Breastfeeding Experiences of Urban Adolescent Mothers

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This qualitative descriptive study examined the breastfeeding experiences of urban adolescent mothers using a combination of focus groups and semi-structured interviews. Analysis of verbatim interview text, field, and debriefing notes was undertaken to discover categories, themes and an emerging conceptual framework. Twenty-three teens, between the ages of 14 and 18, enrolled from two postpartum clinics described the process of teens' breastfeeding decision-making, initiation, continuation, and termination of breastfeeding. Roughly half of the teens were currently breastfeeding and the other half had weaned their infant within the last six months. Adolescent mothers chose breastfeeding mainly for infant health reasons, closeness and bonding. Positive and negative events; barriers and facilitators to continued breastfeeding; and types of support received during breastfeeding illuminated the experience starting in the hospital and extending over time. Among those who weaned, a combination of primary and secondary obstacles or problems, such as perceptions of insufficient milk supply, nipple/breast pain, time demands of school or work, problems with pumping, and feeling overwhelmed and frustrated led to weaning. Many who weaned did not seek out available help and ultimately many reported regret about weaning earlier than intended. Those who continued breastfeeding beyond six weeks reported significant emotional, informational and instrumental support from family, friends, school, and their babies. Implications for nursing practice and research are discussed.

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In 2002 approximately 426,000 adolescents between the ages of 15 and 19 gave birth in the United States (Martin et al., 2003). Low breastfeeding initiation rates as well as short duration of breastfeeding are common in this population. For example, among 29,589 low-income pregnant women in Missouri, 75% of the adolescent mothers never breastfed or did so for only 1 week (Misra & James, 2000). Thus, adolescent breastfeeding rates fall well below the Healthy People 2010 objectives that recommend 75% of all mothers initiate breastfeeding, 50% continue to 6 months, and 25% continue to 1 year (Department of Health and Human Services, 2000).

Interventions to increase breastfeeding initiation and duration are needed for this vulnerable population. However, to better tailor interventions to teen mothers, especially disadvantaged teens, more description is needed of the breastfeeding experiences from the teen’s perspective. Although there are multiple studies concerning adolescents and breastfeeding that contribute significantly to knowledge in this area, there are few recent descriptive or qualitative studies that focus explicitly on the breastfeeding experiences of American teens (Hannon, Willis, Bishop-Townsend, Martinez, & Scrimshaw, 2000; Nelson & Sethi, 2005; Spear, 2006). One recent study described experiences of breastfeeding adolescents in the United Kingdom (Dykes, Moran, Burt, & Edwards, 2003). Other studies are many years older (Baisch, Fox, & Goldberg, 1989; Benson, 1996; Lipsman, Dewey, & Lonnerdal, 1985; Swanson, 1988). In particular, empirical evidence related to the urban, disadvantaged adolescent breastfeeding experience is needed because of low breast-feeding rates in this subpopulation. Such evidence can be used to design...
and tailor interventions to assist these teens in breast-feeding decisions and support. Therefore, the purpose of this study was to examine urban adolescent mothers’ breast-feeding experiences to fill this evidence gap by providing description from a contemporary American perspective.

BREAST-FEEDING EXPERIENCES OF TEEN MOTHERS

Descriptive studies of teen mothers’ experiences illuminate breastfeeding as a bio-psychosocial process including negative and positive aspects as well as the importance of social support during the initiation, establishment, and discontinuation of breastfeeding. This literature review is limited to findings from recent research literature that either focused primarily on or presented information incidentally on teen breastfeeding experiences. Comprehensive reviews of more general studies or of studies on decision-making and breastfeeding experiences conducted prior to 2000 are available for the interested reader (Bar-Yam, 1993; Wambach & Cole, 2000).

