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Underage women's experiences of pregnancy and childbirth and the attitudes of health professionals – a qualitative study[1]

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Abstract: *Introduction and Aim:* Adolescent pregnancy carries significant medical, psychological, and social implications. Young maternal age is associated with an increased risk of perinatal complications and may expose underage patients to stigmatization and inappropriate treatment within healthcare settings. The aim of this study was to explore and analyze the experiences of pregnant minors in the context of healthcare professionals' attitudes and behaviors toward them. *Materials and Methods:* A qualitative design was used, based on semi-structured interviews. The study included eight women aged 19–23 who had given birth to their first child before turning 18. Eligibility required that childbirth had occurred within the previous five years. Data were collected between March 2024 and February 2025. All interviews were recorded, transcribed, anonymized, and analyzed using content analysis. *Results:* Participants reported both positive and negative interactions with medical staff. More than half felt stigmatized due to their young age, and several described insufficient information regarding their own health or that of their newborn. Support from close relatives proved crucial for their sense of safety and emotional stability. Early motherhood was perceived as an ambivalent experience that was both challenging and personally transformative. *Conclusions:* The attitudes of healthcare professionals toward underage patients were inconsistent and often failed to meet standards of respectful, empathetic obstetric care. There is a clear need to increase awareness and strengthen the preparedness of healthcare personnel to work with this vulnerable patient group, as well as to improve access to prenatal education for pregnant minors.

Keywords: childbirth, early motherhood, perinatal care, pregnancy, teenage mothers

1. Introduction

Pregnancy and childbirth are undeniably among the most significant events in a woman's life. The experience of motherhood is a major developmental stage marked by profound physiological, psychological, and functional changes. These changes affect both biological functioning and psychological wellbeing. They also directly influence a woman's individual developmental trajectory and her subjective assessment of quality of life (Miotk-Mrozowska, 2013).

Early motherhood before the age of 18 is a particularly demanding experience for the young mother, leaving a lasting impact on her biological, psychological, and social functioning. According to various authors, both biological determinants rooted in the natural rhythm of fertility and current sociocultural factors suggest that the most optimal age for motherhood falls between 25 and 35 years. The literature highlights the concept of a psychological clock, understood as a specific level of emotional maturity and

1 Article in Polish language: https://stowarzyszeniefidesetratio.pl/fer/64P_szle.pdf

psychological readiness required to assume parental responsibilities, including the capacity to provide care and guidance to a child.

The phenomenon of off-time mothering refers to entering the maternal role at a developmentally non-normative moment, either significantly earlier or later than the biological, social, and psychological timeline would suggest. One example of such an off-time developmental event is childbirth during adolescence, which brings numerous challenges that often exceed the current abilities and psychosocial competencies of an underage mother (Bakiera and Szczerbal, 2018).

Various terms are used in the literature to describe women who give birth to their first child before reaching legal adulthood. These include teenage mothers, adolescent mothers, underage mothers, and minor mothers, with the specific term usually chosen based on legal, medical, or sociological context (Bień et al., 2015).

According to the Civil Code, a minor is defined as an individual under the age of 18 who has not entered into marriage. Marriage grants a minor full legal capacity and thus terminates minor status (Kodeks cywilny z dnia 23 kwietnia 1964 r., 2025).

Data from the Central Statistical Office show that in 2024, there were 1,092 births in Poland among mothers under 18 years of age, representing 0.43% of all live births that year, which totaled 251,782. In earlier years, the proportion of births among underage mothers remained similar, amounting to 0.41% in 2023 and 0.43% in 2022. These figures indicate relative stability in the birth rate within this age group in recent years (Central Statistical Office, 2024).

