CE 1.5 ANCC Contact Hours

Navigating a Minefield: Meta-Synthesis of Teen Mothers' Breastfeeding Experience

Abstract

Teen mothers have lower rates of breastfeeding duration and exclusivity than older mothers. A growing body of qualitative research on teen mothers' experience helps to explain these disparities. Following a systematic search to identify relevant research, we synthesized the findings from 22 primary studies to conclude that teen mothers navigate a minefield that undermines their intention to breastfeed and their breastfeeding confidence and skill. This metaphorical minefield reflects competing norms for infant feeding and good mothering, as evident in mixed support from teens' social networks; fragmented and stigmatizing healthcare; and spaces that are inhospitable to teen mothers and breastfeeding mothers in general.

In recognition of this minefield, we urge clinicians to: respect teen mothers' infant feeding decisions; develop collaborative relationships based on the principles of patient-centered and strength-based care; challenge stigmatizing healthcare practices; welcome teen mothers and their significant others to clinical settings; and press health systems to fully implement probreastfeeding policies. We also recommend further study to extend our knowledge about teen mothers' breastfeeding experiences.

Key words: Breastfeeding; Meta-synthesis; Qualitative; Teen mothers.

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Norms of infant feeding have shifted dramatically over the last half century (Dyson, Green, Renfrew, McMillan, & Woolridge, 2010). Up until quite recently, formula feeding was promoted by hospitals, pediatricians, and formula companies as the scientifically approved, "modern" alternative to breast milk. As evidence of the positive health effects of breastfeeding accumulated, probreastfeeding campaigns have succeeded in raising rates of breastfeeding initiation and exclusivity among older U.S. mothers (American Academy of Pediatrics, 2012). Rates for teen mothers lag behind; among infants born in 2011, 66.9% of mothers less than age 20 initiated breastfeeding but 19.3% were breastfeeding exclusively at 3 months postpartum (Centers for Disease Control and Prevention, 2019). Growing research on teen mothers and breastfeeding is shedding light on these disparities. Three research reviews have been published to date. The first (Hall Moran, Edwards, Dykes, & Downe, 2007) included seven studies published from 1987 to 2005 and focused on support for breastfeeding teens. Their review included two qualitative and five quantitative studies. Grassley's (2010) review included qualitative and quantitative studies (n = 18) and the perspectives of teen mothers, grandmothers, partners, and clinicians. Her review identified five types of social support available to breastfeeding teens. The most recent review examined teen mothers' breastfeeding support, beliefs, and practices (Poole & Gephart, 2014) based on 16 studies published between 2008 and 2013. Six studies were quantitative or mixed-methods, and 10 were qualitative; 6 of the 10 qualitative studies included teen and older mothers, and findings were not differentiated by maternal age. All reviews suggested that breastfeeding support from family members and clinicians was insufficient to mitigate the substantial barriers faced by breastfeeding teens. Poole and Gephart (2014) concluded that a more contextual understanding of breastfeeding was needed to improve clinical care. Given that 6 years have elapsed since the most recent review, the purpose of this meta-synthesis was to describe how social contexts intertwine to shape teen mothers' breastfeeding experience. This broad aim aligns with the strengths of qualitative research in generating insights on hidden and contextual aspects of experience that have the potential to improve clinical care.

Breastfeeding is deeply meaningful to young mothers.

Methods

This review was prepared according to the PRISMA guidelines (Moher, Liberati, Tetzlaff, Altman, & PRISMA Group, 2009) (Figure 1). A systematic literature review was completed on September 26, 2018, and updated on October 11, 2018. Four electronic databases were searched (CINAHL, Scopus, PubMed, and Sciencedirect). Search terms were generated using medical subject headings (MeSH) and key words relating to "teen mother*" or "adolescen* mother*" and breastfeeding. Teen mothering was defined as any woman below the age of 20 who is pregnant or has given birth to a child. Eligible articles included primary studies with expectant or teenage mothers regarding breastfeeding that used qualitative or mixed-methods and were published in English in peer-reviewed journals at any time. Articles were excluded based on the following criteria: 1) duplicate studies; 2) incomplete or ongoing studies; 3) research articles without full-text; and 4) studies that included teen and older mothers but results were not reported separately by maternal age.