Negative Aspects of Breastfeeding Among Teen Mothers

Several barriers or negative events may occur during establishment and maintenance of breastfeeding among teen mothers and in some studies were cited as reasons for weaning. Pain during breastfeeding (e.g., sore nipples, engorgement, mastitis) was cited as both a problem (Dykes et al., 2003; Nelson & Sethi, 2005) and a reason for weaning (Brownell, Hutton, Hartman, & Dabrow, 2002; Hannon et al., 2000; Spear, 2006). Other researchers also identified that difficulties with positioning and latch on, fatigue, and medical complications occurred during breastfeeding (Dykes et al., 2003; Hannon et al., 2000; Nelson & Sethi, 2005; Spear, 2006). In addition, combining breastfeeding with return to school or work caused anxiety and concern for teens in both the studies by Hannon et al. (2000) and Spear (2006), and they expressed particular reluctance to use a breast pump in these settings. Embarrassment during breastfeeding in the presence of others or outside the home was noted repeatedly (Brownell et al., 2002; Dykes et al., 2003; Guttman & Zimmerman, 2000; Nelson & Sethi, 2005; Raisler, 2000) and may be a strong concern for adolescents due to their evolving body image. In contrast, Spear reported that many teens in her study denied embarrassment at breastfeeding around family or friends. Hannon et al. described a subtheme of teens’ unease with the act of breastfeeding that involved a discomfort with using the breast for feeding and others’ criticism of public breastfeeding. Similarly, a lack of confidence and a feeling of being judged by others during the early breastfeeding period were highlighted by Dykes et al. (2003). Nelson and Sethi (2005) in their description of the breastfeeding experience described the early breastfeeding period as one of “learning how to breastfeed” with problems being offset by patience and support from others.

Benefits

Researchers also reported positive aspects of breastfeeding. Closeness and bonding were cited as benefits of breastfeeding in some studies (Brownell et al., 2002; Nelson & Sethi, 2005). In addition to bonding, African American teen mothers in the study by Brownell et al., 2002 reported less infant illness and optimal nutrition as benefits of breastfeeding. Likewise, the grounded theory study by Nelson & Sethi (2005) involving 15- to 19-year-old Canadians who breastfed for relatively long durations illuminated many “good things” such as “advancement of their infants’ health, the close relationship, the enjoyment of breastfeeding, personal changes and evolution, convenience, and economic savings” (p. 620). Almost all the teens in the study by Spear (2006) defined their breastfeeding experiences using terms such as worthwhile, great, and excellent (p. 110).

Support

The influence of personal and professional support was important in the initiation and maintenance of breastfeeding. Teens’ mothers, partners, friends, or sisters encouraged breastfeeding by giving advice and urging perseverance in the face of barriers (Hannon et al., 2000; Nelson & Sethi, 2005). Dykes et al. (2003) specifically focused on and described support needs of adolescent mothers in England, citing emotional, esteem, instrumental, informational, and network support needs from personal and professional sources. Postpartum support from health care professionals was cited in several studies. One 17-year-old mother in the qualitative study by Raisler (2000) spoke of the “really, really good start” that she experienced by breastfeeding her infant immediately postpartum with the help of the midwife (p. 255). In the American study by Hannon et al. (2000), a teen
spoke of how postpartum professional support helped overcome her initial reluctance to breastfeed, stating, “In the hospital they made me try and then she got hooked to it and stopped taking her other milk and I had to breastfeed her” (p. 405). Negative support was also described by teens with pressure to wean from partners and family (Hannon et al., 2000; Nelson & Sethi, 2005). Lack of communication by health care providers regarding the superiority of breast milk was a problem reported by one teen in the Spears (2006) study. In addition, conflicting information offered by health care providers was cited as a hindrance to breastfeeding in the same study.

In summary, the literature indicates that there are both barriers and benefits to breastfeeding for teens. Support systems, both personal and professional, were described and influenced teens’ experiences. Additional descriptive data are needed, especially from disadvantaged and African American teens because breastfeeding rates are lower in these groups (Centers for Disease Control and Prevention, 2004).

STUDY DESIGN AND METHODS

A combination of data collection methods was used for this qualitative descriptive study: focus groups and individual semistructured interviews. Initially, focus groups were used, but due to poor attendance at three scheduled groups, individual interviews in the participants’ homes were instead conducted to complete the study. Thus, this study is illustrative of the principle of emergent design common to qualitative studies, that is, fitting the design to the needs of the participants and the purpose of inquiry (Patton, 2002).

