How Adverse Childhood Experiences Impact Risky Sexual Behavior in Young Women Ages 12-21: An Adlerian Perspective

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Abstract

The purpose of this project and ensuing paper is to educate professionals to better understand how adverse childhood experiences impact young women’s sexual behavior and the resulting cycle that repeats inter-generationally. Based on findings, recommendations will be made as to how to intervene and improve the chances of this cycle not being repeated.
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Definitions

**Adverse Childhood Experiences (ACEs):** Experiencing physical, verbal, or sexual abuse, witnessing domestic violence, emotional or physical neglect, and living with adult family members who are substance abusers, who are mentally ill or suicidal, or have been imprisoned.

**ACE Study:** A survey completed by 17,000 members of Kaiser Permanente’s San Diego care program that included questions about childhood abuse and exposure to forms of household dysfunction while growing up.

**Risky Sexual Behavior:** Sexual behavior that includes early sexual debut, unprotected sexual activity, or more than one partner at a time.

**Secure attachment:** Sensitive and emotionally available parenting helps the child form a secure attachment with primary caregiver that fosters the child’s socio-emotional development and well-being.

**Insecure Attachment:** Created when child experiences strong, frequent, or prolonged adversity without supportive adult interactions.

**Toxic Stress:** Child is not helped to modulate threat, and excessive cortisol is released into the child’s system which disrupts developing brain circuits.
How Adverse Childhood Experiences Impact Risky Sexual Behavior in Young Women Ages 12-21: An Adlerian Perspective

Research has shown that young women ages 12-21 who have adverse childhood experiences are more likely to engage in risky sexual behavior. Adverse childhood experiences (ACEs) include “exposure to household dysfunction, and varying forms of abuse and violence” (Hillis, Anda, Felitti, & Marchbanks, 2001, p. 206). There are long-term consequences of risky sexual behavior both to the young woman and to future generations. Women engaging in risky sexual behavior are more likely to experience unplanned pregnancy. As a result they have additional problems that lead to the cycle repeating with adverse experiences that affect their children.

While it is generally understood that childhood sexual or physical abuse have been associated with “subsequent increases in substance abuse, sexual risk behavior, psychological morbidity and violence, other measures of household dysfunction have received less attention” (Hillis et al., 2001, p. 206). Rather, it is becoming increasingly clear that abuse typically “takes place within a broader context of adversity, including familial dysfunction, deprivation and destructiveness” (Hillis et al., 2001, p. 206). Taking into account the effect family dysfunction and neglect has on a child as well as abuse is imperative to the understanding of risky sexual behavior in young women.

The Adverse Childhood Experience (ACE) Study collected data which assessed “the relationship between adverse experiences during childhood and adult disease and health behaviors associated with leading causes of death and disability in the United States” (Hillis et al., 2001, p. 207). The adverse childhood experiences examined in this study are neglect; “physical abuse; verbal abuse; sexual abuse; witnessing of intimate partner violence; and living
with adult family members who are substance abusers, who are mentally ill or suicidal, or have been imprisoned” (Hillis et al., 2001, p. 207). This study linked exposure to these adverse childhood experiences and the “significantly increased risks of major causes of death and disability in adults, including alcoholism, drug abuse, depression, suicide, smoking, poor self-rated health, physical inactivity, severe obesity, ischemic heart disease, cancer, chronic lung disease, skeletal fractures and liver disease” (Hillis et al., 2001, p. 207). The ACE study has also shown a strong correlation between adversity and unintended pregnancy. “Women exposed to multiple types of adverse childhood experiences had a 50% increase in the likelihood of an unintended first pregnancy” (Hillis et al., 2001, p. 206).

As noted, childhood experiences of adversity put a young woman at risk for a number of potential physical and mental health outcomes. However, the purpose of this study is to focus on risky sexual behavior that results in unintended pregnancy and the cycle of inter-generational problems it brings. Risky sexual behavior is defined as sexual activity before age 15, having multiple sexual partners in a lifetime, and limited use of birth control.

