CE 2.1 ANCC contact hours

Reducing the STIGMATIZATION of Teen Mothers

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Abstract

Teen mothers are stigmatized by stereotypes that they are unmotivated, irresponsible, and incompetent parents. In spite of the pervasiveness of these stereotypes, stigma is rarely described as a contributing factor to teen mothers' difficulties and their health and social disparities. After tracing how teen mothers have been misrepresented and stereotyped over the last half century, I describe what is known about the stigma associated with teen mothering, reasons for its persistence, efforts to reduce it, and its potentially harmful effects. 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. Recommendations for restoring dignity and reducing stigma in healthcare focus on developing recognition practices that are predicated on respect and concern for the teen's well-being and her capacity as a mother. Nurses are also urged to advocate for services and policies that reduce the stigmatization and marginalization of teen mothers.

Key words: Adolescent mothers; Discrimination; Stereotypes; Stigma.

In spite of a steady decline in the United States teen birthrate, the United States lags far behind comparable countries in preventing teen births (Kearney & Levine, 2012). International disparities partly reflect significant policy differences: United States policy ignores sexual desire, promotes abstinence, and highlights the dangers of teen sex, whereas countries with low rates normalize teen sex and promote sexual responsibility (Schalet, 2011). In the United States context, teen sex is construed as dangerous partly due to the poor outcomes and high public costs attributed to teen births. Evidence that poor outcomes have been exaggerated has had little effect in destigmatizing teen mothers (Sisson, 2012).

Stigma occurs when individuals and groups are labeled as different (Goffman, 1963). Difference is pathologized by more powerful groups, leading to the stigmatized group's mistreatment, marginalization, or social exclusion (Link & Phelan, 2001). Teen mothers are especially vulnerable to being stigmatized due to their age, class, and racial/ethnic backgrounds. With few exceptions, media stories, professional discourse, and advocacy organizations portray teen mothers as irresponsible and inept parents whose lives are forever derailed by parenting (Lewis, Scarborough, Rose, & Quirin, 2007). Scientific practices and policies contribute to their stigmatization by downplaying the social inequities that precede teen pregnancies (Sisson, 2012; SmithBattle, 2012).

After briefly reviewing how teen mothers have been misrepresented and stereotyped since at least the 1970s, I describe what is known about the stigma associated with teen mothering, the reasons for its persistence, the few efforts to reduce it, and its potentially harmful effects. Stigmatizing practices are described as violations of dignity (Jacobson, 2009), which impede effective clinical care and contribute to teen mothers' already challenging lives. Recommendations for restoring dignity and reducing stigma are described.

The Misrepresentation of Teen Mothers

The stigmatizing of teen mothers began more than a half century ago. Influential reports claimed that teen pregnancies placed girls on a downward trajectory that led to poverty, family breakdown, and welfare dependence (Alan Guttmacher Institute, 1976). A Time cover story titled "Children raising children" further implied that teens who gave birth (at age 18 or 19) were just too young to raise a child (Stengel, 1985, December 9), yet two decades earlier teens of this age having babies was not uncommon and was accepted. Politicians also began lamenting the poor outcomes associated with teen mothering. (Luker, 1996). In 1994, House Speaker Newt Gingrich proposed a radical fix: deny teen mothers welfare assistance and place their children in orphanages. This proposal resurfaced two decades later when Westman (2009) recommended that children of teen mothers under the age of 18 be removed by the state on the basis of presumptive neglect. Such draconian recommendations reflect and reinforce stigmatizing practices and disregard the scientific evidence that teen mothers fare about as well as older mothers from similar backgrounds.

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Teen mothering emerged as a powerful symbol of individual and family deviance in the context of sweeping social changes that delinked sex from marriage and parenting (Furstenberg, 2007). In the 1950s, pregnancies among older teens were common and occurred in the context of marriage. Almost half of these marriages were hastily arranged to legitimize a premarital pregnancy (Furstenberg, 2007). When a "shotgun" marriage was impossible, White girls avoided a tarnished reputation by being sent to maternity homes for "rehabilitation" where they surrendered their children for adoption (Solinger, 2000). Because single parenting first rose among Black teens (who were excluded from maternity homes), race emerged as a salient factor in the framing of teen mothering by politicians and policy makers: evidence of "unwed" pregnancies among White middle-class teens was erased with adoption, making them fit for marriage, whereas Black teens raised their children at home with the help of families and without public resources (Luker, 1996; Solinger, 2000). Public concerns intensified as the Alan Guttmacher Institute (1976) declared an epidemic of teen pregnancy and the pregnant bellies of White

"unwed" teens began appearing in lay magazines (Arney & Bergen, 1984).