The researchers developed the interview questions based on the purposes of the study and focus group methodology, that is, use of introductory questions, transition questions, key questions, and ending questions (Kruger & Casey, 2000). The questions were essentially the same for each data collection technique because the study purposes remained unchanged despite the data collection method change (Table 1). No differences in response quality or depth were discerned using the two approaches. Both types of qualitative methods are appropriate when insights are needed from preliminary studies before a large-scale study or when there is a need to uncover factors relating to complex behavior such as breastfeeding (Krueger & Casey, 2000). Conducting the study using these data collection methods allowed descriptions of the teens’ experiences (Sandelowski, 2000).

Sample and Setting

English-speaking adolescent mothers, between the ages of 13 and 18, who were currently breastfeeding or had breastfed their infants within the past 6 months, were invited from teen obstetric clinics at two urban university-affiliated medical centers. Institutional review boards from each facility approved the study. Informed consent procedures were used with teens consenting for the study without parental approval because they are considered capable of independent consent in pregnancy and health-related research of low risk (Society for Adolescent Medicine, 2003). Thirty-two teens volunteered for participation, and 23 completed the study. Of the nine not completing the study, two did not meet sampling criteria, five were lost to contact, and two voluntarily withdrew. Four teens participated in the first focus group, two in a second, and one attended a third group (thus an individual interview). Four teens who did not
attend a scheduled focus group later participated in 1 of 17 individual interviews.

Data Management and Analysis

Verbatim audiotape transcripts and fieldnotes were used as the basis for qualitative content analysis. Data were initially organized using Q.S.R. NUD*IST-Version 4 (Qualitative Solutions and Research, 1997). The analysis was based on guidelines for focus group methodology (Krueger, 1998) and principles of content and question analysis (Morse & Field, 1995). Analysis began after the first group interview with the researchers conducting an immediate debriefing to discuss the need for modifying how the questions were asked. Similar debriefings about response themes were held after all subsequent focus groups and individual interviews. Following transcription of each interview, the researchers separately coded the data. They then separately aggregated the codes to develop categories representing the study purposes. A descriptive summary of each category was written. Discussion occurred to reach agreement on the coding and categories. From the categories, more abstract themes reflecting the teens’ perceptions and experiences were identified. Finally, an overall interpretation of the findings and tentative conceptual framework were developed.

Steps taken to establish data trustworthiness (Kruger & Casey, 2000; Morse & Field, 1995) included (a) pilot testing questions for clarity; (b) careful listening and observing during interviews for response ambiguities; (c) conducting member checks; and (d) searching for rival explanations during analysis by reexamining the data and discussing competing themes until reaching agreement. Data collection ended after the 23rd participant, when it was determined that data saturation had been reached, that is, no new information was heard.

RESULTS

The teens were between 14 and 18 years of age ($M = 16.3, SD = 1.2$). There were 14 African Americans, three Hispanics, five Caucasians, and one African. All teens except one were primiparous, and all were single. Completed education level ranged from seventh grade to high school graduate or general equivalency degree. Only three teens participated in teen parent programs and two were enrolled in “homebound” schooling. Incomes were characterized as low to middle (less than *$15,000 to *$45,000) among the 11 teens who knew their family income.

At the time of the interview 13 (56%) teens were still breastfeeding or providing breast milk via pumping, with a range of 15 to 206 days ($M = 76, SD = 61$). Among those still breastfeeding at time of interview, four were exclusively breastfeeding, and nine were using breast milk and formula. Ten had stopped breastfeeding; duration ranged from 7 to 42 days ($M = 23, SD = 15$), with four weaning at 14 days. At the time of the interview, days since weaning ranged from 2 weeks to 5 and 1/2 months.

Categories developed through coding of the data are listed and defined in Table 2. Through further analysis and abstraction of the categories, a phase-based description of teens’ breastfeeding experiences emerged representing prenatal breastfeeding decision-making, breastfeeding initiation experiences, positive and problematic experiences over time, received support, and continued breastfeeding.