ACE Study

In 1985, Dr. Vincent Felitti, a physician and chief of Kaiser Permanente’s Department of Preventive Medicine in San Diego, California couldn’t figure out why so many of the people enrolled in his obesity clinic dropped out. The preventative medicine department Dr. Felitti created was world renowned for “efficient and compassionate care. Every year, more than 50,000 people were screened for diseases that test and machines could pick up before symptoms appeared. It was the largest medical evaluation in site in the world” (Stevens, 2012, p. 1). Dr. Felitti was determined to find the reason for the drop-out rate as it was affecting his ability to build a successful program (Stevens, 2012). This quest turned into a “decade-long and ongoing
study designed to examine the childhood origins of many of our Nation’s leading health and social problems” (Anda, n.d., p. 1). It is noted that “although sociologists and psychologists have published numerous articles about the frequency and long-term consequences of childhood abuse, understanding their relevance to adult medical problems is rudimentary” (Felitti et al., 1998, p. 246). The ACE study is the largest of its kind to date. During 1995-1997, more than 17,000 members of Kaiser Permanente’s San Diego care program completed a survey that “included 60 questions and required 45 minutes to complete” (Hillis et al., 2001, p. 207). The questionnaire “included questions about childhood abuse and exposure to forms of household dysfunction while growing up” (Felitti et al., 1998, p. 246). They were also asked “about health-related behaviors from adolescence to adulthood” (Dong et al., 2004, p. 774). The majority of the population studied were 35 years or older, with an average age of 55; 77% were white, 69% had a college education, 67% were currently married and 41% were employed full-time (Hillis et al., 2001). It is interesting to note the results of the study show more than half of the respondents reported at least one ACE and one-fourth reported two or more categories of childhood exposure to adverse experiences (Felitti et al., 1998).

The ACE Study shows a direct link between child trauma and adult chronic illness such as diabetes, heart disease and lung cancer because prolonged stress in childhood “can disrupt early brain development and compromise function of the nervous and immune systems” (World Health Organization, n.d., p.1). The “higher a person’s ACE score, the higher the risk of chronic disease when they are adults” (Stevens, 2011, p. 1). Because of the behaviors adopted by some people who have faced ACEs, such stress can lead to serious behavioral problems such as alcoholism, depression, eating disorders, unsafe sex and other life altering outcomes (Stevens, 2011).
The ACE study “focuses on the public health aspects of disease, where it occurs, who is at risk, and measures the extent to which childhood trauma translates into poor health and social well-being in life” (Felitti and Anda, 2007, p. 1). It is apparent that adversity in childhood is more common than previously understood “even in this well-educated, predominantly middle class study sample” (Anda, n.d., p. 6). It could be assumed that the likelihood of ACEs would increase in a population that portrayed a lower socioeconomic status due to the additional stressors financial and living concerns place on families who live at or close to the poverty level.

How ACEs are Defined and Scored

Adverse childhood experiences refer to some of the most intensive and frequently occurring sources of stress that children may suffer early in life (World Health Organization, n.d.). The ACE Study assessed ten categories of stressful or traumatic childhood experiences. They are broken down into three subcategories: household dysfunction, abuse, and neglect. Household dysfunction includes: witnessing domestic violence, alcohol or other substance abuse in the home, having mentally-ill or suicidal household members, experiencing the disappearance of a parent through separation, divorce, death or abandonment, and having a family member in jail. Abuse includes: physical, emotional or sexual abuse. Neglect includes emotional and physical neglect.

Because adverse childhood experiences often co-occur, the ACE score is a measure of the cumulative impact of multiple exposures to the above listed experiences. Each type of trauma counts as one point and the points are then summed to give a number between 0-10, which would indicate the ACE Score (Anda, n.d., p. 8). For example “a person who’s been physically abused, with an alcoholic parent, and a mother who was beaten up has an ACE score of three” (Stevens, 2011, p. 1). ACEs are highly interrelated and the occurrence of one should evoke a search for
others (Anda, n.d.). If a person “had one ACE, the likelihood of their having another was 2 to 18 times higher than those reporting no ACEs” (Dong et al., 2004, p. 778). It would appear to be misguided to assume that ACEs happen in a silo.

**Brain Development and ACE Trauma**

To understand how adverse childhood experiences affect physical and emotional health, as well as behavior, it is imperative to have a basic understanding of brain development. “From the prenatal period through the first years of life, the brain undergoes its most rapid development, and early experiences determine whether its architecture is sturdy or fragile” (Center for the Developing Child, n.d., p. 1).

