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Iranian mothers’ experiences of the outcomes of early motherhood: A qualitative study

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ABSTRACT
Early motherhood is a major health challenge in most developing countries. The aim of this study was to explore Iranian mothers’ experiences of the outcomes of early motherhood. This qualitative study was done using the conventional inductive content analysis approach. A purposive sample of 18 Iranian mothers, with the experience of early motherhood, was recruited with maximum variation in terms of their age at their first pregnancy, their children’s age, place of residence, and financial status. Data collection was done via in-depth semistructured interviews and continued up to data saturation. The MAXQDA software (v. 10.0) was employed for handling the data. Iranian mothers’ experiences of the outcomes of early motherhood came into two main categories that were named “realization of the childhood dream of adulthood” and “heavy burden of adulthood on the small shoulders of childhood.” The four subcategories of the first category were the acceleration of intellectual and mental maturation, strengthening of family relationships, developing a strong identity, and closer companionship with the child. The second main category also included four subcategories, namely, experiencing numerous difficulties, threats to mothers’ physical and mental health, threats to children’s health, and missing opportunities. Early motherhood is not merely a negative experience; rather it is also associated with different positive outcomes. Healthcare providers need to provide high-quality prenatal, perinatal, and postnatal care services to adolescent mothers and use available opportunities to strongly support them and their children.

KEYWORDS
Early motherhood; adolescent mothers; outcomes; qualitative study; Iran

Introduction
Adolescence is the critical stage of physical and emotional growth when adolescents learn how to assume adulthood roles (Florescu, Temmeanu, & Mindru, 2016). World Health Organization defines adolescence as the development of secondary sexual characteristics, reproductive ability, mental processes, identity, and independence (Hejazziey, 2016). The most outstanding characteristics of adolescents are indifference to health and safety, mood swings, high-risk behaviors, socioeconomic instability, susceptibility to peer pressure, and lack of knowledge, experience, commitment, and accountability (Sarreira De Oliveira & Néné, 2014). Development of love and libido during adolescence makes female adolescents think about sexual and marital relationships and directs them toward motherhood (Hejazziey, 2016).

Motherhood is among the most important life events for women. It necessitates massive physical, mental, psychological, and socioeconomic adaptations. It is affected by personal and socioeconomic factors as well as prior preparation, knowledge, and capabilities (Javadifar, Majlesi, Nikbakht, Nedjat,
A prerequisite to motherhood is transition to adulthood. Yet the number of adolescent mothers is increasing so much so that early motherhood (EM) in adolescence is currently a major health challenge in most countries (Riva Crugnola, Ierardi, Gazzotti, & Albizzati, 2014). World Health Organization reported that each year 16 million adolescents become mother (Bhandari & Joshi, 2017), with the lowest and highest rates in South Korea and Sahara, respectively. The rate of EM in Iran is 27 cases per 1,000 adolescents (World Bank, 2016). In developed countries, EM is assessed and managed by midwives, gynecologists, pediatricians, sociologists, family physicians, and nurses (Diaconescu et al., 2015).

EM is associated with negative outcomes such as anemia, preeclampsia, genitourinary infection, preterm delivery, dystocia, stillbirth, low birth weight (Bhandari & Joshi, 2017; Ganchimeg et al., 2014; Ishtiaq, Malik, Bugio, & Gajani, 2016; Medhi et al., 2016); mental disorders, aggression, child abuse, depression, marital conflicts, social isolation (Kalb, Le, & Leung, 2015); child abandonment, poor skill training, drug abuse, school dropping out (Bravo, Toomey, Umaña-Taylor, Updegraff, & Jahromi, 2017); poverty, unemployment, and dependence on support centers (Gibb, Fergusson, Horwood, & Boden, 2015; Kalb et al., 2015). Some studies also reported that EM may have positive outcomes such as experience broadening, self-knowledge, growth acceleration (Bowman, 2013); sense of worthiness, psychoemotional maturation, vitality, childrearing ability (Anwar & Stanistreet, 2015); commitment and accountability, meaningfulness in life, greater perceived social support (Watts, Liamputtong, & Mcmichael, 2015); stronger familial relationships, and greater self-confidence and self-esteem (Van Zyl, Van Der Merwe, & Chigeza, 2015).