Although the proportion of births to underage mothers may appear small, it represents an important concern in the context of prenatal and perinatal medical care. Pregnancies among minors carry an increased risk of obstetric complications for both the mother and the child. Researchers note heightened risks of preterm birth, hypertension, iron-deficiency anemia, preeclampsia, and eclampsia compared with adult pregnant women. There is also a higher probability of requiring an emergency cesarean section. Moreover, young maternal age is a risk factor for postpartum depression and challenges with initiating breastfeeding. Infants born to adolescent mothers face increased risks of low birth weight and neonatal respiratory distress syndrome. These risks arise from an interplay of socioeconomic and health-related factors, including limited prenatal care, poorer maternal nutritional status as well as a higher prevalence of smoking among women in this age group (Diabelková et al., 2023; Jeha et al., 2015; Mann et al., 2020).

Respectful relationships between women in labor and medical personnel play a key role in the course of pregnancy and childbirth. Research shows that positive interactions with healthcare providers can significantly increase satisfaction with care. A high level of trust and empathetic communication between the birthing woman and medical staff help reduce stress and create a sense of safety. Clear and accessible communication that aligns with patients' understanding also supports active engagement in perinatal care and strengthens self-care competencies (Leyser-Whalen et al., 2024).

Poor communication and critical comments from medical staff can heighten stress and anxiety and lower a woman's self-esteem. This may lead to avoidance of contact with healthcare providers (Bohren et al., 2015) and contribute to the development of post-traumatic stress disorder (Ertan et al., 2021). Studies show that adolescent mothers often face criticism and stigma from medical staff related to sexual activity before marriage. They also report violations of privacy, which stem directly from age-related prejudice among healthcare workers (Bohren et al., 2015). In a cross-sectional study, the authors found that young age (15 to 19 years) and lack of formal education were the strongest predictors of mistreatment by medical personnel (Bohren et al., 2019).

These findings indicate that many women experience inappropriate treatment during pregnancy and childbirth, with underage mothers being particularly vulnerable (Bohren et al., 2019). Due to biological immaturity, they are also at increased risk of perinatal complications. When combined with mistreatment by healthcare personnel, this can significantly worsen maternal and neonatal health outcomes (Diabelková et al., 2023; Mann et al., 2020).

Existing research focuses mainly on the medical and social consequences of teenage motherhood, yet there is still a lack of qualitative studies exploring interactions between young mothers and healthcare staff and the impact of these interactions on their sense of dignity and psychological wellbeing. Understanding these experiences may help improve the quality of perinatal care and support the creation of a more responsive and respectful healthcare environment for this specific group of patients.

The aim of this qualitative study was to explore and analyze the subjective experiences of underage pregnant women in relation to the attitudes and behaviors of medical personnel toward them. The authors sought to understand how young mothers perceive medical care, with particular attention to the quality of communication, the emotional support they receive, their sense of respect, and any experiences of stigma or discrimination within healthcare settings.

1.1. Methodology

A qualitative research design was used in this study. A qualitative descriptive approach was selected as the most appropriate methodology for capturing the experiences and emotions of adolescent mothers, without relying on existing theoretical frameworks (McIntosh and Morse, 2015). This method was chosen to enable a more complete understanding of the subjective experiences of underage mothers in their interactions with medical personnel during pregnancy, childbirth, and the postpartum period. The qualitative approach made it possible to gather rich, detailed narratives and identify emerging thematic domains, allowing for a deeper exploration of complex psychosocial phenomena from the perspective of young mothers.

In-depth, semi-structured interviews were conducted by the second author (H.M.) between March 2024 and February 2025. Of the eight interviews, four were carried out in person and four online using the Zoom platform. The interviews followed a previously developed interview guide, which ensured consistency in the research process while allowing for flexibility to explore emerging topics relevant to each participant's individual experience.

Key areas of inquiry included experiences related to pregnancy, childbirth, and the postpartum period, the support received, and interactions with healthcare workers such as physicians, nurses, and midwives. When additional clarification was needed, probing questions were used, such as: "Could you tell me more about that?". Each interview lasted between 60 and 90 minutes. To ensure accuracy and completeness of the data, all interviews were audio recorded with the participants' informed consent.

The interviews were then transcribed and anonymized. The transcripts were read multiple times by the first (B.Sz.) and second author (H.M.) to achieve a thorough understanding of the empirical material. Each of the two authors (B.Sz. and H.M.) independently coded the data using content analysis. Before coding began, all authors collaboratively developed and approved a coding tree that captured key statements emerging from the participants' narratives.