Racial disparities in teen birthrates have received more attention than class differences in spite of their strong influence on family formation patterns. In the 1970s, marriage and parenting provided the traditional path into adulthood with the average age of marriage for women at 20 years and men at 23 years (Furstenberg, 2010). Young men, with or without high-school degrees, earned sufficient wages from manufacturing jobs to support families, while mothers cared for children at home. This pattern unraveled as social and economic changes altered the timing of marriage and gender roles (Furstenberg, 2010). With an expanding knowledge and consumer economy, growth of universities, and legalization of birth control and abortion, teens began to control their fertility and pursue college degrees. As educational and career paths broadened, and long-acting and more effective birth control methods came on the market, middle-class girls proved to be effective contraceptive users and were willing to abort an ill-timed pregnancy (CDC, 2012). The pathway into adulthood was extended as college education and economic independence delayed marriage and parenting until the mid-till late 20s (Furstenberg). This longer road to adulthood was inextricably tied to the financial resources and investments of parents, school districts, and communities. As opportunities expanded for middle-class youth, the economic prospects for low-income youth eroded as manufacturing jobs moved offshore, and labor unions, wages, and benefits declined. With less secure and remunerative jobs available, the path into adulthood bifurcated along class lines with disadvantaged youth moving into adulthood earlier and along a more tortuous path than their middle-class peers (Furstenberg).

The timing of marriage has also bifurcated along class lines. As Furstenberg (2003) explains, marriage is a "luxury" that low-income couples can ill afford given poor labor market conditions and growing income equality. Although many low-income women endorse marriage, marriage is typically delayed until couples have gained some financial stability (Trail & Karney, 2012).

In popular and professional discourse, having a baby disrupts a girl's education, undermines job prospects, and leads to welfare dependence. This sequence downplays the unlevel playing field that begins at birth for those growing up in impoverished homes and neighborhoods and attending inferior schools (SmithBattle, 2012). Even if teens complete high school, the future is likely to include menial jobs with no benefits, intense work–family conflicts, and spells of unemployment (Furstenberg, 2010). With few compelling reasons to avoid pregnancy, girls use contraception less effectively (CDC, 2012) and drift into pregnancy precisely because mothering provides meaning and a path into adulthood that pregnancy prevention campaigns and policies routinely disregard (Furstenberg, 2007; Sisson, 2012).

The vast research on teen mothers has promoted stereotypes and exaggerated poor maternal (and child) outcomes by glossing over prior childhood disadvantages (SmithBattle, 2012). Studies that adjust for these factors suggest that teen mothers and their children fare about as well as older mothers and their children from similar backgrounds (Sisson, 2012), and teen mothers with more resources and better childhoods tend to do as well as older middle-class mothers (Hillis et al., 2004; Oxford, Lee, & Lohr, 2010). In taking account of these background factors, Luker (1996) concluded, "…although it is true that teen mothers tend to be poor women, it is much more meaningful to say that poor women tend to become young mothers" (p. 12).

Scholars agree that teen mothers are a vulnerable group of parents, but their vulnerability stems largely from the social inequities and adverse childhood experiences that precede giving birth (Sisson, 2012; SmithBattle, 2012). Early inequities persist and are then compounded by stigmatizing practices and flawed social policies (SmithBattle, 2012). Scholars in the United States and elsewhere suggest that scientific evidence is disregarded by advocacy groups, policy makers, and professionals for many complex reasons (Duncan, Edwards, & Alexander, 2010; Furstenberg, 2007). First, teen mothers are marked by several stigmatized conditions: they are young; disproportionately poor, single, and of color; and viewed as drains on public welfare. Each of these conditions is highly stigmatized (Landy, Sword, & Valaitis, 2009; Usdansky, 2009). Racial discrimination by clinicians for these conditions is also documented (De Marco, Thorburn, & Zhao, 2008; Rosenthal & Lobel, 2011). Second, wide disparities in status and power insulate professionals from the circumstances that predispose to early parenting and reinforce erroneous assumptions that middle-class norms regarding family formation and parenting are "natural" rather than contingent on resources and opportunities that are largely unavailable to disadvantaged groups (Geronimus, 2003). Third, professional training socializes clinicians to selectively attend to teen mothers' flaws while overlooking their resilience, the enduring effects of childhood disadvantage and adversities, and the bureaucratic hurdles that compound their struggles (Breheny & Stephens, 2010; Cassata & Dallas, 2005). Neoliberal assumptions also attribute poverty to character flaws and deviance, ignoring the inequities that are built into educational and economic systems (Furstenberg, 2007; Geronimus, 2003). Lastly, advocacy groups and policy makers attract funding or political support by stigmatizing teen mothers (K. Suellentrop, personal communication, May 14, 2011).