Most previous studies reported EM as a difficult challenge for mothers. Nonetheless, EM outcomes greatly depend on the immediate sociocultural context and the level of perceived support. For instance, in most societies, adolescent mothers are at risk for social stigmatization, whereas in the Islamic culture of Iran, they receive strong family and social support. Iranian culture strongly supports reproduction and greatly values mothers.

An indispensable prerequisite to quality care delivery to adolescent mothers is to precisely determine EM outcomes through in-depth qualitative studies. However, to the best of our knowledge, no qualitative study had yet explored the outcomes of EM in Iran. Most EM-related studies in Iran were done via quantitative designs and focused mainly on the physical outcomes of pregnancy and delivery. Consequently, there are limited data about EM outcomes for Iranian adolescent mothers. The present study sought to bridge this gap. The aim of the study was to explore Iranian mothers’ experiences of the outcomes of EM.

**Method**

This qualitative study was done in 2016 using the inductive or conventional content analysis.

**Participants and setting**

A purposive sample of 18 mothers, with the experience of EM, was recruited from healthcare centers located in the counties of Kerman province, Iran. Mothers were included if they age younger than 19 at the time of their first delivery, spoke and understood Persian, and had no history of serious mental disorders. At the time of data collection, 11 mothers age younger than 20, four age 20 to 35, and three age 36 to 50. Sampling was performed with maximum variation concerning mothers’ age at their first pregnancy, their children’s age, place of residence (i.e., urban or rural areas), and financial status (Table 1).

**Data collection**

Data were collected by the first author via in-depth semistructured interviews. The main interview questions were, “What outcomes did you experience when became mother in adolescence?,” “What positive and negative events happened to you when you became a mother?,” “What did
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you earn and lost after becoming a mother?,” “What changes did occur in your condition when you became a mother?” Based on participants’ responses to these questions, probing questions were used to clarify different aspects of their experiences as much as possible. Interview length varied from 45 to 80 minutes. Interviews were held either at mother’s homes or at their workplaces based on their personal preferences. All interviews were recorded using a digital voice recorder. Data collection started in March 2016 and continued up to data saturation in August 2016.

Data analysis

The data were analyzed concurrently with data collection via the inductive or conventional content analysis approach proposed by (Graneheim and Lundman, 2004; Elo & Kyngäs, 2008). Initially, the interviews were transcribed and the transcripts were perused repeatedly to obtain a general understanding of the data. Then, interview transcripts were again perused line by line and meaning units (words, sentences, or paragraphs) were identified and coded. At the same time, the codes were constantly compared with each other and grouped together to form subcategories and categories based on their conceptual differences and similarities. The first author performed coding while the others supervised the coding process. In case of any disagreement about the codes, the authors discussed to reach agreement. The MAXQDA software (v. 10.0) was employed for handling the data (Schönfelder, 2011).

Trustworthiness

Many different strategies were employed to maintain trustworthiness of the data and the findings. These strategies included spending adequate time on data collection and analysis, establishing appropriate communication with participants, checking the data and the findings with participants (member checking), restricting primary literature review to the abstracts of the relevant publications, and documenting the steps of data collection and analysis. Moreover, we invited a reproductive health doctorate, who was experienced in qualitative study, to assess the soundness of data collection and analysis. She approved that data collection and analysis were done appropriately. In addition, two adolescent mothers who were external to the study read the excerpts from the interviews and the generated codes and approved that the data and the findings were almost the same as their own experiences.

Ethical considerations

Necessary ethical approvals for this study were obtained from the Ethics Committee of Kerman University of Medical Sciences, Kerman, Iran (Approval code: IR.KMU.REC.1394.591). Participants received adequate information about the aim of the study and the quality of publishing and using study findings. We also promised them to maintain their anonymity and ensured them that they could participate in and withdraw from the study voluntarily. All interviews were held in private rooms and all sound files were anonymized using numerical codes. Written informed consent for participation in the study and recording the interview was obtained from each participant.