1.2. Sample

Participants were recruited through purposive sampling in cooperation with non-governmental organizations supporting young parents, including the *Fundacja Javani – nastoletni rodzice* [Javani Foundation for Teenage Parents] and the *Stowarzyszenie Dwie kreski* [Two Lines Association], as well as through online community groups such as *Nastoletnie mamy, czyli życie bez stereotypów*, *Dziewczyny bez tabu*, and *Baby bez tabu*. Eight women aged 19 to 23 agreed to take part in the study. All of them had experienced pregnancy and childbirth before the age of 18. Each participant received detailed information about the aims and procedures of the study.

Two participants gave birth to their first child just before reaching legal adulthood; the delivery occurred shortly before their eighteenth birthday, which they celebrated while still in the maternity ward. Four respondents gave birth at age 17, two at age 16, and one at age 15. At the time of the interviews, between three and five years had passed since delivery. Six participants were from the Mazowieckie

region, one from the Śląskie region, and one from the Lubelskie region. All respondents were students when they learned they were pregnant. Afterward, six continued their education and two discontinued schooling. The demographic characteristics of the sample are presented in Table 1.

2. Results

Content analysis of the interviews with underage mothers led to the identification of two main thematic categories:

1. Pregnancy and childbirth as a difficult experience, and
2. Relationships with medical personnel.

Each category comprised four thematic groups. In the first category, the themes were: *"I wasn't ready for this"* – reaction to pregnancy, Peer marginalization, *"I hid the pregnancy"* – lack of institutional support, and Maturing through motherhood. In the second category, the themes were: Experiencing a lack of empathy and respect, Information deficits, *"Invisible patients"* – quality of interactions with medical staff, and Woman-centered care.

Table 1. Age structure of participants and age at childbirth

l.p.	Age of respondents at the time of childbirth	Age of respondents at the time of the study	Voivodship	Continuing education during pregnancy
1	18 y.o.	23 y.o.	Mazowieckie Voivodship	Yes
2	18 y.o.	23 y.o.	Mazowieckie Voivodship	No
3	17 y.o.	22 y.o.	Mazowieckie Voivodship	Yes
4	16 y.o.	21 y.o.	Mazowieckie Voivodship	Yes
5	17 y.o.	21 y.o.	Śląskie Voivodship	Yes
6	17 y.o.	20 y.o.	Mazowieckie Voivodship	Yes
7	17 y.o.	20 y.o.	Lubelskie Voivodship	No
8	15 y.o.	19 y.o.	Mazowieckie Voivodship	Yes