The search yielded 43 articles; 40 citations remained after duplicates were removed. Review of titles and abstracts yielded 23 articles. The team then reviewed full-text qualitative (n = 21) or mixed-methods (n = 1) studies and reviewed the reference lists for eligible studies; 22 articles met study criteria. All authors independently extracted the major findings from each report and placed these data in a matrix table (Table 1). Coding decisions were reviewed and differences were settled by consensus. The first author reread all primary articles and compared the major findings across studies to identify variations in study contexts (by time or place), and possible links between interpersonal, cultural, and structural levels for supporting or undermining breastfeeding. Specifically, the first author asked how the country of origin, date of publication, research aims, and sample characteristics of primary studies may have shaped findings and intersections. In comparing studies across these dimensions, we propose that teen mothers navigate a minefield of contested norms and inhospitable, stigmatizing spaces. This contextual understanding helps to explain why the many teen mothers who initiate breastfeeding do not continue.

Results

We included all eligible studies without regard to their quality, country of origin, or date of publication to assure an exhaustive review. We reasoned that low-quality studies and research conducted over several decades and across the globe may reveal variations in family, community, or cultural norms. The final sample included 22 articles based on 20 studies that investigated teens' breastfeeding intentions and experiences (Table 1). Most studies were conducted in English-speaking, developed countries, including Australia (1), Canada (3), the United Kingdom (5), and the United States (8). Four studies and five reports originated from Brazil. Teens were recruited from special parenting programs (7), clinics (8), hospitals (2), or from multiple sites (5). Researchers recruited teens during pregnancy (2), postpartum (13), or included pregnant and parenting teens (7). Narrative data were collected with semistructured individual interviews (n = 10), focus groups (n = 4), or both (n = 7). The sole exception was a mixed-methods study that collected teen mothers' written responses to two open-ended questions (Pentecost & Grassley, 2014). All but two studies were cross-sectional; the two longitudinal studies collected data from preg-

nancy until 2 weeks post weaning (Smith, Coley, Labbok, Cupito, & Nwokah, 2012) or to 4 to 6 months post birth (Benson, 1996). Qualitative approaches included thematic analysis (7), content analysis (4), and grounded theory (1); five studies used two methods and two studies used three methods. Research methods were often vaguely described and were not stated in one report (Benson).

Sample sizes of the primary studies ranged from 5 to 90 participants. The combined sample totaled 492 participants; 233 were from the United States and 259 from other countries. Of the cross-sectional studies, 46 teens were pregnant and 297 were mothers. (Two studies did not report if teens were pregnant or parenting.) The race/ethnicity of participants was White/Caucasian (n = 105), Black/African American (n = 74), non-Hispanic (n = 22), Hispanic (n = 21), Latino/Mexican (n = 14), and other (n = 11). Eight studies, including the five from Brazil, did not report race/ethnicity. Participants' socioeconomic background was rarely reported but most appeared to be low-income. The first study was published in 1996; research increased substantially after 2013.

Findings

Teens navigate a minefield that undermines their intention to breastfeed and their development of breastfeeding confidence and skill. This metaphorical minefield reflects competing norms for infant feeding and good mothering, as evident in mixed support from teens' social networks; fragmented and stigmatizing healthcare; and spaces that are inhospitable to teen mothers and breastfeeding mothers in general. Because teens are suspended in social fields where community norms favor formula feeding and early introduction of solid foods, and because exposing the breast in public is taboo (Hunter & Magill-Cuerden, 2014; Nesbitt et al., 2012; Woods, Chesser, & Wipperman, 2013), breastfeeding teens feel conspicuous and exposed for their youth and for breastfeeding (Benson, 1996). Exclusive and prolonged breastfeeding is, therefore, challenging or impossible to maintain (Condon, Rhodes, Warren, Withall, & Tapp, 2012; Hunter, Magill-Cuerden, & McCourt, 2015). Major findings are summarized in Table 2.