Teen Mothers' Experience of Stigma

In spite of the vast research on early childbearing, and the recognition that teen mothers are a stigmatized group, few researchers have investigated the issue. Prevalence may be quite high: Wiemann, Rickert, Berenson, and Volk (2005) reported that 39.1% of teens on a postpartum unit in a Texas hospital felt stigmatized.

Whitley and Kirmayer (2008) found that young Euro-Canadian mothers (ages 18–24) felt strongly stigmatized by their age compared to older Euro-Canadian mothers or Afro-Canadian mothers of any age. Oregon women who were young, single, or lacked private insurance were more likely to perceive discrimination from perinatal providers than older, married women with private insurance (De Marco et al., 2008).

Teen mothers report remarkably similar experiences of stigma in the United States (Fessler, 2008; Gregson, 2009; Kaplan, 1997), Canada (Fulford & Ford-Gilboe, 2004; Landy et al., 2009), and the United Kingdom (Stapleton, 2010; Yardley, 2008), and many of their accounts are corroborated by researchers' observations (Gregson, 2009; Kaplan, 1997; Stapleton, 2010). The most common sources of stigma identified by mothers are media reports and strangers who glare at them or verbally rebuke them in public (Fulford & Ford-Gilboe, 2004; Gregson, 2009; Higginbottom et al., 2006). Although some social service and school staff are seen as supportive, others subject teen mothers to rude behavior, heavy scrutiny, and mistreatment (Horowitz, 1995; Silver, 2008). Teachers tend to treat mothers differently than nonparenting classmates, and differential treatment, even when well-intentioned, is perceived as demeaning (Gregson, 2009). Mandates to participate in programs (e.g., mental health) as a condition of receiving help is also seen as degrading (Gregson, 2009).

Teen mothers also describe being chastised and treated disrespectfully by clinicians (Fessler, 2008; Yardley, 2008) and differently than older mothers (Peterson, Sword, Charles, & DiCenso, 2007); the most blatant example was reported by a teen who was refused an epidural for pain during labor (Fessler, 2008). Teen mothers also felt disqualified by clinicians who doubted their capacity to mother, or who spoke to their mothers while disregarding them (Brubaker, 2007; Fessler, 2008). Stigma was also inferred by teen mothers from well-meaning comments, including expressions of surprise that the child appeared clean and well cared for (Fessler, 2008).

Teen mothers are well aware that they are considered unfit parents (Haynes-Lawrence, 2008; Schultz, 2001). They respond to this stereotype and the fear that their children can be removed from them unjustly by carefully dressing their children in clothes they can hardly afford to appear respectable (Fessler, 2008; Ponsford, 2011; Schultz, 2001). For similar reasons, they alter their attire for prenatal visits (Stapleton, 2010) and avoid disciplining their children in public to avoid misinterpretation (Gregson, 2009; Maxwell, Proctor, & Hammond, 2011).

Teen mothers reported feeling resentment, fear, shame, anger, and worthlessness in response to stigmatizing experiences (Yardley, 2008). Some seemed resigned to stigma, whereas others verbally defended themselves against belittling comments (Fessler, 2008; Fulford & Ford-Gilboe, 2004; Yardley, 2008). Looking up at the ceiling was a common response to being patronized or invalidated (Fessler, 2008). Some mothers tried to avoid stigmatizing situations altogether; when avoidance was impossible, they surrounded themselves with friends and family, particularly during labor and birth (Fessler, 2008). Some mothers resisted stigma by ignoring it (Ponsford, 2011; Yardley, 2008), by disidentifying with stereotypes (Fessler, 2008; Yardley, 2008) or by defying stereotypes (Fulford & Ford-Gilboe, 2004; Yardley, 2008). Teens disidentified with stereotypes when they perceived themselves to be more motivated and capable than other teen mothers; they did not flatly reject the stereotypes, but believed that they were an exception (Gregson, 2009; Yardley, 2008). Others defied stereotypes by describing how mothering strengthened their aspirations and improved their lives (Brubaker & Wright, 2006; Warnes & Daiches, 2011). Inspired by new priorities, they returned to school, avoided risky behavior, and left harmful relationships (Gregson, 2009; Middleton, 2011; Yardley, 2008). Teens whose lives were transformed by mothering expressed determination and pride in their accomplishments, which may protect them against a tarnished identity (Gregson, 2009; Yardley, 2008). Resisting stigma in this way may be positive *and* stressful as mothers attempt to prove themselves capable and respectable (Warnes & Daiches, 2011). As Kelly (1996) argues, taking up a supermom identity "while compelling and even destigmatizing, plays down structural constraints and the benefits of institutional supports like day care and school services, sending instead a signal that young women, given enough individual mettle, can do it all" (p. 443).