**Brain Development**

Research advances over the last two decades have brought great strides to the understanding of the brain and how it affects behavior. Scientists are now able to “locate the neurological structures involved in generating and managing emotions, assessing risk and making decisions, keeping ourselves safe, and processing and storing various kinds of memory” (Bath, 2005, p. 146). The basic and overarching purpose of these complex structures is survival (Perry, Pollard, Blakley, & Vigilante, 1995).

There is also more information on how the brain is constructed. It is known that infants are born with approximately 100 billion neurons, which are the “major working units of the brain” (Perry et al., 1995, p. 273). These neurons are all that is needed “to be Einsteins or Beethovens. But what differentiates Einstein and Beethoven from a neonate, is not the number of neurons, but the connections that those neurons make (the synaptic connections)” (Salomon Weiss & Wagner, 1998, p. 358). An infant’s brain is the most undifferentiated organ in a baby’s body. As development takes place and begins to unfold, “neural pathways are created by means
of synapses that open them up” (Davies, 2002, p. 421). By the time a child grows to adulthood, those neuron pathways increase a thousand fold and form upwards of 100 trillion connections (Salomon Weiss & Wagner, 1998). Couchesne, Chisum and Townsend (1994) coined the phrase “neurons that fire together, wire together” which helps create an impressionable picture of this process. It is important to note “synaptic connections that are not utilized gradually disappear” (Glaser, 2000, p. 100). This process is called pruning.

Though all humans are born with all the neurons needed to become Einsteins or Beethovans, it is through experiences that “authorize genetic instructions to be carried out and shape the formation of the circuits as they are being constructed. This developmental progression depends on appropriate sensory input and stable, responsive relationships to build healthy brain architecture” (National Scientific Council on the Developing Child, 2012, p. 1). It is interesting to note that “neuroscience confirms that those in closest contact with the child will have the most profound influence on the nature of brain growth and development” (Bath, 2005, p. 146). Because “responsive relationships are developmentally expected and biologically essential, their absence signals a threat to a child’s well-being…and this absence activates the body’s stress response systems” (National Scientific Council on the Developing Child, 2012, p. 1). It has also been found that “disruptions of experiences-dependent neurochemical signals during these periods may lead to major abnormalities or deficits in neurodevelopment” (Salomon Weiss & Wagner, 1998, p. 356). The age old discussion of nature versus nurture could be impacted by this research as it appears both nature and nurture are vitally important to the development of a child’s brain. Bath (2005) states it very well: “human connections underlie brain connections” (p. 146).
These brain connections develop into “systems that work together to mediate a set of specific functions. Different systems in the brain mediate different functions” (Perry et al., 1995, p. 247). Paul MacLean, a neuroscientist coined the concept of the triune brain. The work of MacLean “provides evidence that we have not one but three brains, each with its primary task” (Bath, 2005, p. 146). It is MacLean’s theory that each of the three brains specializes in processing survival, emotions or logic. It is important to understand basic brain functioning in order to understand how ACEs impact brain development.

The survival brain “is the most basic brain structure (and) is dedicated to physical survival...It is sometimes called the reptilian brain because this structure is shared by all living creatures, even those most primitive” (Bath, 2005, p. 147). The primary task of the survival brain is to control automatic functions such as heartbeat, body temperature, balance and respiration and also to activate the fight or flight reactions to danger or distress. These fight or flight reactions are instantaneous and unthinking and “ensures our safety when we are under serious threat- or think we are. These reactions are reflexive, instinctive and patterned” (Bath, 2005, p. 147).