<table>
<thead>
<tr>
<th>Category Label</th>
<th>Category Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision making and reasons for breastfeeding</td>
<td>The process and reasoning that teens used in making their breastfeeding decision.</td>
</tr>
<tr>
<td>Best things about breastfeeding</td>
<td>Positive aspects and outcomes of breastfeeding as perceived by the teens.</td>
</tr>
<tr>
<td>Who helped with breastfeeding</td>
<td>Sources and types of help received in the hospital and after discharge.</td>
</tr>
<tr>
<td>Perceived benefits of breastfeeding</td>
<td>The benefits received as a result of breastfeeding.</td>
</tr>
<tr>
<td>Hospital breast-feeding problems</td>
<td>Problems experienced in the hospital during the initiation of breastfeeding.</td>
</tr>
<tr>
<td>Problems within the first week</td>
<td>Maternal and infant based breastfeeding problems were experienced by teens and ranged in number from none to multiple.</td>
</tr>
<tr>
<td>Problems after the first week</td>
<td>Many types of problems occurred after the first week, many of which led up to weaning the infant or supplementing heavily with formula.</td>
</tr>
<tr>
<td>Problems after 3 months</td>
<td>The breastfeeding problems experienced after 3 months reflected infant and maternal issues.</td>
</tr>
<tr>
<td>Overall problems with breastfeeding</td>
<td>The overall or general problems encountered in breastfeeding.</td>
</tr>
<tr>
<td>What keeps you going?</td>
<td>The teens’ quest to continue breastfeeding and the major reasons and ways that was accomplished.</td>
</tr>
<tr>
<td>Weaning</td>
<td>The reasons for and processes used by teen mothers for weaning their babies.</td>
</tr>
</tbody>
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or weaning (Figure 1). The figure depicts the tentative conceptual framework. The findings relative to each of the phases are described along with quotations to illustrate experiences. Some responses were enumerated using frequency calculations to accentuate dominant responses.

**Prenatal Phase—Breastfeeding Decision Making**

Some teens described making their decision to breast-feed prenatally as a process involving thinking about the decision over time; getting informed through reading, videos, and classes; and talking with influential social network members (e.g., their mother, family, friends, nurses, doctors, and school supporters). More teens, however, spoke about why they chose to breastfeed as opposed to the process they used to decide. For seven of the teens having been breastfed themselves was a part of the decision to breastfeed. The main reason for breastfeeding was for the health of the infant; 16 of the 23 teens spoke to reasons such as less infant sickness, breast milk being healthier than formula, and less obesity in breastfed children. The second most frequent reason was the ease of breastfeeding especially for nighttime feedings.

Maternal health and economic benefits were mentioned less as was the naturalness or motherliness of breastfeeding. These attitudinal and social factors resulted in decisions being made before pregnancy \((n = 1)\), in early pregnancy \((n = 6)\), 4 and 5 months \((n = 6)\), 6 months \((n = 1)\), and 7 to 8 months of pregnancy \((n = 6)\).

**Breastfeeding Initiation**

Breastfeeding experiences of the teens during postpartum hospitalization were varied. Four teens reported positive hospital experiences with no problems; the majority experienced some problems, mainly related to learning the mechanics of breastfeeding (e.g., latching \([n = 10]\), positioning \([n = 2]\), and/or nipple problems such as nipple or pain \([n = 3]\) and inverted nipples \([n = 2]\)). Three mothers reported their baby not eating or getting enough and weight loss. Teens who initially had “infant intake” problems often supplemented their newborns with formula.

Positive support from nurses, partners, family, and friends came via hands-on assistance and information regarding problems. There were a few reports of “negative” nursing support consisting of teens feeling ignored, receiving contradictory or inconsistent information, and giving the infants bottles of formula.

**Positive Experiences After Hospital Discharge**

Teens expressed many positives about breastfeeding such as spending quiet time together with their baby, the baby not spitting up, and breastfeeding as “cheaper.” The best thing about breastfeeding for the majority (65%) was the bond and closeness to their infant that breastfeeding conferred. One teen stated, “…you grow a bond with your baby. You can actually see it…So it’s like the closeness that I felt with my baby—I felt like I had her safe, protected and secure.” The ease and convenience of breastfeeding, especially surrounding nighttime feedings, was also positive. “It’s so super easy. Like when it’s bedtime and we’re asleep if he wants to eat in the middle of the night I don’t have to get up and warm bottles and do all that extra stuff. I can just roll over and feed him and we can go back to sleep together.”