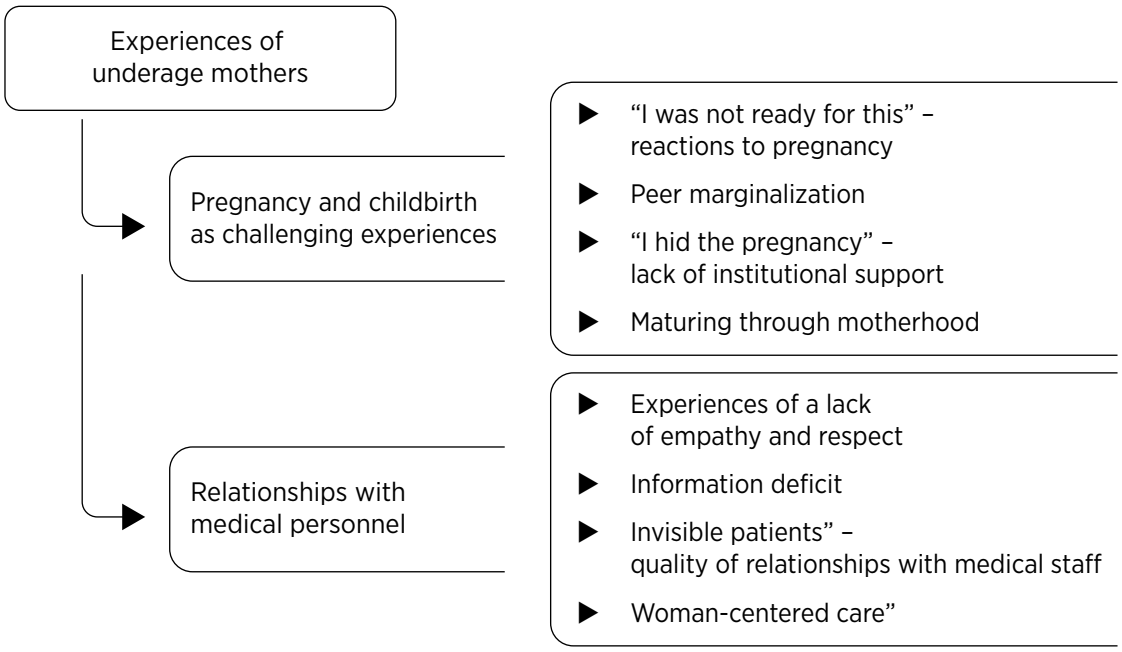

Figure 1 Experiences of underage mothers – thematic categories identified on the basis of content analysis

The structure of thematic groups identified through content analysis is presented in Figure 1.

2.1. Pregnancy and childbirth as a challenging experience

For all respondents, early motherhood involved numerous emotional, social, and practical challenges. Analysis of their accounts shows that pregnancy and childbirth were deeply ambivalent experiences. They brought moments of joy, yet they were also psychologically and physically demanding. Participants strongly emphasized that these experiences were particularly burdensome due to their young age.

Limited emotional resources, lack of life stability, and often insufficient social and family support contributed to feelings of uncertainty and stress. The women described intense emotional strain, shock, fear, loneliness, and a pervasive sense of unpreparedness. These emotions were intensified by concerns about how others would react, including both close relatives and medical staff.

Many narratives also reflected distrust toward institutions, which often resulted in avoiding prenatal care and, in extreme cases, hiding the pregnancy until childbirth.

2.1.1. "I wasn't ready for this" – reaction to pregnancy

Most young women described a strong sense of destabilization and the need to rapidly adjust to the new reality of an unplanned pregnancy. Several accounts highlighted feelings of isolation and a lack of adequate emotional and material resources, reflected in concerns about financial insecurity and uncertainty regarding their relationship with the child's father. The dominant emotions were deep anxiety and fear of an unpredictable future. At the same time, some respondents expressed an emerging willingness to face the challenge ahead:

> It sort of turned everything upside down, definitely. And I was a bit scared of what was going to happen, I was really frightened. (R4)

> At first it was a huge shock. A really big one. And at the same time, I felt immediate fear. I was almost alone. I was still in school, I didn't have a job. I didn't know how the father of the baby would react, and I knew it would simply change my whole future. I kept wondering if I would manage. (R7)

Six participants continued their education during pregnancy. Most of them, fearing social exclusion, decided to hide their pregnancy, which led to delayed medical consultation and prolonged lack of proper prenatal care.

Fear of stigma resulted in strategies of silence, adopted to avoid social judgment. One respondent described her experience:

> At school we had a presentation about social problems, and teenage pregnancy was one of them. Hearing the kids laugh and mock it, and seeing no disapproval or broader perspective from the teacher made me certain that I wouldn't get any support, so it felt safer to keep it to myself. (R5)

2.1.2. Peer marginalization

A recurring theme in the narratives of young mothers was the experience of being excluded from their peer environment, which often emerged early in pregnancy. Participants noted that early motherhood is perceived as a major deviation from the "normal" developmental trajectory of adolescence, creating growing distance between them and their peers. The loss of previous friendships was often described as an inevitable consequence of feeling different, lacking shared experiences, and facing misunderstanding or rejection:

> I lost a lot of friends because I was at a different stage in my life. They were going to parties and so on... you know. They had their topics, and I already had topics like cribs, strollers, things like that. (R1)