The emotional brain, or more commonly called the limbic brain, is the area responsible for emotions such as fear, anger, love. The primary task of the emotional brain is to “sort incoming stimuli as pleasurable or threatening. The sentry or danger detector of the emotional brain is the amygdala” (Bath, 2005, p. 147). “The amygdala is the brain’s security system, alert for danger or opportunity. In effect, it scans incoming sensory data and signals other brain areas to pay attention” (Bath, 2006, p. 249). It gives quick feedback on positive or negative stimuli and is “especially sensitive to facial cues and tones of voice that signal aggression or affliction” (Bath, 2006, p. 249). Bath (2006) states
When a potential threat is detected, the amygdala sends out alarms that result in the release of the so-called stress hormones epinephrine, also known as adrenalin; norepinephrine; and cortisol as the most well-known) and the activation of the sympathetic nervous system-these prepare the body to “fight” or “flee”. (249)

The amygdala sits on top of the hippocampus, which is responsible for storing emotionally charged memories of thoughts, sensations, sounds, smells and feelings of the event (Bath, 2006). The purpose of emotions is to “motivate action, such as to approach, avoid, attack” (Bath, 2005, p. 147).

The logical brain is also called the neo-cortex or pre-frontal brain. This brain is the last to develop and research shows that it is not fully developed until a person reaches the twenties (Bath, 2005). This area “plays a key role in planning, weighing alternatives, making decisions and regulating emotional impulses” (Bath, 2005, p. 147). The tasks of the logical brain “are sometimes called the executive functions because they organize and manage the brain like an executive handles a company” (Bath, 2005, p. 147).

ACE Trauma on Brain Development

During early brain development “there are sensitive periods during which particular experiences affect brain maturation” (Glaser, 2000, p. 100). This “early brain development may be conceptualized as the transformation of external into internal regulation” (National Scientific Council on the Developing Child, p. 205). The experiences necessary for the maturation of the experience-dependent infant brain is created within the framework of the attachment of the infant to its primary caregiver (Schore, 2001). Development of the human brain depends upon an “extraordinary set and sequence of developmental and environmental experiences that influence the expression of the genome” (Anda et al., 2006, p. 174).
Research has shown, if this sequence is subject to extreme, repetitive, or abnormal patterns of stress during critical periods of childhood, brain development can be impaired, often permanently with profound and lasting neurobehavioral consequences (Anda et al., 2006). During these sensitive periods “healthy emotional and cognitive development is shaped by responsive, dependable interaction with adults” (Center for the Developing Child, n.d., p. 1). The primary caregiver of an “emotionally attached infant affords emotional access to the child and responds appropriately and promptly to his or her positive and negative states” (Schore, 2001, p. 205). “Because stable attachment bonds are vitally important for the infant’s continuing neurobiological development, these dyadically regulated events scaffold an expansion of the child’s coping capacities” (Schore, 2001, p. 205).

When the primary caregiver reacts to the infant’s expressions of emotions and stress inappropriately, or produces minimal or unpredictable engagement during various types of the arousal regulating processes a weak attachment will be created for the infant. This kind of experience for the infant will also induce traumatic states of enduring negative affect. It is noted that the quality of early attachment not only affects behaviors in infancy but is known to affect the development of an individual’s style of engaging and seeking out supportive relationships later in life (Schore, 2001). Therefore, “converging evidence from neurobiology and epidemiology suggests that early life stress…causes enduring brain dysfunction that, in turn, affects health and quality of life throughout the lifespan” (Anda et al., 2006, p. 175).

Learning how to cope with adversity is an important part of healthy child development. Perry, et al. (1995) states:

When threatened, a human will engage specific adaptive mental and physical responses.

Increasing threat alters mental state, style of thinking (cognition), and physiology (e.g.,
increase heart rate, muscle tone, rate of respiration). As the individual moves along the threat continuum- from calm to alarm, fear, and terror-different areas of the brain control and orchestrate mental and physical functioning. The more threatened the individual, the more “primitive” (or regressed) becomes the style of thinking and behaving. (p. 274)

When a child is threatened the brain activates the body to respond. Stress hormones, such as cortisol, are released into the system by the amygdala, which in turn, engages the fight, flight or freeze response.

When a child is protected by supportive relationships with adults, he or she learns to cope with everyday challenges and the stress response system can return back to baseline, allowing the child to work through what scientists call positive stress (Center for the Developing Child, n.d.). However, stress becomes toxic when strong, frequent, or prolonged adversity is experienced without supportive adult interactions. This happens when the child is not helped to modulate the threat, and the excessive cortisol that is dumped into the system disrupts developing brain circuits (Center for the Developing Child, n.d.). A child experiencing toxic stress “ is often, at baseline, in a state of low-level fear-responding by using either a hyper-arousal or a dissociative adaptation-the child’s emotional, behavioral, and cognitive functioning will reflect this (often regressed) state” (Perry et al., 1995, p. 274).

