CE 2.5 ANCC Contact Hours

Abstract

Teen mothers are stigmatized for violating age norms for parenting and for being members of devalued racial or socioeconomic groups. Stereotypes of young mothers perpetuate stigma by teen pregnancy prevention campaigns, television shows, sex education programs, professionals, and the general public. How teen mothers became a stigmatized group; updates on research about their experience of stigma; and resources for reducing stigma are presented. Because stigma is pervasive and has damaging effects, nurses are urged to reduce stigma and discrimination by assuring that health settings are safe and welcoming, and that pregnant and parenting teens are treated with respect and dignity. Doing so is consistent with our professional commitment to promote social justice and mitigate the social inequities that contribute to health disparities for all parents, irrespective of age, gender, ethnicity, immigration status, or income.

Key words: Discrimination; Health disparities; Stigma; Teen mothers; Young mothers.

WALKING ON EGGSHELLS: AN UPDATE ON THE STIGMATIZING OF TEEN MOTHERS

Lee SmithBattle, PhD, RN

Good Mom
NICU twins; homeless black teen mom.
Sullen, aloof.
Tender with babies.
40-min bus ride to hospital.
"Not here enough," worries middle-class staff.
"Demanding….Irresponsible."
Tempers flare. Child protective services called.
Mutual disrespect. Trust shattered.
Failure of compassion.
Medicine is cold and white.
No room at the inn for you.
Who are the grown-ups?
I'm sorry.
Mary D. Wagner, MD (Wagner, 2015)

Wagner, a physician, was apparently troubled by staff interactions she observed with a teen mother in a neonatal intensive care unit (NICU). Her poem captures how the social distance between teen mothers and clinicians can spiral into mistrust and misunderstanding. The words paint a picture of NICU staff judging a distraught mother for behavior that is inconsistent with their expectations of good mothering. We can imagine how interactions went awry; worried about her babies and housing situation, mom acted "aloof" and "demanding" and may have taken offense if she overheard staff make demeaning comments about young mothers. Looming in the background is her fear of losing custody. Her worst fears are confirmed when child protective services show up, the penultimate judgment that she is a bad mother. Can she dare hope that this person will treat her with respect and empathy, and connect her to resources that will preserve and strengthen her family? She is walking on eggshells.

Seven years ago, I authored an article in *MCN* to describe "what is known about the stigma directed at teen mothers, reasons for its persistence, efforts to reduce it, and its potentially harmful effects" (SmithBattle, 2013, p. 235). The literature on teen mothers as a stigmatized group has expanded over the last decade. How teen mothers came to be stigmatized in the United States; updates on research about their experience of stigma; and resources for mitigating stigma are presented. Although teen fathers are also stigmatized (Conn et al., 2018), they are not included here because their experiences are understudied.

The Creation of Spoiled Identities

Irving Goffman (1963) is credited with describing how stigma "spoils" the identities of those who violate social norms or whose characteristics are disfavored. Teen mothers violate age

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Teen mothers are stigmatized in the media and health care settings and by sex education campaigns.

norms for parenting and are further stigmatized for often being members of devalued racial and income groups (Ellis-Sloan, 2014; Nayak & Kehily, 2014). Like other stigmatized groups, teen mothers encounter harmful stereotypes and discrimination that contribute to stress, shame, social isolation, and health disparities (American Nurses Association [ANA], 2018).

Pregnant and parenting teens were rarely stigmatized prior to the 1970s. Although teen birth rates were high from the 1940s to 1970s (Ventura et al., 2014), premarital sex was concealed through "shotgun" marriages and adoptions (SmithBattle, 2018). As marriages and adoptions declined, single mothers of any age faced intense scrutiny and stigma. Declaring (inaccurately) that teen births were at "epidemic" levels, the Alan Guttmacher Institute (1976) linked early childbearing to poverty, family breakdown, and crime. Poor outcomes became the refrain of policy makers, health experts, and politicians. The phrase "children having children" became part of the public vernacular when it appeared as the caption on a Time cover story featuring a very pregnant teen (Stengel, 1985). No one questioned why teen mothers of a few decades earlier had escaped this demeaning label.

Linking teen parenting to social problems contributed to public anxieties related to female sexuality and race at a time when women and people of color were advocating for equality and civil rights. Public anxieties were reinforced by research reporting that teen mothers fared worse than older mothers in education, income, employment, and parenting outcomes (Hans & White, 2019; SmithBattle, 2018). Because parenting was believed to compromise their development and the future of their children, it followed that delaying childbearing would help to reduce poor maternal–child outcomes and the nation's social problems. This logic abetted stereotypes that teen mothers were irresponsible, incompetent parents who were looking for handouts.