Breastfeeding Intentions

Pregnant teens expressed interest in breastfeeding, having learned of its benefits from various sources (e.g., family members, clinicians, prenatal classes, support programs, school, TV, and reading materials) (Condon et al., 2012; Hannon, Willis, Bishop-Townsend, Martinez, & Scrimshaw, 2000; Monteiro et al., 2014; Nelson & Sethi, 2005; Smith et al., 2012; Tucker, Wilson, & Samandari, 2011). Teens initiated breastfeeding given their aspirations to be good mothers (Hunter et al., 2015; Monteiro et al.). Teens who felt pressured to breastfeed were not always motivated to continue (Condon et al.; de Azevedo Mazza, da Silva, Gonçalves, de Fátima Mantovani, & Tararthuch, 2015; Nelson, 2009; Nesbitt et al., 2012). Teens were also deterred by early experiences of pain, exhaustion, fear, embarrassment, or by misconceptions regarding breastfeeding (Hannon et al.; Hunter et al.; Nesbitt et al.; Smith et al.; Souza, de Araújo, Teixeira, & Mota, 2016; Tucker et al.). Conversely, teens who were strongly motivated by the health benefits of breastfeeding were more likely to persevere if they had strong support from family members or clinicians (Nelson & Sethi; Tucker et al.). These teens expressed deep satisfaction with the emotional intimacy and health benefits associated with breastfeeding (Hunter & Magill-Cuerden, 2014; Tucker et al.).

Strong support from teen mothers' mothers, partners, and others played a key role in teens' breastfeeding intentions and practices (Nelson, 2009; Nesbitt et al., 2012; Smith et al., 2012). Although these individuals were crucial in supporting breastfeeding, they sometimes lacked practical knowledge and breastfeeding experience to guide mothers through practical difficulties (Smith et al.). Strong support could be offset by peers or family members who favored formula feeding or the early introduction of solid foods (de Azevedo Mazza, Nunes, Tararthuch, Alexandre, & Patel, 2014; Nelson; Smith et al.; Souza et al., 2016). Mixed support from teens' social networks compromised the best of intentions as they coped with the demands of caring for an infant and the logistics of breastfeeding in interpersonal and geographic spaces that provided limited practical support, privacy, or respect.