Studies have shown that “exposure to adverse environments early in life permanently alters the ‘set point’ of the Hypothalamic-Pituitary-Adrenal Stress-response (HPA) axis at the level of the hypothalamus, amygdala, hippocampus and prefrontal cortex…(and) may result in an increase HPA activity and cortisol production” (Wekerle, Waechter, Leung, & Leonard, 2007, p. 12). Changes in this set point also impacts brain function that corresponds with cognitive and regulatory functions (Wekerle et al., 2007). Research has demonstrated that patients
experiencing chronic stress or repeated traumas associated with maltreatment “differ from normal controls in terms of HPA axis-related functioning” (Wekerle et al., 2007, p. 12).

Wekerle et al. (2007) states that this has been noted in the:

1) Hypothalamus, where there is lower regional activity and poor regulation in arousal and physiological function, 2) Amygdala, where there is higher regional activity/reactivity and exhibited heightened anxiety to fear-related stimuli, 3) Hippocampus, where there is lower regional activity resulting in poorer memory consolidation/retrieval and habituation to adverse stimuli, and 4) Prefrontal cortex, where there is lower regional activity resulting in poor impulse control regulation of mood and attention and inhibition of distracting thoughts and irrelevant stimuli. (p. 13).

When certain parts of the brain that are involved in the fear response are in chronic activation mode areas in other parts of the brain that would normally be activated can ‘wear out’ resulting in an imbalance of functioning (Wekerle et al., 2007). Those suffering from ongoing adverse experiences show a marked deficit in areas such as reasoning, attention, and emotionally laden tasks. It is important to note that even small differences of processing can have significant consequences for social functioning (Wekerle et al., 2007). Studies show that the “right prefrontal cortex is thought to be important for making judgments and decisions in ambiguous and real-world situations, such as those regarding sexual health, social relations and substance abuse” (Wekerle et al., 2007, p. 13).

Neurobiologists have analyzed the ACE Study data against neurobiological defects that result from early trauma and found that “early experiences have profound long-term effects on the biological systems that govern responses to stress” (Anda et al., 2006, p. 176).
In summary, “deprivation of developmentally appropriate experiences may reduce neuronal activity, resulting in a generalized decrease in neurotrophin production, synaptic connectivity, and neuronal survival resulting in profound brain organization and storage” (Anda et al., 2006, p. 175). It is also noted, “childhood trauma has a profound impact on the emotional, behavioral, cognitive, social and physical function of children” (Perry, Pollard, Blakley, & Vigilante, 1995, p. 271).

**Risky Sexual Behavior**

The ACE Study demonstrates a strong correlation between exposure to adverse childhood experiences and risky sexual behavior producing negative reproductive outcomes (Hillis et al., 2001). “Risky sexual behavior includes early sexual debut, unprotected sexual activity, inconsistent use of condoms, high-risk partners, sex with a partner who has other partners or more than one partner at a time” (Taylor-Seehafer & Rew, 2000, p. 15) Adolescent women who participate in risky sexual behavior are at risk for sexually transmitted diseases and unintended pregnancy. Research indicates that as the number of categories of adverse childhood experiences increased, the prevalence of early onset of intercourse, of having 30 or more partners, and engaging in unprotected sex consistently increased (Hillis et al., 2001). It is clear that risky sexual behaviors puts young women on track for negative life-long consequences.

**Early Sexual Debut**

According to the Guttmacher Institute, on average, young people have sex for the first time at about age 17, 16% of teens have sex by age 15 and fewer than 2% teens have had sex by the time they reach their 12th birthday (Guttmacher Institute, 2013). Hillis., et al. (2001) state, “compared with women who had experienced no types of adverse childhood experiences, those who experienced one or more of them were significantly and increasingly more likely to initiate
intercourse at ages 15 years or younger” (p. 7). The ACE Study revealed the “prevalence of early onset of intercourse ranged from 4% for those reporting no adverse childhood experiences to 31% for those reporting 6-7 types of experiences” (Hillis et al., 2001, p. 8).