According to Link and Phelan (2001), individual efforts to resist stigma are rarely effective. Fessler (2008) suggests that teen mothers' resistance to stigma may reinforce stereotypes, as for example, when clinicians misinterpret teens' behavior (e.g., looking up at the ceiling, missing appointments) as signs of immaturity or apathy, rather than a response to being disqualified and disrespected.

Efforts to Destigmatize Teen Mothers

Three high-school programs serving teen mothers promoted efforts to destigmatize this group. Teen mothers in a Canadian school created and performed a play to dramatize their experiences of stigma (Kelly, 1997). This goal was diluted by the director's insistence that the play addresses the dangers of teen pregnancy. Teen mothers in a U.S. school were encouraged to write a newspaper story to counter media stereotypes but their efforts were met with a barrage of negative letters to the editor (Gregson, 2009). Kelly (2003) observed a Canadian school program whose mission to empower teen mothers was similarly undermined by the stigma from nonprogram teachers and students. These small-scale efforts confirm Schultz' (2001) contention that marginalized groups who challenge stereotypes face significant barriers and backlash.

National campaigns to destigmatize teen mothering are rare. The Fable and Fact Young Mothers and Fathers Project, sponsored by UK Youth (www.ukyouth.org), trained young parents to research and respond to the

stereotypes of young parenting. Participants wrote press releases and provided workshops to inform social workers and healthcare professionals of their stigmatizing experiences. Healthy Teen Network (HTN), a U.S. advocacy organization, is unique in its mission to foster a "national community where all adolescents and young adults, including teen parents, are supported and empowered to lead healthy sexual, reproductive, and family lives." In support of this mission, Healthy Teen Network collaborated with the FrameWorks Institute "to identify, test and deploy new messages that might have the potential to change the public conversation about support for young families" (Bales & O'Neil, 2008, p. 2). An analysis of newspaper articles led Bales and O'Neil to the following cautionary conclusion: "This is an extremely difficult topic to reframe. Situated as it is at the crossroads of Sex, Youth, and Race/Poverty, it seems to generate innumerable stereotypes that are deeply ingrained in American cultural thinking and politics" (p. 35). The Massachusetts Alliance on Teen Pregnancy has accepted these challenges by working to prevent teen pregnancy *and* support teen parents. Their many activities include hosting an annual Teen Parent Lobby Day that brings teen parents, service providers, and state legislators together.

Social media offer a virtual community for reaching young mothers. In 1999, a teen mother established a social networking site whose mission, as described on the website, is to "encourage all young mothers to stand up for themselves, to fight for their children, to empower themselves and to defy the notion that being young means that you are unworthy of parenthood" (www.girlmom.com, retrieved 4/27/2009). The site provides a useful forum and peer support for teen mothers and promotes girl-mom as a more empowering term than teen or young mother (see Lewis et al., 2007).

Discussion

Parenting is a fulfilling and challenging experience for mothers of any age. For teen mothers, the challenges of parenting are intensified by stigma from media reports and educational, social service, and healthcare staff. Stigmatizing experiences contribute to teen mothers' social isolation, distress, and loss of confidence (Fulford & Ford-Gilboe, 2004). They also dampen trust and reduce help seeking. Teen mothers withdraw from staff who are judgmental or show disrespect, which may lead to missed appointments or dropping out of school to avoid stigma (Fessler, 2008; Peterson et al., 2007). Mistrust compromises care when teen mothers do not receive the education and services they deserve, either because nurses prejudge them or because teens withdraw from stigmatizing encounters. Although Horowitz (1995) studied a job readiness program serving teen mothers years ago, her findings provide compelling evidence of the corrosive effect of stigma: teachers in the program who assumed teen mothers' deviance used their power and status to distance themselves from student mothers. They focused on training and information transfer, expected obedience, and were blind to how stigmatizing practices fostered teen mothers' dependence, passivity, or rebellion, the very behavior they found objectionable. Other teachers fostered dialog and found common ground with the teen mothers by validating their concerns related to mothering, work, and school. The authority of these teachers was based on dialog and relationships that promoted teen mothers' independence. Similar findings are reported for nurses who are adept at engaging or disengaging from teen mothers (Cassata & Dallas, 2005; Peterson, Davies, Rashotte, Salvador, & Trépanier, 2012).