Figure 1. Flow Diagram of Article Search and Selection Process

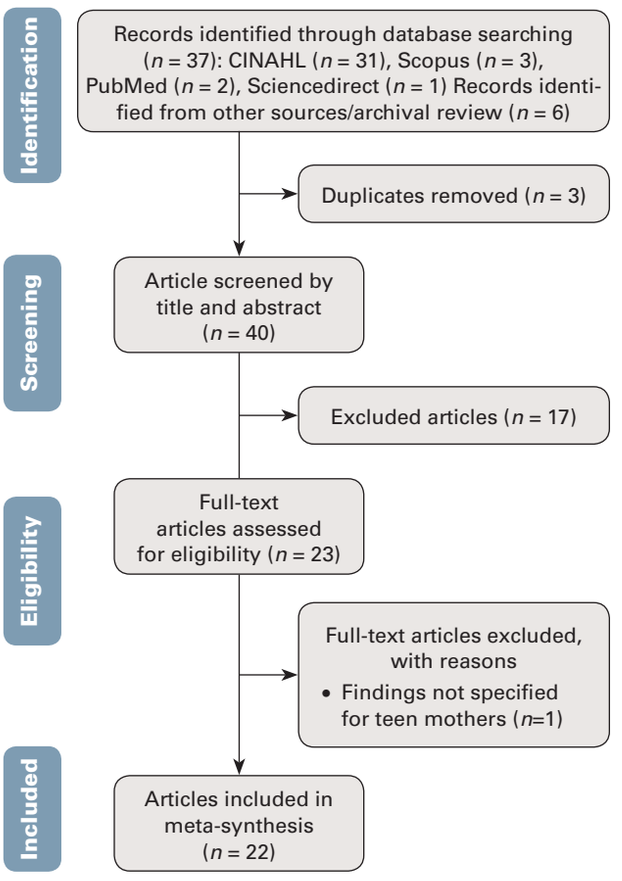

Table 1. Primary Studies

First Author	Year	Country	Sample			Method[a]	Codes[b]							
			Age	*N*	Details		1	2	3	4	5	6	7	8
Benson	1996	Australia	13–18	74	Followed from pregnancy to 4–6 months postpartum: 74 at first interview, 18 at third - Race/ethnicity not reported	6	x	x	x	x	x			
Condon	2013	United Kingdom (U.K.)	<18	29	- 23 White British - 4 Black British - 1 British Asian - 1 White	7		x						
de Azevedo Mazza	2014	Brazil	NR	9	- Race/ethnicity not reported	7	x	x						
de Azevedo Mazza	2015	Brazil	NR	9	- Race/ethnicity not reported	7	x	x						
de Bairros Tamara	2017	Brazil	14–18	9	- Race/ethnicity not reported	7	x	x						
Dykes	2003	U.K.	14–19	20	- White	7	x	x	x			x		
Dyson	2010	U.K.	16–19	17	- White	5/8				x	x			
Hannon	2000	U.S.	12–19	35	- 21 African American - 14 Latina	4	x	x				x		
Hunter	2014	U.K.	16–20	15	- 12 White British - 1 Portuguese - 2 Mixed White British/ Black African	7	x	x	x					
Hunter	2015	U.K.	16–20	15	- 12 White British - 2 Mixed White/Black African - 1 Portuguese	7		x						
Monteiro	2014	Brazil	14–18	10	- Race/ethnicity not reported	4/7/8	x	x				x	x	
Nelson	2005	Canada	15–19	8	- 6 White - 1 Arabic - 1 Aboriginal	1								x
Nelson	2009	Canada	<19	16	- Race/ethnicity not reported	6						x	x	
Nesbitt	2012	Canada	17–19	16	- Race/ethnicity not reported	4	x	x	x	x		x	x	
Pentecost	2014	United States (U.S.)	15–20	90	- Race/ethnicity not reported	4/8		X						
Rossman	2017	U.S.	15–19	15	- 12 Black - 3 Hispanic	4	x	x				x	x	
Smith	2012	U.S.	14–17	5	Followed from pregnancy to 2 weeks post weaning - 3 African American - 1 White - 1 Asian	2/4/6	x	x				x	x	x
Souza	2016	Brazil	<19	12	- Race/ethnicity not reported	4/7	x				x	x		
Tucker	2011	U.S.	13–17	22	- 8 Black - 6 White - 8 Hispanic	7/8	x	x				x		

Table 1. Primary Studies (*Continued*)

First Author	Year	Country	Sample			Method[a]	Codes[b]							
			Age	*N*	Details		1	2	3	4	5	6	7	8
Wambach	2004	U.S.	14–18	14	- 12 African American - 2 White	4	x					x	x	
Wambach	2009	U.S.	14–18	23	- 14 African American - 3 Hispanic - 5 Caucasian - 1 African	4/6	x	x				x	x	
Woods	2014	U.S.	15–20	29	Ethnicity: 22 non-Hispanic - 7 Hispanic Race: - 18 Black - 2 American Indian - 15 White	6	x	x	x			x		

[a]**Method**

1. Grounded theory
2. Phenomenological
3. Narrative
4. Content analysis
5. Ethnographic
6. Not described or vague
7. Thematic analysis
8. Mixed methods

[b]**Codes**

1 = Social support
2 = Professional support
3 = Stigma of being a teen mother
4 = Breastfeeding norms
5 = Early introduction of solids
6 = Breastfeeding concerns, barriers, challenges
7 = Advantages of breastfeeding
8 = Process over time

Early breastfeeding efforts were also shaped by the lactation support that teen mothers received from clinicians immediately following the birth and thereafter. Lactation support varied tremendously: teens reported interactions that were helpful, encouraging, and responsive, or judgmental, rushed, and stigmatizing (Dykes, Moran, Burt, & Edwards, 2003; Hunter et al., 2015; Nelson, 2009; Pentecost & Grassley, 2014). Teens without strong support from a trusted clinician experienced healthcare as fragmented, impersonal, and task-oriented (Dykes et al.; Hunter et al.; Smith et al., 2012). Bureaucratic healthcare practices reinforced teen mothers' passivity (Hunter et al.). The lack of lactation support dampened teen mothers' perseverance when breastfeeding issues (e.g., pain, fatigue, low milk supply, infant teething) surfaced (Condon et al., 2012; de Bairros Tamara, Dutra Sehnem, Mendes Lipinski, Gonçalves Tier, & Deitos Vasquez, 2017; Smith et al.; Tucker et al., 2011; Wambach & Cohen, 2009). If teens also lacked family members to advise them on practical issues, weaning earlier than intended became a real disappointment (Nelson & Sethi, 2005; Wambach & Cohen). Conversely, teens who received lactation guidance from a trusted professional or parenting program were in a better position to weather breastfeeding difficulties (Rossman, Meier, Janes, Lawrence, & Patel, 2017).