Findings

Our participants’ experiences of EM came into two main categories that were named “realization of the childhood dream of adulthood” and “heavy burden of adulthood on the small shoulders of childhood” (Table 2).
Realization of the childhood dream of adulthood

EM had realized participants’ childhood dream of adulthood. Accordingly, they had acquired the abilities to think, behave, and attempt like adults and, thus, had honorably assumed adulthood roles. This main category included four subcategories that are explained in what follows.

Acceleration of intellectual and mental maturation
EM had caused significant changes in participants’ thinking and behavior and had helped them acquire abilities such as deliberate thinking, commitment, accountability, carefulness, and reflection. Moreover, it had enabled them to distance themselves from childhood behaviors, to become more compassionate, and to better understand life, environment, and others:

My behavior, temperament, and appearance significantly changed as soon as I became a mother. Before it, I used to think about worthless things and had no specific purpose in life. However, when I became a mother, I understood that I need to seriously think about the future, my life, and my child. (p. 12)

Strengthening of family relationships
EM had required mothers to attempt in strengthening their relationships with their husbands, families, and significant others. It had improved their marital love and minimized their marital disputes. The existence of a child had showed them the value of life and family. Thus, after delivery, they seriously attempted to create a better future for their children:

Since delivery, the behavior of my husband and mine has changed greatly. Now, we less frequently enter disputes, pay greater attention to each other, engage in better conduct toward each other, and put greater importance to our life. My husband has also become better and values his job more. (p. 11)

Development of a strong identity
Following motherhood, mothers had achieved great popularity and status among their families and in the society and had been accepted as important and respectful individuals. Assuming the role of motherhood had given them the senses of adulthood, importance, and self-worth:

It was a good feeling. I found myself an important adult. I had become an adult because I had shouldered the responsibility of a mother. I thought about how to be a good mother. My peers were learning and playing; but I had a new responsibility. I thought that I could rear a child and be a mother. (p. 6)

Closer companionship with the baby
Because of the narrow age gap with their children, mothers were energetic enough to play with and tolerate their children. They effectively communicated with their children and were able to positively react to their emotions and feelings:

Unlike older mothers, I devote more time to my child and play with him more patiently. My child is comfortable with me. He confides in me and communicates his decisions with me. I don’t get angry at his behaviors and don’t enter into dispute with him. I never hit my child. (p. 15)
Heavy burden of adulthood on the small shoulders of childhood

The small shoulders of adolescent mothers could hardly carry the heavy burden of adulthood. Some mothers had faced numerous difficulties, experienced different health problems, and missed many opportunities. These problems and difficulties were mainly due to their lack of physical, mental, and socio-economic preparations for motherhood. This category also had four subcategories which are explained in what follows.

Experiencing numerous difficulties

Some mothers had experienced difficult conditions because they were not competent and prepared enough to independently manage their lives and assume maternal roles. Financial problems and childrearing incompetence had increased their dependence on their families. Motherhood had given them many awesome responsibilities. Moreover, adolescence-motherhood mismatch had created many difficulties for them:

I gradually understood that things were not as I expected. Life had many difficulties. Childrearing was very difficult and took all of my time. Most nights, I didn’t sleep and thus, suffered from headache. I was not accustomed to do all those tasks at the same time. I felt very tired and was unable to spend time for myself. (p. 2)

Threats to mothers’ physical and mental health

Almost all participants (except two) had experienced physical problems due to EM. These problems were related to their sexual relationships (vaginal rupture, fistula, vaginismus), pregnancy (abortion, anemia, pica, preeclampsia, vitamin deficiency, and placenta previa), delivery (dystocia, preterm or postterm delivery, and cesarean), and breastfeeding (mastitis and nipple fissure).

In the first months of my pregnancy, I was terribly ill and was hospitalized most of the times. I developed anemia because I had inadequate nutrition and suffered from bleeding. Doctor said that I had placenta previa. I was badly swollen. My blood pressure had reached eighteen and they said I had preeclampsia. I also experienced seizure at the time of delivery. (p. 4)

Participants had also experienced psychological problems such as fear and anxiety (due to maternal role insufficiency), sense of regret (due to unwanted pregnancy or missing opportunities), shamefulness (due to maternal role insufficiency or attempts for abortion), depression, and marital conflicts (due to husbands’ failure to understand and support them):