Early research overstated the negative outcomes of teen mothering by overlooking the systemic inequities and discrimination that contribute to teen births, in effect blaming young parents for their circumstances and broader social problems (Breheny & Stephens, 2007; Sheeran et al., 2018). A wealth of evidence now suggests that poor maternal–child outcomes are largely predicted by the social disadvantage, minority status, and childhood adversities that precede teen pregnancy (Weed et al., 2015); these social inequities predispose youth to engage in unprotected sex and contribute to poor outcomes (SmithBattle, 2018).

Bearing Stigma

Despite this evidence, teen mothers continue to be stigmatized in the media and by sex education campaigns, health care providers, and the public at large (Vinson, 2018). For example, in 2013, a photo of a teen mother with her baby was rejected for inclusion in her high school yearbook, even though students were told that photos could include props to represent their achievements (Sieczkowski, 2013). The teen at the center of the controversy believed that graduating from high school as a mother was a noteworthy achievement. Her photo was excluded based on the erroneous assumption that acknowledging teen sex might induce peers to engage in sex, a view used decades earlier to exclude teen mothers from high school (Chase, 2017).

Stereotypes are perpetuated by teen pregnancy prevention campaigns and sex education programs that emphasize adverse outcomes of teen births to promote abstinence or safer sex (Vinson, 2018). Early examples included posters distributed by the National Campaign to Prevent Teen and Unplanned Pregnancy (NCPTUP) that labelled pregnant teenagers as "cheap" or "dirty" (Vinson, see pp. 24–26). In 2013, the New York City campaign to prevent teen pregnancy placed posters on buses and subways that featured toddlers with captions addressed to their parents like: "Honestly mom…chances are the [child's father] won't stay with you. What happens to me?" Or "I'm twice as likely not to graduate high school because you had me as a teen." Within a few days, the posters were removed in response to mounting criticism and a statement by Planned Parenthood that the campaign overlooked the "racial, economic and social factors that contribute to teenage pregnancy and instead stigmatized teenage parents and their children" (Taylor, 2013, p. 1). Similarly, the Baby Can Wait program sponsored by United Way and Waukesha County of Milwaukee in 2014 caricatured teen parents as hand puppets, jack-in-the-boxes, or pull toys controlled by huge babies (Baby Can Wait, 2014). All of these campaigns exaggerate the poor outcomes of teen pregnancy while disregarding the structural inequities that contribute to teen pregnancy.

Stereotypes are also fueled by reality TV shows, such as *16 and Pregnant* that aired in 2009 with the endorsement of NCPTUP (Behm-Morawitz et al., 2019). Teen mothers perceive these and similar shows to be stigmatizing in suggesting that their lives are ruined; that teen fathers are absent; and that drug use is widespread (Harrison et al., 2016). Stereotypes that circulate via TV shows and sex education campaigns help to explain why high school students stigmatize and bully teen parents for an actual or rumored pregnancy, contributing to fear, social isolation, and dropping out of school (Kuckertz & McCabe, 2011).

Teen Mothers' Experience of Stigma

In research published since 2012, stigma is frequently reported by teen mothers. They describe being scrutinized, treated more negatively than older mothers, and labelled as irresponsible, unfit parents who are "ruining their lives" (Bermea et al., 2018; Ellis-Sloan, 2014; Harrison et al., 2017; Nayak & Kehily, 2014). They report being subjected to demeaning looks, offensive comments, and low expectations based on pervasive stereotypes (Conn et al., 2018).

To defend themselves against a "spoiled" identity, teen mothers are keen to show others that they differ from the stereotypical teen mom. To counter the label of irresponsibility, they refer to the pregnancy as "accidental" (Cashdollar, 2018; Ellis-Sloan, 2014) and hide or dampen their emotional responses out of concern that expressing either joy or distress about the pregnancy or their baby might be misinterpreted by others (Ellis-Sloan; Jones et al., 2019). Teen mothers may intend to give birth naturally or to breastfeed to measure up to the ideals of good mothering (Carson et al., 2017). To refute the stigma that they have "ruined their lives," they describe mothering as a catalyst for returning to school, refraining from risky behavior, and becoming good parents (Cashdollar). By demonstrating that they are exceptions to the stereotypes, teen mothers portray themselves as morally worthy (Ellis-Sloan; Jones et al.; Leese, 2016).