Stigma

A stigmatizing gaze by professionals and strangers further complicated teen mothers' breastfeeding experience. Teens felt exposed, watched, judged, and stereotyped (Benson, 1996; Dykes et al., 2003; Hunter et al., 2015; Nelson, 2009; Nesbitt et al., 2012). Surveillance of teen mothers in healthcare settings reflected pervasive stereotypes that teen mothers are immature, irresponsible, dependent on welfare, and incapable of good mothering (Benson; Dykes et al.; Hunter & Magill-Cuerden, 2014; Nesbitt et al.; Woods et al., 2013). Teens were keen to disprove the stereotypes (Benson; Hunter & Magill-Cuerden). Because breastfeeding was endorsed by clinicians, breastfeeding offered one way to affirm they were good mothers. They also attempted to gain respectability as good mothers by bringing their partners to clinical appointments or being vague about where they lived (in disadvantaged neighborhoods) (Benson; Hunter et al.).

Inhospitable Spaces

Teen mothers inhabit spaces that do not accommodate breastfeeding. Being disproportionately low-income, they typically live in disadvantaged communities, attend public schools, work in low-skill positions, and depend on public transportation that tend to be inhospitable to breastfeeding. As teen mothers navigate spaces that do not accommodate pregnant or lactating bodies, they are subjected to disapproving looks and demeaning comments (Condon et al., 2012; Nesbitt et al., 2012). Returning to high school is especially challenging (Hannon et al., 2000; Tucker et al., 2011); when schools do not provide private spaces to pump breast milk, teens resort to using bathrooms or ask infant caregivers to supplement breast milk with formula. In some cases, high school nurses or guidance

counselors accommodate the needs of breastfeeding students (Smith et al., 2012; Wambach & Cohen, 2009; Woods et al., 2013). The most fortunate students attend high schools with on-site day care that provide safe and comfortable spaces to breastfeed (Tucker et al.; Woods et al.). Teens who combine multiple roles (mothering, working, and attending school) face overwhelming challenges (Smith et al.). Some spaces exclude teen mothers' babies as well. For example, a teen who was required to live in a college dorm during her freshman year was not permitted to bring her infant to her dorm room (Smith et al.).

The sexualized breast and the stigmatizing gaze of the stranger created inhospitable spaces. Teens were reluctant to expose their breasts to avoid the male gaze (Dyson et al., 2010). Because breastfeeding in public was taboo, teen mothers avoided public shaming by staying home, breastfeeding in public bathrooms, or bottle feeding in public (Condon et al., 2012; Dykes et al., 2003; Dyson et al.; Hannon et al., 2000; Nelson & Sethi, 2005; Woods et al., 2013). Some male and female family members also expected the teen to breastfeed privately that was problematic in crowded homes (Dyson et al.). In one report, a teen breastfed in the car (Hunter & Magill-Cuerden, 2014). Teens made difficult trade-offs between breastfeeding and spending time with family members or risking isolation (Hunter & Magill-Cuerden).

In summary, contested norms and inhospitable spaces intersected with limited or mixed support and a stigmatizing gaze from clinicians and strangers to undermine breastfeeding. Initial family and partner support was insufficient to support breastfeeding duration when teen mothers returned to school, became employed, and navigated public spaces. Support could also be withdrawn when partners ended relationships, or when grandmothers took on demands that limited their availability and support. Resources were rarely available to fill in the breach. When breastfeeding difficulties arose, lactation consultants were rarely available. The baby's preferences for breast or bottle also played a role when mothers or infant caregivers introduced formula or solids foods to cope with breastfeeding difficulties, interpersonal conflicts, or life events (e.g., returning to school or work, illness of mother or baby). Teens also reported that they discontinued breastfeeding to resume cigarette smoking or to consume soda or alcohol (Woods et al., 2013).

Table 2. Major Findings

• Teens navigate a minefield that undermines their intention to breastfeed and their development of breastfeeding confidence and skill.
• Community norms may favor formula feeding and early introduction of solid foods.
• Nevertheless, many teens initiate breastfeeding for its health benefits and to affirm they are good mothers.
• Teen mothers typically live in disadvantaged communities, attend public schools, work in low-skill positions, and depend on public transportation that tend to be inhospitable to breastfeeding.
• Teens often lack practical support from family members and clinicians to manage breastfeeding difficulties.
• Fragmented healthcare and a stigmatizing gaze from clinicians (and strangers) also undermine breastfeeding.