Positive experiences were voiced by teens who continued to breastfeed and also by those who had weaned at the time of the interview.

**Problem Experiences After Hospital Discharge**

Problem experiences following discharge from the hospital were described for early (i.e., within the first week of hospital discharge) and later (i.e., after the first week home) in time. The nature of the problems experienced by the teens was consistent with the time period in which they were described. During the first week only two teens reported no problems. Others reported breast-related (inverted nipples, engorgement, leaking, and/or nipple trauma/pain) or latch problems, and insufficient milk concerns such as perceived low milk supply or infant weight gain problems. Maternal physical
problems such as a urinary tract infection and fatigue or psychosocial problems such as impatience or lack of family encouragement were reported infrequently. Infant problems such as jaundice also occurred infrequently.

After the first week maternal problems included low milk supply, breast/nipple problems, school/work separation, mastitis, maternal anemia, as well as psychosocial problems such as depression, frustration, and embarrassment while nursing in public. Infant problems included poor weight gain and, infrequently, infant hospitalizations.

Among long-term breastfeeding mothers (i.e., longer than 3 months) problems included infant teeth, infant pulling on the mother’s shirt, mastitis, and a perceived need for strict maternal diet/nutrition practices. One teen anticipating weaning stated, “another thing is I don’t like eating healthy. So I don’t want to stop him from getting the stuff he needs...I can’t eat all them vegetables. I hate milk.”

Support

Early support came from nurses, the teen’s mother, father of the baby, and other family and friends. They helped with technique, teaching, and encouragement. For example, one teen commented, “The nurse who was here, she helped her really to latch on. And plus my boyfriend helped me out a lot with that.” Negative support also was reported, with at least three teens receiving direct discouragement from their mothers. One teen stated, “my mother she don’t like it...ugh, why don’t you give her a bottle.”

Later support in the form of providing space and time for breast pumping, encouragement, and advising came from the teens’ mothers, family, school personnel, the baby, day care teachers, and a pediatric office nurse. One teen commented about her baby helping her because “he didn’t have no trouble.” Encouragement from other teen mothers was described. One of two teens individually interviewed who were close friends and who were still breastfeeding beyond 6 months noted, “we worked together this summer and even when I didn’t want to pump, she said pump, so you supply more for him and all this stuff, so she really helps me out a lot.” School settings were also described as supportive when they provided time and space for pumping or to nurse the baby when in-school day care was available. One teen noted, “They’re very, very, very supportive at my school. Like all the principals and everybody knows me. They had a nurse’s room but she actually moved out so they let me have the room for breastfeeding.”

It was apparent from longer-term breastfeeding mothers (i.e., longer than 3 months) that emotional, informational, and instrumental support assisted the teens in their breastfeeding efforts along with other factors that kept them breastfeeding. The long-term breastfeeding mothers all reported support from their own mother or father, mainly in the form of encouragement and guidance. All three long-term breast-feeders noted support from their school, with one teen having her baby at an on-site day care center.

Continued Breastfeeding

What kept the teens breastfeeding during good times and bad? The perceived health benefits for infant, convenience and ease, and maternal emotional benefits were reported as contributing to persistence in breastfeeding. One teen mother stated “love, growth, love” is what kept her going. More practically, pumping, not giving formula, having baby at school, and relieving nipple pain assisted the teens in continued breastfeeding. Continued breastfeeding was also related to teens’ self-esteem. One teen, who had breastfed for 2 weeks and pumped for another 2 weeks, commented that along with knowing that breastfeeding was better for the baby, “another reason is just to prove to my mom, you know, it ain’t me that was going to make it stop.” Another teen, commented with apparent pride that “It felt good that I breastfed. It made me feel good.”

Weaning

All of the teens in this sample who weaned did so before 6 weeks postpartum (n = 10). One of those mothers had intended to breastfeed only 1 week, and she did so. The majority of teens who weaned had intended to breastfeed longer than they actually did.