> A big part of my friends, I think, turned away from me. At that age they had different interests, spent their time differently. They didn't have responsibilities or that level of responsibility like I did, so our paths just split. (R7)

> I was definitely a bit socially rejected, because all my friends were going out and I couldn't. They didn't understand it, so I stopped having friends. (R6)

2.1.3. "I hid the pregnancy" – lack of institutional support

Pregnancy in adolescence, particularly in societies where parenthood is socially accepted primarily after reaching adulthood, is often accompanied by strong stigma. The women in this study, fearing social judgment and negative labeling, tended to avoid using available perinatal support services. Their accounts revealed a clear fear of disapproval, which led them to withdraw from antenatal classes and limit contact with institutional forms of prenatal care. Avoidance of childbirth education stemmed not only from limited resources but also from anxiety about being judged and stigmatized:

> I wasn't under prenatal care and I didn't attend any childbirth classes. I hid the pregnancy until the very end. My first visit with a doctor who deals with pregnancy was actually a few hours before giving birth. (R5)

> I didn't go to childbirth classes, I didn't want to reveal myself. (R8)

2.1.4. Maturing through motherhood

Participants often described early motherhood as a catalyst for personal growth. Looking back, they emphasized that becoming a mother at a young age allowed them to gain deeper self-understanding and develop emotional competencies such as empathy, tenderness, and sensitivity. Although early motherhood is frequently perceived socially as a misfortune, the women also experienced it as a period of significant psychological development and an opportunity to strengthen their relationship with the child's father:

> One positive thing is that you learn, you experience, and you gain so much more than an ordinary teenager. You learn this unconditional love, because not everyone gets it from their parents. You become wiser, simply wiser, if you choose to. More tender, more empathetic. For me, my son really developed my empathy. I think I might even have too much of it now. I became more sensitive, I just appreciated life more, appreciated the gift that life is. (R2)

> I gained more trust in my partner, and our relationship is definitely stronger now. And the fact that I already have a child, and that I will raise them sooner and later have more time for myself, for growing and developing... I think that despite everything I went through, I wouldn't trade my child for anything, for any kind of freedom. (R7)

2.2. Relationships with medical personnel

For most underage mothers participating in the study, interactions with medical personnel were difficult and emotionally taxing. Their accounts revealed a recurring theme of being perceived primarily through the lens of their age and life circumstances. Respondents pointed to a lack of empathy, emotional distance, and verbal and nonverbal cues they interpreted as dismissive or degrading. Several narratives also highlighted a clear asymmetry in the relationship: young patients felt insufficiently informed about medical procedures, and their emotional needs and questions were often minimized.

2.2.1. Experiencing a lack of empathy and respect

Most participants recalled situations in which medical staff commented on their age or personal circumstances in a humiliating way, undermining their sense of safety and trust in the care they received:

> The doctor said that since I knew how to stick my butt out to make this baby, why couldn't I do it for the anesthesia? Hearing something like that was really hard. It broke me down mentally. (R7)

> The woman who was taking care of me during childbirth was terrible to me. I was scared to talk to her. (...) She told me to stop screaming and to shut up. (R7)

One respondent emphasized the need for her physical and emotional boundaries to be respected, a need ignored by the medical staff. At age fifteen, she requested to be examined by a female gynecologist — a request that should have been treated with particular care given her age:

> The problem came when, at 15, I didn't want to be examined by a man. The doctors, who didn't know anything about my history — I could have been raped, for example — made a huge problem out of my request to be examined by a woman. [...] They rolled their eyes and spoke to me with clear contempt in their voices. (R5)

Some women described a lack of emotional support after giving birth. They felt excluded and overlooked within the perinatal care system and wanted to be treated the same way as adult mothers:

> I had very clear signs that I had postpartum depression or just depression in general. [...] I wasn't coping mentally or emotionally. And to this day I'm very angry that no one in the hospital sent me to a psychologist, that I didn't get any emotional support. I think it would've been easier for me to get through it if I'd had that help. And hospitals do have the ability to provide it. (R6)

