



The past is prologue? The long arc of childhood trauma in a multigenerational study of teen mothering

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ARTICLE INFO

Keywords:

Teenage mothers
Trauma
Adverse childhood experiences
Childhood family strengths
Multigenerational research
Longitudinal qualitative research

ABSTRACT

The purpose of this interpretive phenomenological study was to describe intergenerational patterns in adverse childhood experiences (ACE) and protective childhood experiences among teen mothers, their parents and children, and to include social disadvantage as a source of ACE. At the seventh wave of a study that has followed teen mothers and families beginning in 1988 for 28 years, 42 family members were reinterviewed in 2016. Adult participants also completed two tools that identify ACE and childhood family strengths. After narrative data were coded inductively, Interpretive Family Profiles were created to facilitate case and cross-case analysis. Of the 9 participating teen mothers at Time 7, 4 reported few ACE and many family strengths; their parents and children reported similar scores. Of the 5 mothers reporting high ACE, children's scores improved with one exception. Findings suggest that mothers' aspirations to shield their children from trauma was a fragile endeavor for mothers who faced ongoing trauma and economic hardships. Clinicians may facilitate intergenerational repair by capitalizing on mothers' aspirations with trauma-informed care and referrals to community resources. Trauma assessment should also include poverty-related ACE and experiences related to stigma and discrimination.

Despite declining teen birth rates in the U.S. (Martin et al., 2017), teen mothering is identified as a significant public health issue. Beginning in the 1970s, researchers and policy makers raised concerns as study after study reported that teen mothers had poorer social, health, and educational outcomes than older mothers (SmithBattle, 2018a). Although these findings brought national attention to early childbearing, early research exaggerated negative effects by overlooking significant background differences between teen and older mothers (e.g., growing up in disadvantaged families and living in distressed neighborhoods (Braveman et al., 2017; Weed et al., 2015). Studies that controlled for these factors suggest that the effects of young maternal age are negligible or small for low-income teens, but may be greater for teens who grow up with more resources (Diaz and Fiel, 2016). Despite the growing number of studies that offer a more complex perspective on early childbearing (Braveman et al., 2017; Erdmans and Black, 2015), policymakers continue to emphasize teen mothers' poor outcomes (Mollborn, 2017; SmithBattle, 2018a).

Childhood trauma is one of the many understudied factors that potentially contribute to teen mothers' poor outcomes (Hillis et al., 2004). Adverse childhood experiences (ACE) were defined in the landmark study by Felitti et al. (1998) as exposure to child mistreatment or household dysfunction. A graded relationship between ACE and poor health outcomes at mid-life was identified; that is, individuals

reporting ≥ 4 ACE were at greater risk of chronic health conditions (e.g., heart and respiratory disease, cancer) and premature death than those with fewer ACE. Subsequent studies have confirmed this dose-response relationship among adults (Felitti and Anda, 2010) and children; children with more ACE are more likely to experience cognitive, behavioral and health problems in childhood than those with few ACE (Burke et al., 2011; Freeman, 2014). While ACE research has mushroomed over the last two decades, multigenerational studies are rare so little is known about the intergenerational effects of ACE and protective factors.

The original ACE study restricted childhood adversities to family or household dysfunction and did not include the insidious effects of social disadvantage (e.g., housing insecurity, neighborhood violence, racial discrimination) since the original sample was primarily white and employed (Mehra et al., 2017; Sacks and Murphey, 2018). The lack of attention to social disadvantage in ACE studies is a significant omission since adults who report higher ACE during childhood are more likely to report living in poverty as adults (Metzler et al., 2017), and in one small study, impoverished mothers reported more ACE and distress than more advantaged mothers (Steele et al., 2016). In addition, childhood disadvantage predisposes youth to early sex, young parenting, and poor adult outcomes (Kennedy et al., 2017; Mollborn, 2017). The links between poverty, early childbearing, and ACE argue for a broader

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<https://doi.org/10.1016/j.socscimed.2018.09.013>

Received 12 April 2018; Received in revised form 11 September 2018; Accepted 12 September 2018

Available online 13 September 2018

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assessment of ACE (Braveman et al., 2017).

Although childhood traumas are reported by many teen mothers from low-income and minority backgrounds (Erdmans and Black, 2015; Kennedy et al., 2017), few studies have examined childhood trauma using established tools. Hillis et al. (2004) provide an exception; using the original ACE tool, the risk of teen pregnancy increased as women reported an increase in the number of ACE; teen pregnancy occurred only in 16% of women reporting 0 ACE but rose to 53% for women reporting 8 ACE. Teen mothers with more ACE also reported more psychosocial problems at mid-life than those with few ACE. Psychosocial problems included family issues, financial and job problems, and high levels of stress. A dose relationship between ACE and risky health behavior was also reported among pregnant teens and adult women (Chung et al., 2010). However, childhood family strengths (CFS) were inversely related to the number of ACE, and protected teen mothers from psychosocial problems at mid-life (Hillis et al., 2010). No known studies have examined ACE and CFS over 2–3 generations with family members' perspectives on how childhood trauma and family strengths shaped their lives. This issue was explored in the seventh wave of a qualitative study that has followed teen mothers and families for 28 years. Six years had elapsed since the sixth wave in 2010. The primary aim of this sub-study was to describe intergenerational patterns in ACE and CFS among teen mothers and their parents and children and to include social disadvantage as a source of ACE.