Discussion

We pooled the findings from 22 qualitative articles published over 2 decades from primarily English-speaking, high-income countries to contextualize and extend what is known about teen mothers' breastfeeding experience. Our results highlight how family and healthcare support, community and cultural norms, and geographic spaces intersect to undermine breastfeeding duration and exclusivity among teen mothers, despite their early attempts to breastfeed. Our synthesis is consistent with a study describing high breastfeeding initiation (91.1%) among teens, but 61% had stopped by 3 months and 87% by 6 months (Cota-Robles, Pedersen, & LeCroy, 2017, p. 176). Weaning occurred early due to breastfeeding difficulties (pain, insufficient milk supply, poor latching, baby self-weaning or biting, or inhospitable spaces for pumping milk). The findings of this meta-synthesis situate these difficulties within the intersecting realities of teen mothers' lives. Breastfeeding support from key players was either lacking or contested by the teen's larger social network of peers and family or eroded over time. Mothers responded to community norms favoring formula feeding, the early introduction of solids, and stigma. To avoid public embarrassment and the male gaze, teens were consigned to breastfeed in private spaces. Babies also made their preferences known as formula and solid foods were introduced. Infants were also weaned when teen mothers lacked lactation guidance (Wambach & Cohen, 2009; Woods et al., 2013).

Breastfeeding is saturated with meaning for teens. Teens are well aware of the benefits of breast milk but are sensitive to public and professional stigma for being young, single, low-income, or of color (Hans & White, 2019; SmithBattle, 2013). Extensive research has documented that teen mothers are motivated to be good mothers and to defy the stereotypes that young mothering ruins their lives and harms their children's health and development (Anwar & Stanistreet, 2015; Conn, de Figueiredo, Sherer, Mankerian, & Iverson, 2018). Although breastfeeding may demonstrate to middle-class professionals that teens are good mothers (Hunter & Magill-Cuerden, 2014), choosing to breastfeed is risky in light of mixed support from family members, limited lactation guidance, material hardships, conflicting norms, and inhospitable spaces. Breastfeeding may be foiled by personal embarrassment, leaky or painful breasts, tensions in interpersonal relationships, withdrawal of family/partner support, and the baby's preferences. Teens who feel pressured to breastfeed by clinicians or family members may be concerned about letting people down or of confirming stereotypes if they stop breastfeeding (Nesbitt et al., 2012). Compared with middle-class

women, teen mothers can rarely count on unqualified support or the emotional and economic resources that sustain breastfeeding. Rather, conflicting norms and inhospitable spaces combine to create trade-offs between good versus bad mothering, between breast versus formula feeding.

Social Worlds Collide

"The lure of the bottle" (Hunter & Magill-Cuerden, 2014, p. 49) conditions teen mothers' infant feeding decisions and practices. Clinicians are more often lured by the breast and its health benefits. These benefits may be exaggerated by studies that do not adequately control for background differences between women who breastfeed and those who do not. Geronimus (2013) makes this point forcefully: "…On average, compared with other mothers, US mothers who breastfeed are more highly educated, economically better off, disproportionately White, have sufficient job flexibility to breastfeed, have a cultural commitment to and social support for breastfeeding, and have sufficient nutrition and low stress levels to produce the necessary milk supply. Accordingly, scientists should not be surprised to find that breastfed babies have lower adult rates of obesity, diabetes, and hypertension. However, they should be cautious in the extent to which they attribute this association to the direct impact of breastfeeding, per se, because populations with low breastfeeding rates differ from those with high rates… (p. 558)." As our findings suggest, the lure of the breast versus bottle reflects social worlds that differ markedly by meanings, cultural norms, and geographic spaces. The social distance between clinicians and teen mothers should enjoin nurses to be aware of professional and scientific prejudices and to be sensitive to the plight of teen mothers as they traverse the minefields associated with breastfeeding.