Why did these teen mothers wean their babies? A combination of primary and secondary obstacles of various kinds led to weaning. A major reason centered on insufficient milk—perceived or real low milk supply, not knowing if the baby was getting enough, and perceptions that the baby was unsatisfied at the breast. One young woman who weaned very early (8 days after birth) spoke of difficulty in getting the baby latched and receiving help from the nurses in the hospital. However, “it seemed she was latched on but she wasn’t and she ended up losing weight and so
that’s when I started pumping and I did that for the rest of the half week that I did breastfeeding. And it seemed like I wasn’t getting enough and that’s when I stopped.”

Pain, nipple soreness, and/or bleeding, soon after birth, contributed to weaning between 1 and 6 weeks for at least five of the teens. One teen was especially upset with her experience stating: “I promised I would do it for a week but he was greedy and it hurt...I will never do it again!”

Teens also spoke to embarrassment with public breastfeeding or reluctance to breastfeed outside their home and thus switching to the bottle to avoid breastfeeding in public. One teen described her experience as: I wanted everybody to see her and since I was afraid to breastfeed out in public I got nervous and stuff about it and I talked to the doctor and they said that I could go ahead and switch her on just regular formula. And if I still wanted to I could keep pumping and give that to her instead of having like regular breastfeeding out in public. So I did that for another week and then it got real difficult because too much milk was coming out so I went ahead and started bottle-feeding (breastfed for 3 weeks).

Other reasons for weaning centered on returning to school, work, or just not having time to breastfeed with a busy schedule. One teen reported a combination of these reasons: “I was focusing on getting back into school and I was trying to figure out how could I breastfeed her exclusively with going to school and trying to find a job. I was always going here and there and she didn’t get enough to eat because I never had time. So I started feeding her the bottle during the day and breastfed during the night and then after a while my milk stopped coming.”

How did the teens wean? Some stopped abruptly (e.g., a teen diagnosed with thrush at 6 weeks). Others progressed gradually to weaning. A typical early weaning example often included early postpartum supplementation with formula for technique problems, infant weight loss, or perceived low milk supply; then pumping/expressing breast milk temporarily; and gradually tapering off at the breast and pumping due to frustration with the process. These mothers faced the primary obstacle of providing sufficient milk for their babies but then encountered secondary obstacles such as difficulty with pumping (either too little or too much milk), or having to return to work or school. Nine of the 11 mothers who weaned had access to some type of breast pump and many perceived difficulties with the pumping process.

Repeatedly, the young mothers described instances of frustration and apparent difficulties with accessing support, even when it was available. Although teens were under the care of a health care provider who encouraged breastfeeding, only one teen requested or sought help in the face of an obstacle that led to weaning.

Finally, among the teens who weaned at the time of the interview many reported regret. In various ways teen expressed disappointment. One teen expressed, “It was fun—I wish I wouldn’t have stopped.” Another teen admonished herself stating, “I shouldn’t have stopped breastfeeding, I wanted to breastfeed him longer.” A sense of sadness seemed apparent at having to stop: “I wish I could have kept on breastfeeding.”

Timing of Breastfeeding Decision-Making and Outcomes (Weaning and Experiences)

To discern if there were differences, timing of the original decision to breastfeed was examined among those who continued to breastfeed and those who had weaned at the time of interview and in terms of positive and problem experiences. Timing of decision was spread across the gestation as noted earlier; however, among those teens who continued to breastfeed after 3 months all had made early pregnancy decisions. Among those who had weaned by 3 weeks postpartum, one had made an early pregnancy decision, and the other four made their decision between 5 and 8 months of pregnancy. Early decision-making did not appear to guarantee positive experiences however, as both short-term and long-term breastfeeding teens experienced early and ongoing problems.

Summary Interpretation of Breastfeeding Experiences

The breastfeeding experiences of teen mothers in this study began with the decision-making process and culminated in breastfeeding initiation following their infants’ births. Timing of decision to breastfeed was spread across the gestational period among the teens; however, the longer term breastfeeding mothers in this sample had made early pregnancy decisions to breastfeed. Among those who had weaned by 4 weeks postpartum, most had made a decision to breastfeed mid to late pregnancy. Early experiences did appear instrumental in the continuation and cessation of breastfeeding. For those who weaned in the
first few weeks, problems in mechanics of breastfeeding and establishing lactation often led to supplementation or use of a breast pump to augment lactation. Those problems, coupled with an inability or low motivation to seek assistance, clearly contributed to early weaning. For those who persisted in breastfeeding longer than 3 months, perceived benefits of breastfeeding influenced continued efforts along with supportive networks that directly influenced the continuation through emotional, informational, and instrumental support.