1. Design

The Time 7 (T7) study re-interviewed teen mothers and family members who had first participated in 1988–89, when the teen mothers' first-born children were eight months old. All waves were based on interpretive phenomenology (IP) (Benner, 1994). IP is an established qualitative method that reveals self-world relations and varied patterns in human meanings and practices. A major premise of IP is that human beings primarily relate to the world by engaging in practical activities as members of a family, community, social class, and culture; that is, we learn how to act and relate to others by absorbing the meanings embedded in everyday activities (SmithBattle, 2008). These meanings precede us and provide the background intelligibility for our actions. From this perspective, mothers and family members dwell in meaningful life-worlds that are revealed by a) conducting in-depth interviews in ways that preserve the life-world; b) engaging in a circular process to articulate self-world relations; and c) refining and consensually validating findings with others. An interpretive researcher read all data from a minimum of four families at each wave to challenge and refine my interpretations. All studies were approved by a university ethics committee. Participants assented/consented to the study and received gift cards for their participation.

Sample: Ten families and 42 family members participated at T7, including 9 teen mothers and 1 partner; 22 offspring (\geq age 12) and 2 of their partners; and 8 grandparents (teen mothers' parents) (Table 1). In the original study in 1988, 16 teen mothers participated; they were single, non-Latina White or African-American (Black), and raising a first-born infant. Nineteen grandparents, three partners and one sibling of teen mothers also participated. Families were diverse with respect to grandparents' marital status, education, and income. Teen mothers' first-born offspring were invited to participate for the first time at T4; other offspring (\geq age 12) were invited at T6. At T7, mothers' ages ranged from 43 to 46 years; grandparents–63 to 82; and offspring–15 to 28. Four participating grandparents had died by T7. Despite attrition of six families, families remained diverse by marital status, education, income, and race.

Procedures: Data were collected in fall 2016 in participants' homes; four participants were interviewed by phone. Former teen mothers, partners, and offspring who were parents (and their partners) were interviewed twice about a month apart; two sessions elicited participants' responses to four Interview Guides (Table 2). The second session

was also used to clarify responses from the first session. Two Interview Guides structured the one session with grandparents and non-parenting offspring. Interview Guides were modified for T7 to reflect study aims and participants' older ages. Mothers and grandparents provided an update on life events since T6 (*Life History Review*). *Coping Interviews* asked participants to describe difficult and rewarding situations. Non-parenting offspring described their relationships and activities related to family, school, work, and community (*Child Interview*); the version of the *Child Interview* used depended on the child's age. The *Family Routines Interview* prompted parents to describe daily routines and how current routines compared to their childhood experience; participants typically recalled positive and negative childhood experiences and reflected on how these experiences shaped their lives. Teen mothers and grandparents completed the ACE and CFS tools after the *Life History Interview*; adult offspring completed the tools after the *Child Interview* or *Becoming a Parent Interview*. The latter interview queried offspring who had become parents (since T6) about the circumstances of the pregnancy and birth, how parenting had changed their lives, and role models for parenting. Interview sessions lasted a maximum of 1.5 h.

The original ACE tool identifies exposure to child abuse and household dysfunction before age 18 (Felitti and Anda, 2010). Items include parental separation or divorce; being emotionally, physically or sexually abused; and household members' problems related to crime, drugs, alcohol, or partner violence. The total number of adverse experiences is summed to provide an ACE score for a maximum of 10. A modified version, created by the author, included 10 or 11 additional items for a maximum score of 20 or 21 (Table 3); items came from the literature on teen mothering and teen mothers' reports of difficult childhood experiences from earlier waves of the study (e.g., being bullied in school, spending time in foster care, witnessing violence, being put down as a teen mother). Since the last item was only relevant for teen mother participants, the total score (20 or 21) for each person depended on which modified version was completed.

The CFS tool contains 7 statements that represent positive family childhood experiences such as "People in your family felt close to each other," "Your family was a source of support," "You felt loved" (Hillis et al., 2010). Responses ranged from "never true" to "very often true." "Often true" or "very often true" was scored as 1, for a maximum score of 7.

Data Management and Analysis: Interviews were digitally recorded, professionally transcribed, corrected for accuracy, and treated as a meaningful text (Benner, 1994). In the first stage of analysis, family members' interviews were read as a set and marked with codes in the margins of transcripts. Early codes were refined as additional transcripts were analyzed. Coded excerpts were then copied and moved as a block to Interpretive Family Profiles (IFPs). After IFPs were created, I reviewed ACE and CFS scores for each family member. Because a graded relationship has been established between ACE \geq 4 and poor outcomes for adults and children (Felitti et al., 1998; Freeman, 2014), a score of 4 on the original tool was used as the cut point for high/low ACE. ACE scores over 2–3 generations were used to categorize families as stable, improving, worsening, or mixed. Patterns were then examined in light of participants' narratives with a search for data that were consistent and inconsistent with ACE and CFS scores.

2. Findings

One teen mother did not participate at T7; her family's data were excluded from this analysis. Of the nine participating teen mothers, four reported $<$ 4 ACE and high CFS scores, suggesting few childhood traumas and many family strengths. Three of these teens were White and one was Black; none were disadvantaged as children. Because their participating family members also reported low ACE and high CFS, these families were categorized as stable with low ACE. The remaining five teen mothers (3 Black, 2 White) reported \geq 4 ACE; their CFS scores ranged from 1 to 6. When scores for family members were examined,

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