Although professional authority and expertise may encourage teens to initiate breastfeeding, routinized care and a stigmatizing gaze can spiral into miscommunication, ineffective care, and health disparities (Hall, Kusunoki, Gatny, & Barber, 2015; Sheeran, Jones, & Perolini, 2019; SmithBattle, 2013). Stigma is described in many qualitative reports (Anwar & Stanistreet, 2015; Banister, Hogg, Budds, & Dixon, 2016; Recto & Champion, 2018) and may help to explain the differential treatment of teen mothers in U.S. maternity settings. Based on the Baby-Friendly Hospital Initiative (BFHI) and the Ten Steps to Successful Breastfeeding, teen mothers (age 18–19) reported receiving less nursing support to initiate breastfeeding than mothers aged 30 or older (Sipsma, Jones, & Nickel, 2017). Teen mothers were also more likely to receive a pacifier at the hospital and less likely to room in with their babies, practices that are less conducive to breastfeeding. Teen mothers who reported rooming in with their babies were four times more likely to breastfeed exclusively at 1 week compared with teens who did not room in with their babies. Sipsma et al. (2017) concluded that these findings "highlight possible inequities in exposure to maternity care practices" (p. 278). Olaiya, Dee, Sharma, and Smith (2016) also reported breastfeeding outcomes for teen mothers (age 12–19) using national data on BFHI practices. Of the nine BFHI-aligned maternity practices teen mothers experienced, four were experienced by 80% of teens (receiving information about breastfeeding, receiving assistance with breastfeeding, rooming in with the newborn, receiving a phone number to call for lactation assistance after hospital discharge) but only 7% reported all five of the practices associated with positive outcomes, and 9.6% reported receiving none (p. 19). Any breastfeeding for ≥8 weeks was 40% lower than for women ≥age 20; and exclusive breastfeeding was approximately 25% lower than for women ≥age 20.

Defying Stereotypes

Stereotypes also showed up in teen mothers' accounts of their efforts to defy the stereotypes to demonstrate their worth (Benson, 1996; Hunter & Magill-Cuerden, 2014). That some teens applied the stereotypes to other teen mothers demonstrates the pervasiveness of stigma (Ellis-Sloan, 2014; Jones, Whitfield, Seymour, & Hayter, 2019). In the context of stigma, teen mothers worked to shore up their worth by prioritizing the baby's needs and initiating breastfeeding. For similar reasons, teen mothers reported dressing infants in their best clothing and modifying their own appearance (Banister et al., 2016; Ponsford, 2011). Unfortunately, inhospitable and bureaucratic healthcare spaces reinforce teen mothers' passivity and alienation that may contribute to their social isolation, psychological distress, and reluctance to keep appointments or seek help (Hall et al., 2015; Hunter et al., 2015; SmithBattle, 2013).

Findings from this meta-synthesis suggest that breastfeeding teen mothers often lacked breastfeeding support in maternity units and access to lactation guidance after hospital discharge (de Azevedo Mazza et al., 2014; Hunter et al., 2015). Healthcare was fragmented and largely unavailable to address breastfeeding challenges as confirmed by other studies (Cota-Robles et al., 2017; Poole & Gephart, 2014). Even in the best of circumstances, teen mothers with strong family or partner support found it difficult to persevere when breastfeeding norms were weak and interpersonal and geographic spaces did not accommodate lactating mothers (Condon et al., 2012; de Azevedo Mazza et al., 2015).

The assumption that mothers are the primary decision makers in how they will feed their babies (de Azevedo Mazza et al., 2014; Wambach & Koehn, 2004) is overly simplistic and divorced from teen mothers' social worlds. Because of their youth, teen mothers tend to coreside with family members who participate in infant care. Family members may disagree on infant feeding and disagreements may introduce family tensions (Hunter & Magill-Cuerden, 2014). Other infant caregivers may be relied upon when teen mothers return to school or work. The infant feeding practices of these many players may support breastfeeding or encourage early weaning and the introduction of solid fools.

Strengths, Limitations, and Future Research

Although a medical librarian was consulted to assure that our search was exhaustive, we may have missed relevant

Clinical Implications

- Nurses are urged to be sensitive to the wide social distance that exists between themselves and teen parents in material resources, norms, and values.
- Include teen mothers' significant others in discussions on infant feeding.
- Nurses can use their professional authority to advocate for the implementation of probreastfeeding practices for all mothers.
- Advocating for breastfeeding must be tempered by an ethos that demonstrates respect for mothers' infant feeding decisions.
- Pregnant teens are the experts on their personal situation and know firsthand the support available to them and the inhospitable spaces they will navigate.
- Nurses are called to challenge stigma and advocate for patient-centered and strength-based care that welcomes teen mothers, family members, and partners to clinical settings.

studies. Our findings are also limited by the quality and scope of the studies. Inclusion criteria, sample characteristics, and procedures for collecting and coding data were not always well described, raising concerns about the quality of individual studies. For example, it is unlikely that data were saturated when individual interviews were limited to 15 minutes (de Azevedo Mazza et al., 2015) and focus groups lasted less than 50 minutes (Wambach & Cohen, 2009).

