoke to me openly and honestly about their lives. I would also like to acknowledge support from Kings College London and particularly Iain Ryrie who was a friend and support throughout.

## CONFLICT OF INTEREST

The authors confirm no conflict of interest in the execution of the research or preparation of the manuscript.

## AUTHOR CONTRIBUTIONS

Amy Bucknall, responsible for the conception, design, data collection and analysis of the original research; responsible for drafting and revising the manuscript. Professor Debra Bick, Responsible for the supervision and guidance of the conception, design, data collection and analysis of the original research; Responsible for critical review of the manuscript, advising, drafting and approving revisions.

## ORCID

Amy Bucknall  <https://orcid.org/0000-0001-8947-2335>

## REFERENCES

- Baldwin, M., & Edelman, A. (2013). The effect of long-acting reversible contraception on rapid repeat pregnancy in adolescents: A review. *Journal of Adolescent Health, 52*, 47–53. <https://doi.org/10.1016/j.jadohealth.2012.10.278>
- British Pregnancy Advisory Service. (2018). Social media, SRE, and sensible drinking: Understanding the dramatic decline in teenage pregnancy. Retrieved from <https://www.bpas.org/media/3037/bpas-teenage-pregnancy-report.pdf>. Accessed 20 July 2018 .
- Charles, J. M., Rycroft-Malone, J. O., Aslam, R., Hendry, M., Pasterfield, D., & Whitaker, R. (2016). Reducing repeat pregnancies in adolescence: applying realist principles as part of a mixed-methods systematic review to explore what works, for whom, how and under what circumstances. *BMC Pregnancy and Childbirth, 16*, 271. <https://doi.org/10.1186/s12884-016-1066-x>
- Conroy, K. (2016). Promoting uptake of long-acting reversible contraception among teen mothers. *Journal of Adolescent Health, 58*, 598–599. <https://doi.org/10.1016/j.jadohealth.2016.03.031>
- Demie, F., & McLean, C. (2015). The underachievement of black Caribbean pupils in schools. Retrieved from [https://lambeth.gov.uk/rsu/sites/www.lambeth.gov.uk/rsu/files/The\\_Underachievement\\_of\\_Black\\_Caribbean\\_Heritage\\_Pupils\\_in\\_Schools\\_-\\_Research\\_Brief.pdf](https://lambeth.gov.uk/rsu/sites/www.lambeth.gov.uk/rsu/files/The_Underachievement_of_Black_Caribbean_Heritage_Pupils_in_Schools_-_Research_Brief.pdf)
- Department of Health. (2010). *Teenage Pregnancy Strategy: Beyond 2010*. London, UK: DH.
- Haamid, F., & Wiemann, C. (2010). You're pregnant again?! which adolescent mothers experience multiple repeat pregnancies? *J Adolescent Health, 46*, 3. <https://doi.org/10.1016/j.jadohealth.2009.11.076>
- Health and Social Care Information Centre. (2016). *Statistics on Sexual and Reproductive Health Services England 2015/16*. London, UK: Health and Social Care Information Centre.