Stigma opposes the ethical obligation of nurses to treat patients with respect and dignity. Clinical encounters that are condescending or discriminate against teen parents represent violations of dignity that threaten personhood, undermine autonomy, and make it difficult for clinicians to see and respond to the other (Jacobson, 2009). Restoring dignity requires the development of recognition practices that promote trust, collaboration, dialog, and understanding (Aranda & Jones, 2010; SmithBattle, 2009). Recognition practices are premised on the assumption that the self is formed and cultivated by relationships that show respect and genuine concern for the teen's well-being and her capacity as a mother (Table 1).

Table 1. Clinical Implications: Promoting Recognition Practices and Reducing Stigma

• Reflect on one's personal assumptions of pregnant and parenting teens.
• Earn the teen mother's trust. Be aware that prior stigmatizing experiences may shape her response.
• Acknowledge your power as a clinician to shape the teen mothers' experience, and her confidence, trust, and willingness to return for care.
• Avoid an authoritarian stance that suggests you know what is best for her.
• Develop a partnership with the teen mother by acknowledging that her concerns and priorities are important to you.
• Provide reassurance, encouragement, and pragmatic suggestions based on her specific interests, concerns, and aspirations. Avoid standardized care plans.
• When accompanied by her parents or partner, offer privacy. Do not encourage her parents or partner to talk for her.
• Ask if she has experienced stigma or discrimination. Make it clear that you want to be notified if she experiences stigma in your setting.
• Assess her interest in and need for community resources and inform her of www.girlmom.org.
• Evaluate the prevalence of stereotypes at your setting.

Stigma opposes nursing's ethical obligation to treat patients with respect and dignity.

Such practices require that nurses support teen mothers' strengths and aspirations (SmithBattle) and collaborate with them on mutually identified goals (Norris, Howell, Wydeven, & Kunes-Connell, 2009), which takes time, openness, and skill, especially when prior experiences of stigma lead teens to protect themselves from expectations of stigma by being defensive or avoiding care (Porr, Drummond, & Olson, 2012). Partnering and teen-friendly services may mitigate these expectations (Norris et al., 2009; Peterson et al., 2012).

Violations of dignity are reinforced by healthcare settings that reinforce silence and passivity and emphasize efficiency, power, and surveillance. Restoring dignity requires institutional cultures that promote nurses' relational and ethical skills. Although restoring dignity and reducing stigma in healthcare settings is an ethical imperative, these goals are best advanced in concert with comprehensive reforms located upstream that reduce social inequities (Jacobson, 2009; SmithBattle, 2012).

In spite of the vast research on teen mothers, we know very little about the prevalence of stigma and even less about the harmful effects of stigma on teen mothers' short- and long-term outcomes. Investigating these relationships are warranted because pregnant teens report higher levels of distress than nonpregnant teens or older pregnant women (Mollborn & Morningstar, 2009) and experience high levels of depression (Wang, Wu, Anderson, & Florence, 2011). Stigma and discrimination may also contribute to health disparities (De Marco et al., 2008; Hall, Moreau, & Trussell, 2012). Lastly, clinicians and researchers are urged to collaborate in identifying and developing the recognition practices that restore dignity and reduce stigma for teen mothers.

Conclusion

Teen mothers are frequently dismissed, scorned, and discriminated against. Entrenched stereotypes emphasize teen mothers' risks and deficits while downplaying the role that social inequities, flawed social policies, and stigma play in eroding their confidence, increasing their distress, and widening their health and social disparities. Stigmatizing practices harm the teen mother when they contribute to her social isolation, create barriers to services, and make it difficult for nurses to recognize and foster teen mothers' strengths and resilience (SmithBattle, 2009). Such practices also violate nurses' ethical obligation to treat patients with respect and dignity. Efforts to reduce stigma and restore dignity for teen mothers have been rare, limited in scope, and ineffective or counterproductive. Restoring dignity in healthcare settings requires that nurses challenge pervasive stereotypes of teen mothers and advocate for services and policies that reduce their stigmatization and marginalization. ✣

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