2.2.2. Information deficits

The accounts of underage mothers reveal a clear pattern of inadequate communication from medical personnel: lack of information, unclear procedures, and exclusion from decision making. These narratives show the disorientation and helplessness experienced by young women during hospitalization, childbirth, and postpartum care. Respondents recalled numerous situations in which they were left without any explanation. They did not know where their newborn was, what the next steps in treatment would be, or when they would be discharged. This lack of transparency heightened fear and frustration and deepened their sense of isolation and loss of control. Particularly distressing were situations in which actions were taken regarding the baby without the mother's knowledge or consent, such as removing the newborn for examinations without notice:

> In the hospital I didn't know what was going on. I stayed there for two days and no one explained to me why I was waiting so long. Zero information. (R8)

> I still remember the situation when it was the middle of the night and I heard a baby crying. I woke up because of the crying. And it turned out that the midwife took my baby for some tests, but didn't even tell me she was taking him. I got really angry. (R6)

Women also described receiving contradictory information from medical staff. Uncertainty about the discharge date or upcoming diagnostic steps negatively affected their emotional state and sense of security. The absence of clear, consistent, and empathetic communication at such pivotal moments in their lives created growing tension, anxiety, and anger:

> I was getting completely different information. At one point they said I'd leave the next day, then that maybe it would be a week. It wore me down mentally because I didn't know what was happening. (R6)

> During the delivery itself, I didn't get any information about how everything would proceed or what would be done at each moment, or what decisions would be made. (R7)

2.2.3. "Invisible patients" – quality of interactions with medical staff

Most respondents highlighted a clear contrast between care received within the public health system (NFZ) and care obtained in private clinics. The standard of public healthcare was often inadequate, lacking respect and even basic humane treatment. This led many young mothers to seek private medical care, where they felt acknowledged and supported without moral judgment. They emphasized that empathetic, non-stigmatizing care allowed them to feel like "normal" mothers:

> I went for my first visit... I think the first two visits were under the public system. And I wasn't satisfied. The gynecologist I saw was very rough and unpleasant. He didn't tell me anything, I didn't learn anything at all. I left even more terrified and shaken. [...] But when I went for a private visit, I saw that they treated me differently. Not like I had ruined my life, but just normally, humanely, I would say. But that was because I had private visits. I usually see the difference when I go privately. (R1)

> When I was going to the doctors at the hospital, I met a really nice doctor who took care of my pregnancy. [...] He was a great person, always understanding, never judged me, always guided me, and I think he even did more ultrasounds than he had to, so I could look at the baby. That was nice. I felt calm and treated like a normal mom. (R6)

The narratives also strongly reflected feelings of being ignored or abandoned by medical staff. Young mothers described situations in which they were left without supervision, information, or basic care during their hospital stay. Their physical and emotional needs were overlooked. Instead of feeling cared for, they felt like a burden rather than patients requiring particular sensitivity:

> They were unfriendly, hostile, I don't know why. Instead of helping a young person, there was zero help. I was lying in bed for a long time before giving birth, and they hooked me up to the machine that monitors the baby's heartbeat. They told me not to move and left, and no one came for four hours. I was so thirsty. I called out for someone, but no one came. (R8)

> I had no cooperation with the staff at all, because no one even came into our room. No one asked how we were feeling or checked whether everything was healing properly, whether the wound was healing... (R6)

2.2.4. Woman-centered medical care

Despite many difficult experiences, some respondents recalled situations in which they encountered attentiveness, kindness, support, and professionalism from medical staff. These interactions helped foster a sense of safety and shaped their overall perception of medical care in a positive way:

> There was this wonderful doctor later on who explained everything to me — what to do, how to do it, how to take care of the baby. And even if something didn't seem right, I could call her. (R8)

> The midwives and nurses gave me tremendous support, both emotional and physical. [...] They tried to ease my tension by joking with me all the time. They explained the entire process of childbirth. (R5)

Participants also spoke about positive aspects of their perinatal experience related to genuine support from staff, especially in the area of lactation. These moments of care and engagement played an important role in strengthening young mothers' sense of safety, competence, and agency. Respondents emphasized the value of individualized attention and the staff's willingness to help. They described specific midwives who took the initiative to assist with breastfeeding, offering not only technical guidance but also empathy, gentleness, and understanding:

> I have very fond memories of the midwife who helped me position the baby for breastfeeding. She gave me many useful tips, but she was also incredibly kind, and I felt safe with her. (R7)

> I remember a lactation specialist came to see me and said that we would do it manually. And she just started expressing the milk by hand. They gave me a small cup, and I expressed the milk manually from each breast. And it actually helped me. (R6)

3. Discussion

This study described the experiences of eight underage mothers during pregnancy and childbirth, with particular focus on the attitudes and behaviors of medical personnel toward their early motherhood. Analysis of the interviews shows that the young age of the patient often prompted negative reactions from healthcare providers, reflected in dismissive or derogatory treatment. At the same time, several respondents also reported episodes of genuine support and respect. Beyond the healthcare setting, participants experienced social stigma and exclusion from their peer groups.

Existing research shows that young maternal age (15 to 19 years) is frequently associated with mistreatment by medical staff (Bohren et al., 2019). These findings align with results of the present study, in which respondents reported disrespectful attitudes toward their early motherhood and insufficient access to information regarding their own and their child's health.

Our data show that some participants were not informed about their own medical condition or their newborn's health in a complete and comprehensible manner. Such practices contradict Article 9 of the Act on Patients' Rights and the Patient Ombudsman (Journal of Laws 2024, item 581), which guarantees every patient, including minors, the right to information. Under Article 17(1–2) of the same Act, minors aged 16 and above also have the right to receive information about their treatment and to provide consent jointly with a legal guardian.

The attitudes of medical personnel are crucial for the quality of care offered to underage pregnant patients. Other authors emphasize that a lack of age-sensitive and trauma-informed approaches can significantly disrupt the relationship between young patients and healthcare staff, leaving adolescents feeling unheard, judged, or shamed (Michaud et al., 2020). A systematic review by Chilinda et al. (2014) found that negative attitudes among healthcare workers, including unprofessional behavior and the absence of youth-friendly reproductive health services, constitute major barriers to adolescents' access to healthcare. Such attitudes can discourage young women from seeking perinatal care. Similarly, Jonas et al. (2017) reported that mistreatment and disregard for young women's preferences serve as significant barriers to accessing prenatal and other health services.

Fear of social judgment and stigma can lead to delayed presentation to healthcare providers and prolonged lack of adequate prenatal care. These delays are associated with increased risk of pregnancy complications and adverse health outcomes for both the mother and the child (Gruszyńska, 2023; Lee et al., 2016). Other studies highlight that adolescent mothers are at higher risk of perinatal complications affecting their own health and the health and devel-

opment of their infants, underscoring the importance of early medical monitoring (Diabelková et al., 2023; Mann et al., 2020). Our findings confirm that fear of stigma, family repercussions, and negative reactions from others contributed to concealment of pregnancy and limited or absent medical care.

A positive aspect identified in this study was genuine support from medical personnel, particularly in the area of lactation. Respondents emphasized the importance of individualized care and the willingness of staff to assist. Acts of care, attention, and emotional presence played a significant role in fostering a sense of safety, competence, and agency among young mothers. Prior research shows that breastfeeding difficulties can be especially stressful for adolescent mothers, and positive, empathetic care helps improve psychological comfort and supports parental competence (Decker et al., 2021).

Effective support for underage mothers during the perinatal period requires an integrated approach that takes into account their unique emotional and social needs. Only holistic and empathetic perinatal care can promote the development of mature, responsible parenthood. Failures in this area may worsen young mothers' mental health and undermine trust in the healthcare system (Lesinskienė et al., 2025). The quality of interactions between underage pregnant women and medical personnel plays a central role in building safety and trust. A model of perinatal care based on partnership, respect, and inclusion of minors in the decision-making process can improve their experiences and promote more positive attitudes toward the healthcare system in the future (Pietrusiewicz, 2018). Inadequate care may also stem from dysfunctional relationships between patients and staff. Failure to address basic needs during labor can lead to traumatic memories that persist for years (Afulani et al., 2020).