**DISCUSSION AND CLINICAL IMPLICATIONS**

This study provided additional description of what it is like to breastfeed as a teenage mother. About half of this sample was still breastfeeding, and half had weaned at the time of the interviews, providing information about current and overall breastfeeding experiences. Both prenatal and postpartum clinical implications can be drawn from the findings. Clinical interventions that acknowledge the developmental characteristics of the teen will be most effective. These suggestions may be useful to all breastfeeding women, but are intended to address the specific developmental issues of adolescence. Focus on the present, concern with body image, and strong identification with the peer group are known adolescent developmental characteristics that influenced recommended clinical interventions (American Academy of Child and Adolescent Psychiatry, 1997).

**Prenatal Education and Support**

Study findings provided a description of the process of decision-making and when during pregnancy the infant-feeding decision was made. With the exception of one prepregnancy decision, roughly one third of those reporting decided in each of the three trimesters of pregnancy. These findings parallel Nelson and Sethi (2005) who found both prepregnancy and midpregnancy decisions to breastfeed. Mid- to late-pregnancy decisions were prominent among those who weaned by 4 weeks and early decisions were prominent in long-term breastfeeders. As found in Hannon et al. (2000) and Nelson and Sethi (2005), a major reason for breastfeeding was for infant health reasons. These findings reinforce that early and repeated exposure to information about breast-feeding benefits during pregnancy may assist the teen in making the breast-feeding decision. Simple facts about reduced infant ear infections and allergies are suggested as opposed to more long-term benefits that teens may have a harder time identifying with.

The early (first week) and later (after first week) problems that this sample of teens encountered are similar to those reported in other studies (Hannon et al., 2000; Nelson & Sethi, 2005; Spear, 2006) and suggest additional prenatal education needs. Teens need education on breastfeeding basics to help them avert preventable problems such as sore nipples. Breastfeeding classes should be provided in the prenatal clinic during appointments or school settings at convenient times. The study findings suggest that they need simple concrete information on frequency of feeds, latch-on and positioning, monitoring infant intake and output, choosing and using a breast pump, and storing expressed milk. During class or prenatal visits, recognition of teens’ concerns about nursing in public can be dealt with in a sensitive manner by stressing the naturalness of breastfeeding and how to use clothing for covering during feedings. Counseling should include how they might provide breastmilk for their infants while they are out with their friends. Teens should be informed that they will need support and be encouraged to ask family and friends for support. Teens should be provided with written information on peer counselors, either in teen-mentoring programs or The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), for support.

**Postpartum Education and Support**

The teens in this study had some problems in the hospital with initiating breastfeeding. These problems were similar to those reported in the adult and adolescent breastfeeding literature (Dykes et al., 2003; Hannon et al., 2000; Nelson & Sethi, 2005). Prenatal education as noted might assist teens to anticipate what to expect. However, lactation support in the hospital during initiation is paramount to early success (International Lactation Consultants Association [ILCA], 2005). In this study, support in the hospital was mainly positive, although some nurses gave inconsistent information and fed infants bottles of formula. This negative social support, is a phenomenon described in the literature by researchers as influential in health outcomes, especially among disadvantaged at-risk women (Campbell-Grossman, Hudson, Keating-Lefler, & Fleck, 2005; Keating-Lefler, Hudson, Campbell-Grossman, Fleck, & Westfall, 2004; Revenson,
nurses need updated and continuing education to support all breastfeeding mothers, including teens. Furthermore, avoiding supplementation except when medically necessary is a must (ILCA, 2005). In institutions with lactation consultants, it is recommended that every teen mother be given early and repeated assistance to reinforce practices that are known to support lactogenesis. In cases where family and friend support and role modeling are not present, professional support is even more important and should continue after hospital discharge via home visits by nurses. Community or WIC-based peer counselors can also help to support the breastfeeding teen after discharge home (Arlotti, Cottrell, Lee, & Curtin, 1998; Kistin, Abramson, & Dublin, 1994; Shaw & Kaczorowski, 1999). The health care provider should initiate support, as many teens in this study failed to seek expert help with breastfeeding problems despite the knowledge that it was available. These findings echo the sentiments of one teen in the Spear (2006) study who stated, “Nurses should contact you more than once after you go home from hospital” (p. 111).