Multiple Sexual Partners

Research has also shown that adverse childhood experiences significantly impact the number of sexual partners one has over a lifetime. The ACE Study revealed, “the odds of having 30 or more partners climbed from 1.6 among those with one type of adverse childhood experiences to 8.2 among those with 6-7 such experiences” (Hillis et al., 2001, p. 7).

Unprotected Sex

Contrary to common thought, knowledge of sexual risk alone is not sufficient to change behavior. Research “indicates there is little connection between knowledge of HIV/AIDS and self-protective sexual behavior” (Taylor-Seehafer & Rew, 2000, p. 16). The early onset of sexual activity is detrimental to the use of protection due to the fact that “cognitive processes change significantly during adolescence including developing the ability to reason abstractly, to foresee consequences of actions, and to understand the social context of behaviors” (Taylor-Seehafer & Rew, 2000, p. 19). Therefore, “adolescent females who are still thinking at a pre-operational or concrete level may see themselves as invulnerable and have an optimistic view of their risks” (Taylor-Seehafer & Rew, 2000, p. 19).

In summary, as stated previously, the pre-cortex brain, which plays a key role in logic, cause and effect, decision making and regulating emotional impulses, is not fully developed until a person reaches the twenties. For a young woman with ACEs her brain development may have been altered and her impulse control may be significantly affected. Her understanding of the
severity of risk she puts herself in while having unprotected sex may be significantly skewed and would certainly impact her willingness to assert her need for protected sex.

Hillis, et al., (2001) notes:

> Among individuals with a history of adverse childhood experiences, risky sexual behavior may represent their desperate attempts to achieve intimate interpersonal connections. Growing up in families unable to provide needed protection, these individual may be unprepared to protect themselves and may grossly underestimate the risks they are taking in their hopeful, yet potentially misguided, attempts to achieve the intimacy that was lacking in their childhood. (p. 6)

**Intergenerational Cycle of Problems**

**Unintended Pregnancy**

The Center for Disease Control reports that 49% of pregnancies were unintended. Among women aged 19 years and younger, more than 4 out of 5 pregnancies were unintended and 98% of the pregnancies among teens younger than 15 were unintended. Large increases in unintended pregnancy rates were found among women with lower education, low income, and cohabiting women. One in five teenage mothers will have a second unintended pregnancy (Centers for Disease Control, 2013). Research indicates that “women exposed to abuse, violence, and family strife in childhood are more likely than those without such experiences to have a teenage pregnancy and the greater the number of adverse childhood experiences, the higher the likelihood of pregnancy” (Tamkins, 2004, p. 88).

The ACE Study data reported a total of 1193 women ages 20-50 years whose first pregnancy occurred at or after 20 years old. More than 45% of those women reported that their first pregnancy was unintended, and 65% of those women reported exposure to 2 or more types
of childhood abuse or household dysfunction (Dietz et al., 1999). The likelihood of a woman “having had an unintended pregnancy rose from 32% to 64% as the number of types of abuse or dysfunction she had experienced increased from zero to four or more” (Olenick, 2000, p. 47). Women who had experienced sexual abuse or frequent psychological or physical abuse were significantly more likely to have had an unintended pregnancy (Olenick, 2000). It is noted that 66% of pregnant adolescents report histories of sexual abuse (Taylor-Seehafer & Rew, 2000, p. 17). Research shows that exposure to childhood abuse and family dysfunction “may affect women’s ability or motivation to prevent an unintended first pregnancy” (Olenick, 2000, p. 48).

Poverty

Early childbearing is both a result of poverty as well as a predictor of poverty. Research has shown that poverty is an especially “strong predictor of teenage childbearing among daughters of teenage mothers. In these families, girls who lived below the poverty threshold were more than twice as likely to become teenage mothers” (Meade, Kershaw, & Ickvics, 2008, p. 426). And likewise, “early childbearing significantly impacts socioeconomic achievement, family formation, and family stability” (Hayward, Grady, & Billy, 1992, p. 750). This cycle continues the inter-generational pattern of poverty and adverse experiences for the next generations of offspring.