Fearing loss of custody (Cashdollar, 2018; Recto & Champion, 2018; Robb et al., 2013), teen mothers may avoid behaving or dressing in ways that indicate they are very young, low-income or dependent on public resources (Banister et al., 2016; Hamilton et al., 2018). Dressing the baby in nice clothes and rejecting used items is intended to avoid the stigma of poverty (Nayak & Kehily, 2014). Because using public benefits is stigmatizing, some teens report rejecting public assistance (Breheny & Stephens, 2009). Others reject treatment for depression to avoid the added stigma of mental illness (Recto & Champion) or remain with abusive partners to avoid the "double" stigma of being a teen and single mother (Wood & Barter, 2015).

Past experiences of stigma may heighten teen mothers' sensitivity to concerns about their competence as parents (Harrison et al., 2017; Robb et al., 2013). They may avoid stigma by dropping out of school. They may delay clinical care; selectively disclose clinically important information (e.g., being homeless or depressed); and reject clinical guidance or resources (Bermea et al., 2018; Ellis-Sloan, 2014; Recto & Champion, 2018). Acting aloof, defiant, or passive are other self-protective responses to stigmatizing interactions that may unintentionally reinforce stereotypes that young mothers are uncooperative or immature.

Although research suggests that stigma is pervasive, young parents (n = 370; aged 13–24) who participated in a national panel reported fairly low stigma (Rice et al., 2019). Mean age of the participants at first birth was 18.3 years (SD = 2.4); 80% were female and 20% male. Parents were white (138, 35%), Hispanic/Latino (103, 28%), Black (42, 11%), Arab/Middle Eastern (36, 9.8%), or other (49, 13%), and resided in the West (131, 39%), South (102, 30%), Northeast (61, 18%), and Midwest (43, 13%). Stigma was elevated among teen fathers, Arab/Middle Easterners, parents who received public benefits, non-Christians, sexual minorities (LGBTQ), and residents of the South or Northeast. Stigma may have been lower than expected because 28% of the sample were not teen parents, and teen parents may have disidentified from stigma or emphasized how they differ from other teen parents to maintain self-respect (Jones et al., 2019).

Discussion and Clinical Implications

More than 15 years ago, Cassata and Dallas (2005) identified a cultural chasm between teen mothers and nurses, which remains apparent in this research and in a national survey that evaluated hospital maternity practices based on the Baby-Friendly Hospital Initiative (Sipsma et al., 2017). Teen mothers (age 18–19) reported receiving less nursing support to initiate breastfeeding; were more likely to receive a pacifier; and less likely to room in with their infants compared with mothers ≥ age 30. These findings raise concerns about the potential contribution of stigma to reduced breastfeeding rates among teen mothers.

The cultural chasm between nurses and teen mothers is largely hidden in divergent norms related to family formation, the timing of pregnancy, and the meanings of parenting (Smith et al., 2016; Stevens, 2015). Preventing pregnancy is normative for middle-class teens whose (lengthening) pathway into adulthood is secured with family and community resources and access to reproductive health care (Bell et al., 2014; Kuckertz & McCabe, 2011). For disadvantaged teens who face many hardships and lack vocational and educational options, a promising future appears dim, making it less likely for them to use contraception effectively compared with middle-class peers who have far more to lose from early parenting. Although most teens do not plan to become pregnant (Cashdollar, 2018), parenting is often welcomed as a path to adulthood that offers meaning and purpose (Cherry et al., 2015; Sheeran et al., 2016).

The social worlds that contribute to teen parenting may be unfamiliar to nurses and nursing students, and academic programs may not effectively bridge the chasm (Cassata & Dallas, 2005). Nursing textbooks and journal articles exacerbate social distance when they emphasize teen parents' risks and deficits while ignoring the stigma and parenting challenges that many face (Sheeran et al., 2016; SmithBattle, 2018; SmithBattle et al., 2019). On a positive note, Kim et al. (2013) reported that undergraduate nursing students (n = 279) held positive attitudes toward teen mothers, and positive attitudes were highest among senior students. Unfortunately, positive attitudes among graduate students declined with greater time in the program. According to Kim et al., this unexpected finding may reflect the limited number of maternal–child graduate students in the program. Because nursing students were recruited solely from one university, results may not be representative of nursing students in general.

Efforts by advocacy groups and teen parents to resist stigma represent a welcome development. A growing number of resources (Table 1) are also available to help nurses mitigate stigma, including ANA's (2018) position statement. This statement acknowledges the contribution of discrimination and stigma to health disparities and directs nurse educators, clinicians, administrators, and researchers to confront stigma's insidious effects.