I’m always worried about whether I can properly rear the child or not and whether my childrearing approach is accurate or not. I always need my mother’s help. I’m very worried about what to do if my mum stops helping me. I don’t know what will happen and what I should do if my child gets ill. (p. 9)

Threats to children’s health

Some participants noted that their children were at risk for health problems. Their children suffered from different health problems such as congenital defects, growth and development disorders, and child abuse due to mothers’ childrearing incompetence or poor emotional conduct:

I annoyed my boy when he was a child. I restricted him and required him to do things that were inappropriate for his age. I didn’t allow him to play freely. Now, my 20-year-old son is an obsessive person and makes all things difficult for himself. (p. 6)

Missing opportunities

Most participants referred to different instances of missing opportunities. For instance, they had missed the opportunities to continue their educations, learn skills, do recreational activities, work, attend social occasions, and spend time with friends. Missing opportunities was the most negative outcome of EM and therefore, it had caused a sense of regret for most participants:
When I got pregnant, my husband didn’t allow me to go to school. I liked studying, going to university, and doing a job very much; but it was not possible. When I got pregnant, I didn’t feel comfortable in school. Moreover, after delivery, I couldn’t study and rear the child at the same time and was hence compelled to leave the school. (p. 7)

Discussion

The aim of this study was to explore Iranian mothers’ experiences of the outcomes of EM. Findings indicated that EM was associated with positive and negative outcomes for Iranian mothers. The positive outcomes of EM were the acceleration of intellectual and mental maturation, strengthening of family relationships, development of a strong identity, and closer companionship with the baby. Studies in England (Anwar & Stanistreet, 2015), Western Cape (Van Zyl et al., 2015), Ethiopia (Cheru, 2015), Australia (Smith, Skinner, & Fenwick, 2012; Watts et al., 2015), and Spain (Barona-Vilar et al., 2013) also reported the same findings.

Study findings showed that EM accelerates adolescent mothers’ intellectual and mental maturation. The presence of a baby encourages mothers to think deliberately, carefully, and accountably. To fulfill their maternal roles, adolescent mothers feel compelled to change their thinking, temperament, and behaviors (Cheru, 2015; Smith et al., 2012). Most adolescents equate motherhood with perfection and consider it as a symbol of adulthood (Barona-Vilar et al., 2013). EM is associated with accountability, commitment, flexibility, and emotional growth (Watts et al., 2015). A study also reported that mental maturation among adolescent mothers is manifested by motivation and accountability for childrearing, attempt to realize dreams, use of the past experiences to create a better future, and a better attitude toward life (Bowman, 2013). Like adults, adolescent mothers learn to abandon their own desires and devote themselves to childrearing. The presence of a child also helps them discover important aspects of their personality (Bowman, 2013).

We also found that EM strengthens family relationships. Adolescents usually have high-risk behaviors. However, EM gives meaning to life, brings happiness and vitality to life, and thereby encourages mothers to change their lifestyles, protect their health and their families, attempt to create a better future for their babies, and strengthen their familial and marital relationships (Anwar & Stanistreet, 2015; Van Zyl et al., 2015; Watts et al., 2015).

Another finding of the present study was that EM improves adolescent mothers’ social status and gives them a strong identity and a sense of honor. Some adolescents consider motherhood as a success, a mark of self-esteem, an opportunity to demonstrate potentials, and a boost to self-confidence (Anwar & Stanistreet, 2015). EM helps adolescents obtain better social cognition, greater self-knowledge, and a new attitude toward life and hence expedites the process of their socialization and helps them learn social skills more quickly than their nonmother counterparts (Bowman, 2013).

Findings also showed that due to narrow mother-child age gap, adolescent mothers have closer companionship with their children. Previous studies also showed that adolescent mothers are closer to the world of their children (Bowman, 2013), establish better relationships with them, easily understand them, and can even remember from their recent past what is suitable for their children (Anwar & Stanistreet, 2015).