Our study also found that young women often avoided antenatal classes due to organizational difficulties and fear of negative judgment. A systematic review by Athinaidou et al. (2024) demonstrated that participation in antenatal education effectively reduces fear and anxiety related to childbirth and increases acceptance of vaginal delivery without medical intervention. Other research shows that antenatal classes improve maternal mental health and promote vaginal delivery (Zaman et al., 2025). For underage mothers, who often have limited access to reliable information and social support, participation in such programs may serve as an important protective factor, supporting emotional stability and facilitating adaptation to their new role. Antenatal education programs provide not only practical skills but also social support, which is especially important for young women at risk of marginalization. Research confirms that adolescent mothers often lose previous social relationships, both due to self-withdrawal and distancing by peers (Gruszyńska, 2023; Wiemann et al., 2005).

Our findings further indicate that respondents who received support from a partner or family described their experiences more positively. Lack of support deepened feelings of isolation and made it more difficult to adjust to motherhood. Participants frequently cited social exclusion as a negative consequence of early motherhood. Clemmens (2001) demonstrated a direct link between social support for adolescent mothers and their interactions with their infants, suggesting that lack of support may negatively affect maternal attitudes toward the child.

The data also show that some respondents encountered supportive and respectful attitudes from particular healthcare providers, indicating that the quality of care varies depending on the institution and the interpersonal competencies of individual staff members. Similar conclusions appear in the *Rodzić po Ludzku* Foundation report (2018), which found that women's experiences of perinatal care depend strongly on the facility in which care is provided.

A report by the European Parliament on the reproductive health needs of adolescents in EU countries noted that nearly half of the member states lack specialized youth health centers that could provide comprehensive, age-appropriate care (Michaud et al., 2020). This often leads to insufficient professional training and inadequate preparation of healthcare personnel, negatively affecting care quality.

Perinatal care for pregnant adolescents in Poland centers primarily on standard medical procedures, without significant differentiation from the care provided to adult women (Drosdzol-Cop et al., 2023). The narratives of young mothers point to a lack of systemic psychological support and insufficient ad-

aptation of staff attitudes to their needs. A key issue appears to be the absence of protocols designed for this patient group and the lack of a dedicated care coordinator who could ensure consistent, interdisciplinary support throughout pregnancy, childbirth, and postpartum.

Best practices from the United Kingdom (National Institute for Health and Care Excellence, 2010) and Australia (The Royal Australian College of General Practitioners, RACGP) (Mann et al., 2020) emphasize the importance of comprehensive, individualized care for pregnant women in socially vulnerable situations. These models include continuous support from a designated midwife or family physician acting as a care coordinator, along with integrated psychological support, health education, and prevention of mental health disorders. Such an approach increases access to medical services for women in particularly vulnerable life circumstances, improves health outcomes, and strengthens their confidence in the healthcare system.

4. Limitations

This study was conducted on a small sample, as only eight women agreed to participate. This limits the representativeness of the findings and prevents generalization to the wider population of underage mothers in Poland. The conclusions should therefore be viewed as a qualitative exploration of the phenomenon rather than a representative picture. Furthermore, the study was retrospective. Participants described events that had occurred three to five years earlier, which introduces the risk of recall bias, particularly since the events involved intense and often traumatic experiences. Given these limitations, the findings should be treated as a starting point and an indication of the need for further, more comprehensive research involving a larger sample.

Conclusions

The study revealed significant gaps in empathetic communication from medical personnel toward underage mothers, contributing to their feelings of confusion, stigma, and reduced sense of safety. These findings highlight the urgent need for staff training in patient rights, effective communication, reporting inappropriate behaviors, and understanding the specific needs of this patient group.

The variation in the experiences of underage mothers underscores the lack of consistency in the quality of care, stemming from the absence of systemic solutions addressing their needs. Introducing a dedicated care coordinator for this population could help ensure more coherent, individualized, and supportive perinatal care.

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