The findings regarding weaning also provide clinical suggestions. In contrast to teens who weaned early, it appeared teens that who were able to garner available support and information continued to breastfeed. Among those having difficulty or those who had weaned, there were definite misconceptions and lack of knowledge of what was normal or expected. Other research points to the needs expressed by teens for information, emotional, and practical assistance to initiate and continue breastfeeding (Dykes et al., 2003; Hannon et al., 2000; Nelson & Sethi, 2005). Thus, prenatal education as earlier outlined can assist in preventing problems and potential weaning, but ongoing support is important.

Finally, the teens’ return to school or work was a turning point that was either a block to continued breastfeeding or if supported by their school or social network, was merely a transition in their continued breastfeeding. Hannon et al. (2000) also reported challenges of breastfeeding in conjunction with return to school and Nelson and Sethi (2005) reported that returning to work or school played an important part in the decision to continue or end breastfeeding. Therefore, teens need to know how to prepare for returning to work or school. They need to determine how they will care for their infant while in school—they need to speak to and elicit support from their teachers, nurses, and administrators before giving birth to prepare for their return. Supportive prenatal health care providers can encourage teens in this important area. Lastly, the findings clearly point to regret and sadness among teens who weaned earlier than expected. Other research has found similar expressions of missing the closeness of breastfeeding (Nelson & Sethi, 2005), although the teens in that study had longer durations of breastfeeding than this sample and clearly participated more in infant-led weaning. Thus, efforts to educate and support teens to help avert early weaning are important, not only for infant health but also for maternal mental health.

Although negative events and problems were part of the breastfeeding experiences of these teens, so were positive experiences. The best thing about breastfeeding, as reported by the teens, was that it provided a bond with their infants. An older study by Neifert, Gray, Gary, and Camp (1988, p. 472) reported that the closeness of the nursing relationship was the most enjoyable part of breastfeeding in her teen mother sample. Nelson and Sethi’s recent research corroborated that closeness and bonding were important aspects of the breastfeeding experience. Ease of breastfeeding, especially at night, was also a benefit in this sample. This finding was not reflected in the American literature on breastfeeding experiences of teens, although it was cited in the Canadian study by Nelson & Sethi (2005) and in one older Australian study (Benson, 1996). Informing pregnant teens on the bonding and ease that breastfeeding can offer is important.

**LIMITATIONS AND CONCLUSIONS**

A limitation of the study may include the use of two qualitative data collection methods (group and individual interviews). However, there was no evidence that the different techniques influenced responses significantly in nature or depth. Second, the sample was socioeconomically homogenous, and thus findings cannot be generalized to all teenage mothers or to those with different demographic characteristics. However, the findings contribute to the relatively limited knowledge in the area of breastfeeding experiences of urban, mainly African American, single teenage mothers. Finally, the sample was mainly recruited during the 6-week postnatal check-up. Thus, the sample was likely restricted in terms of representation of teens who breastfeed and/or wean after 6 weeks.

The findings suggest that teens are capable of positive breastfeeding experiences but may need
additional support and education due to their age and place in life. This work in describing the breastfeeding experiences of teen mothers is important to tailoring interventions for this vulnerable population. For example, in the first author’s recently completed intervention study, special emphasis was placed on how to breastfeed discreetly and how to combine breastfeeding and return to school by identifying support persons prenatally and learning about and providing a breast pump. Finally, because infants of teens may be at risk socially and healthwise, it is doubly important to give them the best start, that is, through breastfeeding. Thus continued emphasis on improving breastfeeding rates and duration is important to the health of these mothers and their children.

REFERENCES