On the other side of the coin, EM was associated with different negative outcomes for Iranian mothers. These outcomes are numerous difficulties, threats to mothers’ and children’s health, and missing opportunities. Previous studies also showed that due to lack of physical, mental, psychological, and socioeconomic preparations for assuming maternal roles, adolescent mothers experience a wide range of problems. These problems include, but are not limited to, physical fatigue, multiple responsibilities, inappropriate decision making, loneliness, social isolation, poverty, low income, unemployment, financial dependence, homelessness, domestic violence, familial or social boycott, social stigmatization, senses of loss and failure, and inability to go to school and work (Alenkhe & Akaba, 2013; Aparicio, Pecukonis, & O’Neale, 2015; Diaconescu et al., 2015; Meneses & Saratan, 2015; Van Zyl et al., 2015; Watts et al., 2015).
Study findings also showed that EM threatens adolescent mothers’ physical and mental health and causes them sexual, pregnancy-, delivery-, and breastfeeding-related problems. Pregnancy in adolescence is considered as high-risk pregnancy because it can be associated with anemia, preeclampsia, preterm delivery, bleeding, urinary tract infection (Alenkhe & Akaba, 2013; Leppälähti, Gissler, Mentula, & Heikinheimo, 2013) and dystocia, and more need for cesarean (Bhandari & Joshi, 2017; Ganchimeg et al., 2013; Ishtiaq et al., 2016). In addition to physical health problems, EM may cause depression, anxiety (Angelini & Mierau, 2015); emotional distress, fear, social isolation, lack of independence (Kalb et al., 2015); senses of loss and failure, altered well-being, sorrow, and regret (Wright, Rosato, Doherty, & O’Reilly, 2016). The reasons behind such problems are lack of emotional and psychological preparation for pregnancy, maternal role insufficiency, inability to bring stability and confidence to life, loss of opportunities, poor interpersonal relationships, financial problems, unwanted dependence on others, and social stigmatization (Angelini & Mierau, 2015; Wright et al., 2016).

Another finding of the study was the negative effects of EM on the child health. These children are at greater risk for impaired fetal growth and development, fetal death, asphyxia, low birth weight, neonatal or infantile death (Alenkhe & Akaba, 2013; Diaconescu et al., 2015; Florescu et al., 2016); mental retardation, motor disabilities, frequent episodes of illnesses (Afraz, Ahmadi, & Sajedi, 2015; Branson, Ardington, & Leibbrandt, 2015); psychosomatic disorders, and speech problems (Florescu et al., 2016). Besides, adolescent mothers may be less committed to childrearing and pay little attention to their children. Thus, their children may have problems in their socialization (Riva Crugnola et al., 2014). Moreover, as adolescent mothers experience a wide range of physical, mental, familial, and socioeconomic problems such as marital conflicts, drug abuse, and emotional disorders (Alenkhe & Akaba, 2013; Coyne, Långström, Lichtenstein, & D’Onofrio, 2013; Diaconescu et al., 2015; Goossens, Kadji, & Delvenne, 2015; Wright et al., 2016), their children are at great risk for child abuse, neglect, and abandonment (Dhayanandhan, Bohr, & Connolly, 2015; Diaconescu et al., 2015).

Some of our participants considered motherhood as missing many opportunities. Most adolescent mothers lose the opportunities of education, skill training, and employment and, therefore, have poor financial status and great financial dependence on their families and support organizations (Alenkhe & Akaba, 2013; Bravo et al., 2017; Bellamy, 2017; Narita & Diaz, 2016; Wright et al., 2016).

Conclusion

Contrary to the findings of most previous studies, the results of this study indicate that EM is not merely a negative experience. Rather, Iranian mothers consider EM also as a good opportunity for intellectual and mental maturation, strengthening family relationships, developing a strong identity, and closer companionship with their children. Of course, they suffer from different physical and mental problems and miss some opportunities; yet they receive strong social support and adequate healthcare services. Healthcare providers, particularly nurses, need to provide high-quality prenatal, perinatal, and postnatal care services to this group of mothers and use available opportunities to strongly support them and their children and turn EM into a positive experience for them. Moreover, healthcare providers can identify adolescent mothers’ educational needs and high-risk behaviors and implement educational programs to enhance mothers’ childbearing and childrearing knowledge and skills, modify their high-risk behaviors, and thus improve the health of mothers and children.

Acknowledgments

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This work was carried out in collaboration between all authors. All authors read and approved the final manuscript and have declared that no competing interests exist. All authors have seen and approved the manuscript being submitted.

Authors declare that they have no competing interests nor conflicts of interest.

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