Teen mothers (and fathers) deserve safe health settings; to be treated with respect and dignity; and to have their strengths and vulnerabilities addressed (SmithBattle et al., 2020). Nurse educators contribute to these goals by evaluating classroom and textbook content for stigmatizing messages. Educators can also assign a stigma survey in class (Kim et al., 2013) and share deidentified results to stimulate class discussion and student reflection. Student reports of witnessing stigma in clinicals also offer an opportunity for instructors to review professional ethics.

TABLE 1. SELECTED RESOURCES FOR SUPPORTING YOUNG PARENTS AND CHALLENGING STIGMA

Chirp https://www.chirp.love/ As per the website, "Chirp empowers young parents to make informed decisions on their health, education, and futures." The site offers a "chatbox" for answering young parents' questions and connects teen parents to peers and mentors.
Healthy Teen Network (HTN) www.healthyteennetwork.org "…fosters a national community where all adolescents and young adults, including youth who are pregnant or parenting, are supported and empowered to thrive." Members include adolescent health care professionals and organizations devoted to improving adolescent health and wellbeing.
Justice for Young Families (J4YF) was launched by California Latinas for Reproductive Justice (CLRJ). Their mission is to advocate for policies supportive of "the health, equity and dignity of young families." https://californialatinas.org/our-work/justice-for-young-families/
National Women's Law Center www.nwlc.org The website describes NWLC as "advocates, experts, and lawyers who fight for gender justice, ….especially for women facing multiple forms of discrimination." NLWC addressed childcare, health care, reproductive health care, immigration, and discrimination of pregnant and parenting teens by public schools.
#NoTeenShame www.noteenshame.com was started by young mothers in 2013. The mission, as stated on the website, "is to improve policy and eradicate the stigma that negatively impacts young parents' access to quality health care, education, and community support."

Clinicians bridge the cultural divide by practicing strength-based, family-centered, and trauma-informed care (SmithBattle et al., 2020; see clinical implications at the end of the article). Affirming teen parents' strengths capitalizes on parenting as growth promoting and risk reducing and has the potential to reduce situations that threaten maternal identity, including long-standing stereotypes that they are destined for failure and undeserving of assistance. Social distance is reduced when trusting relationships enhance teen mothers' willingness to disclose their challenges and vulnerabilities.

Conclusion

Teen mothers traverse a minefield of denigrating stereotypes that "spoil" maternal identity (Goffman, 1963). Wagner's (2015) poem captures how stigma contributes to social distance, compromises health care, and corrodes the ethical imperative to treat patients with respect and dignity (Dalton & Miller, 2016; Harrison et al., 2017; Hunter et al., 2015; Leese, 2017; Recto & Champion, 2018). Stereotypes that teen parents are unfit and irresponsible,

CLINICAL IMPLICATIONS FOR REDUCING STIGMA AND DEVELOPING TRUST

- Work with colleagues to eliminate stigma and discrimination. Create a welcoming environment and express interest in teens' concerns and experiences.
- Reflect on how your interactions with teen versus older parents promote confidence, self-disclosure, and inclusion.
- Advocate for youth-friendly services that are confidential and accessible regardless of parenting status, gender, citizenship status, sexual orientation, etc.
- Recognize that teens are experts on their own lives. Avoid making assumptions based on their age, gender, ethnicity, income, or any demographic factors.
- Educate parents on the full range of options (e.g., birthing plans, infant feeding, family planning methods). Respect their choices.
- Capitalize on teens' aspirations. Consider writing one of their goals on a prescription pad and cosigning with them.
- Commend teens for making progress toward their goals and offer emotional support when they encounter setbacks or roadblocks.

or that their lives are "ruined" are especially damaging because parenting has the potential to redirect teens' lives in positive ways. This statement from 7 years ago remains valid today: "Stigma should be of concern to nurses because stigmatizing practices impede effective clinical care, contribute to teen mothers' many challenges, and violate the nursing ethic that patients be treated with respect and dignity" (SmithBattle, 2013, p. 235). Doing so is consistent with our professional commitment to promote social justice and mitigate the social inequities that contribute to health disparities for all parents, irrespective of age, gender, ethnicity, immigration status, or income. ✣

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This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749 for 2.5 contact hours. LPD is also an approved provider of continuing nursing education by the District of Columbia, Georgia, and Florida, CE Broker #50-1223.

Payment:

- The registration fee for this test is $24.95.