Because most primary studies in this review were cross-sectional, longitudinal studies are needed to explore how breastfeeding trajectories unfold in response to critical events (e.g., return to school, loss of housing, relationship conflicts, maternal or infant illness, postpartum depression) and family and community norms and resources. Recruiting teen mothers from varied settings (e.g., foster care, homeless shelters, day care programs) might reveal additional (in)hospitable spaces for breastfeeding. Investigating the impact of adverse childhood experiences and recent stressful events on teen breastfeeding should also be considered because both are associated with teen mothering (SmithBattle & Freed, 2016) and with suboptimum breastfeeding outcomes in two U.S. studies (Kitsantas, Gaffney, Nirmalraj, & Sari, 2019; Ukah, Adu, De Silva, & von Dadelszen, 2016). Unfortunately, these two studies did not address maternal age as a covariate.

Although teen mothers in the United States are disproportionately and increasingly disadvantaged (Driscoll, 2014), economic disadvantage was often invisible in the primary studies. This omission is curious because material hardships make it difficult to purchase nutritious food and breastfeeding supplies. Poverty also contributes to high levels of stress (Mollborn & Morningstar, 2009); strains family and partner relationships (Mollborn & Jacobs, 2012; Sherman, 2017); and is associated with unstable or crowded housing (SmithBattle, 2019). Because these factors interfere with breastfeeding, future research should report teen mothers' socioeconomic status and their exposure to food insecurity and housing instability.

Clinical Implications

Nurses are powerful advocates for breastfeeding. They can extend their authority and expertise by advocating for the full implementation of BFHI policies for all mothers, regardless of maternal age (Olaiya et al., 2016; Sipsma et al., 2017). Pressing health systems to provide lactation support in early postpartum and thereafter (Tucker et al., 2011) is essential for helping teen mothers develop breastfeeding skill and confidence. Referring pregnant and parenting teens to parenting groups and resources that provide nutrition and breastfeeding supplies are also recommended. Advocating for breastfeeding, however, must be tempered by an ethos that demonstrates respect and sensitivity, irrespective of maternal age and infant feeding decisions. Pregnant teens are the experts on their personal situation and know firsthand the support available to them and the norms and spaces they must navigate. Their decisions should be respected (Hunter et al., 2015) in recognition that infant feeding decisions and practices are influenced by other infant caregivers and inhospitable spaces. For these reasons, they deserve to be fully informed on formula feeding and breastfeeding in a dialogue (Brand, Morrison, & Down, 2014; Pentecost & Grassley, 2014; SmithBattle, 2013) that avoids treating them as passive recipients of professional expertise (Hunter et al.). Including grandmothers and partners in clinical care whenever possible may help to sustain breastfeeding (Tucker et al.) as suggested by a recent probreastfeeding clinical trial that included teen mothers and grandmothers (da Silva, Nunes, Schwartz, & Giugliani, 2016).

Healthcare settings should be hospitable. Clinicians are called to challenge a stigmatizing gaze and advocate for patient-centered and strength-based care that welcomes teen mothers, family members and partners (Brand et al., 2014; Conn et al., 2018; Kiselica & Kiselica, 2014). Group models of clinical care should be considered whenever possible. Clinical trials of group prenatal care have shown improvement in birth outcomes for teen mothers (Trotman et al., 2015) and emotional and financial support from partners who attended at least one session (Smith, Buzi, Kozinetz, Peskin, & Wiemann, 2016). To our knowledge, breastfeeding outcomes associated with group care have not been studied. Group well-child care (Bloomfield & Rising, 2013) may also prove helpful in fostering partner and peer support for coping with parenting, infant feeding difficulties, and stigma.

In conclusion, teen mothers' infant feeding decisions and practices are socially embedded. Intersecting contexts help to explain why rates of breastfeeding duration and exclusivity among teens are low relative to older mothers and to the high rate of breastfeeding initiation by teens. As this study documents, teens navigate a minefield of contradictory norms and inhospitable, stigmatizing spaces, as captured in teen mothers' accounts and in the disparities

in implementing probreastfeeding policies by maternity sites. These lived realities call clinicians to: respect teen mothers' infant feeding decisions; develop patient-centered and strength-based care; challenge stigmatizing healthcare practices; welcome teen mothers' significant others to clinical settings; and press health systems to fully implement probreastfeeding policies. Doing so is aligned with the broad goals of promoting reproductive justice and eliminating health disparities for all girls and women (Hans & White, 2019). ✣

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