- Herrman, J. (2007). Repeat pregnancy in adolescence: intentions and decision making. *American Journal of Maternal Child Nursing*, 32, 89–94. <https://doi.org/10.1097/01.NMC.0000264288.49350.ed>
- Kelsey, S. (2017). Contraception for teenagers: Accessible sexual health advice. *Practice Nursing*, 28, 236–241. <https://doi.org/10.12968/pnur.2017.28.6.236>
- Kreager, D., Matsueda, R., & Erosheva, E. (2010). Motherhood and criminal desistance in disadvantaged neighborhoods. *Criminology*, 48(1), 221–258. <https://doi.org/10.1111/j.1745-9125.2010.00184.x>
- Lewis, L. N., Doherty, D. A., Hickey, M., & Skinner, S. R. (2010). Predictors of sexual intercourse and rapid repeat pregnancy among teenage mothers: an Australian prospective longitudinal study. *Medical Journal of Australia*, 193, 338–341.
- Mental Health foundation. (2013). Young Mums Together: Promoting young mothers' wellbeing. Retrieved from <https://www.mentalhealth.org.uk/sites/default/files/young-mums-together-report.pdf>
- Mental Health Foundation. (2018). Young Mums Together: An evaluation of a peer support project to improve the wellbeing of young mothers and their families. Retrieved from <https://www.mentalhealth.org.uk/publications/young-mums-together-report>
- Merki-Feld, G., & Gruber, I. (2014). Broad counseling for adolescents about combined hormonal contraceptive methods: The choice study. *The Journal of Adolescent Health*, 54, 404–409. <https://doi.org/10.1016/j.jadohealth.2013.06.019>
- National Institute for Health and Care Excellence. (2014). Long-acting reversible contraception; Clinical Guideline 30. Retrieved from <https://www.nice.org.uk/guidance/cg30/chapter/appendix-a-features-of-the-larc-methods-to-discuss-with-women>
- Nolan, S., Hendricks, J., Ferguson, S., & Towell, A. (2017). Social networking site (SNS) use by adolescent mothers: Can social support and social capital be enhanced by online social networks? – A structured review of the literature. *Midwifery*, 48, 24–31. <https://doi.org/10.1016/j.midw.2017.03.002>
- Office for National Statistics. (2015). Ethnic factors influencing births and infant mortality: 2013. Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/pregnancyandethnicfactorsinfluencingbirthsandinfantmortality/2015-10-14#age-of-mother-at-birth-of-baby>
- Olds, D., Eckenrode, J., Henderson, C., Kitzman, H., Powers, J., & Cole, R. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect. Fifteen-year follow-up of a randomized trial. *The Journal of the American Medical Association*, 278, 637–643. <https://doi.org/10.1001/jama.1997.03550080047038>
- Olds, D., Robinson, J., O'Brien, R., Luckey, D., Pettitt, L., Henderson, C., ... Talmi, A. (2002). Home visiting by paraprofessionals and by nurses: A randomized, controlled trial. *Paediatrics*, 110, 486–496. <https://doi.org/10.1542/peds.110.3.486>
- Prochaska, J., & DiClemente, C. (1986). Toward a comprehensive model of change. In W. Miller, & N. Heather (Eds.), *Treating addictive behaviours: Processes of change*. New York, NY: Plenum Press.
- Public Health England. (2016). *Teenage mothers and young fathers: Support framework*. London, UK: HMSO.
- Public Health England. (2018). *Teenage Pregnancy Prevention Framework Supporting young people to prevent unplanned pregnancy and develop healthy relationships*. Retrieved from [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/673458/TP\\_Prevention\\_Framework.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/673458/TP_Prevention_Framework.pdf)
- Ritchie, J., & Spencer, L. (1994). Qualitative Data Analysis for Applied Policy Research. In A. Bryman, & R. Burgess (Eds.), *Analyzing qualitative data* (pp. 173–194). London: Routledge.
- Robling, M., Sanders, J., & Owen-Jones, E. (2015). *The building blocks trial: department of health policy research project programme evaluating the family Nurse Partnership Programme in England: A randomised control trial*. Cardiff: Cardiff University.
- Skinner, R., & Marino, J. (2016). England's Teenage Pregnancy Strategy: A hard-won success. Retrieved from [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(16\)30589-X.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)30589-X.pdf)
- Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London, UK: Sage.
- Social Exclusion Unit. (1999). Teenage pregnancy: Report by the Social Exclusion Unit presented to Parliament by the Prime Minister by command of Her Majesty, June 1999. Retrieved from <http://dera.ioe.ac.uk/15086/>
- Society for Adolescent Health and Medicine. (2017). Improving knowledge about, access to, and utilization of long-acting reversible contraception among adolescents and young adults. *Journal of Adolescent Health*, 60, 472–474.
- Stevens, J., Lutz, R., Osuagwu, N., Rotz, D., & Goesling, B. (2017). A randomized trial of motivational interviewing and facilitated contraceptive access to prevent rapid repeat pregnancy among adolescent mothers. *American Journal of Obstetrics and Gynecology*, 217, 423.e1–423.e9. <https://doi.org/10.1016/j.ajog.2017.06.010>
- United Nations Population Fund. (2015). *Girlhood, not motherhood: Preventing adolescent pregnancy*. New York, NY: UNFPA.
- Wartella, E., Rideout, V., Zupancic, H., Beaudoin-Ryan, L., & Lauricella, A. (2015). *Teens, Health, and Technology: A National Survey*. Northwestern University, Illinois US: Center on Media and Human Development.
- Whitaker, R., Hendry, M., Booth, A., Carter, B., Charles, J., Craine, N., ... Rycroft-Malone, J. (2014). Intervention Now to Eliminate Repeat Unintended Pregnancy in Teenagers (INTERUPT): A Systematic Review of Intervention Effectiveness and Cost-Effectiveness, and Qualitative and Realist Synthesis of Implementation Factors and User Engagement. *Health Technology Assess*, 20, 16.
- World Bank Group. (2017). *World Development Indicators 2017*. Washington DC: World Bank Group.
- World Health Organization. (2018). Adolescent pregnancy. Retrieved from <https://www.who.int/en/news-room/fact-sheets/detail/adolescent-pregnancy>

**How to cite this article:** Bucknall A, Bick D. Repeat pregnancies in teenage mothers: An exploratory study. *J Adv Nurs*. 2019;00:1–11. <https://doi.org/10.1111/jan.14140>

The *Journal of Advanced Nursing (JAN)* is an international, peer-reviewed, scientific journal. *JAN* contributes to the advancement of evidence-based nursing, midwifery and health care by disseminating high quality research and scholarship of contemporary relevance and with potential to advance knowledge for practice, education, management or policy. *JAN* publishes research reviews, original research reports and methodological and theoretical papers.

For further information, please visit *JAN* on the Wiley Online Library website: [www.wileyonlinelibrary.com/journal/jan](http://www.wileyonlinelibrary.com/journal/jan)

**Reasons to publish your work in *JAN*:**

- **High-impact forum:** the world's most cited nursing journal, with an Impact Factor of 1.998 – ranked 12/114 in the 2016 ISI Journal Citation Reports © (Nursing (Social Science)).
- **Most read nursing journal in the world:** over 3 million articles downloaded online per year and accessible in over 10,000 libraries worldwide (including over 3,500 in developing countries with free or low cost access).
- **Fast and easy online submission:** online submission at <http://mc.manuscriptcentral.com/jan>.
- **Positive publishing experience:** rapid double-blind peer review with constructive feedback.
- **Rapid online publication in five weeks:** average time from final manuscript arriving in production to online publication.
- **Online Open:** the option to pay to make your article freely and openly accessible to non-subscribers upon publication on Wiley Online Library, as well as the option to deposit the article in your own or your funding agency's preferred archive (e.g. PubMed).