It could be assumed there is a higher possibility of family dysfunction of those living in poverty due to the increase in the amount of stress involved to make ends meet. Children living in poverty are more likely to be crowded into small living quarters and often are exposed to adult behaviors and dysfunction they do not understand (Taylor-Seehafer & Rew, 2000).
Repeating ACE Cycle

While there are stories of heroic youth who overcome the most disadvantageous of backgrounds, for most, early adversity casts a long shadow into adult life and even into the next generation (Brent, 2013, p. 1777). Tamkins (2004) states, a greater proportion of women reporting at least one adverse childhood experience than women who reported none were daughters of adolescent mothers. “Children of teenage mothers tend to have fewer economic and social resources; are more likely to grow up in single-parent homes…have lower levels of cognitive attainment and higher rates of school failure, emotional distress and problem behavior” (Meade, Kershaw, & Ickvics, 2008, p. 419).

It could be assumed that young mothers who have experienced adversity in their childhood would most likely perpetuate the pattern of abuse or dysfunction. Compared with women who had not experienced adversity in childhood, those who had 1-2 ACEs had elevated odds of serious family, job and financial problems, high stress and fear of inability to control anger and the odds of this happening increased as the number of ACEs increased (Tamkins, 2004). Therefore, the offspring of these mothers would most likely continue in the cycle of adverse childhood experiences and the devastating intergenerational outcomes.

According to Adlerian theory, a person’s private logic is based on observation and interpretation of experiences and relationships and one’s lifestyle is set by early childhood. Behavior is set in motion as one “acts as if” those things are true from that point on. Early intervention with the mother who has experienced adversity in her childhood could greatly increase the opportunity to break the generational cycle with her own child.
Dreikurs & Soltz (1987) state:

Life consists only of the present moment, and if we do the right thing at this moment, we move toward improvement. On the other hand, if we do not fulfill the requirements of a given situation or do not know how to deal with it, then the chances for improvement are slim indeed. (p. 66)

**Recommendations for Interventions**

Research clearly indicates that exposure to adversity in childhood increases the probability of risky sexual behavior and yet, “common public health interventions have focused on reducing sexual risk behaviors including delaying initiation of sexual intercourse and increasing use of condoms” (Hillis et al., 2001, p. 7). This mode of intervention has met with limited success but it continues to be the most widely used model: Just say no to sex, but if you do, make sure to use a condom.

There are also models of intervention that focus on building up the adolescent’s self-esteem, self-efficacy, and communication skills (Taylor-Seehafer & Rew, 2000). But it is interesting to note that researchers estimate one-third of teenage pregnancies could be prevented by eliminating exposures to childhood experiences of abuse, violence, and family strife (Tamkins, 2004). While it may be important to educate youth about their reproductive options, it is apparent that it is vital to intervene in the cycle at a much earlier life stage. Tamkins (2004) states that “programs that focus on reducing family dysfunction have the potential to prevent teenage pregnancy and psychological and social problems in adulthood” (p. 89).

Hillis, et al., (2001) states:

Interventions that have focused on changing (these) sexual risk behaviors have meet with only modest success, which suggests that programs attempting to alter sexual behavior
after their development may be insufficient to achieve the desired magnitude of change. Broader interventions that focus on reducing exposure to familial violence and household dysfunction have been shown to achieve their desired goals. Such interventions, though more challenging, may ultimately lead to greater reductions in sexual risk behaviors decades later.” (p. 7)

In light of this research, this writer will explore two stages of pivotal intervention. One stage of intervention would focus on the mother/child dyad. Another stage of intervention would focus on the mother and breaking the cycle of ACEs by preventing additional unintended pregnancies.

**Intervention within the Mother/Child Dyad**

The intervention within the mother/child dyad would seek to educate the mother of the importance of a healthy family atmosphere. A mother who faced adversity in her childhood may not have an accurate understanding of what a healthy family atmosphere includes. Because of her experiences within her family of origin, she may have a distorted worldview of how families function and what a child needs to thrive both developmentally and emotionally.

This intervention would focus on educating the mother on the importance of attachment for her child and the difference between secure and insecure attachment. The opportunity for the child to form a secure attachment is fostered when the mother is regularly sensitive to the child’s needs and emotionally available during times of stress. Due to experiencing frequent and prolonged adversity without supportive adult interactions during her childhood, the mother may have weak or insecure attachment herself. She may not have a frame of reference of what it looks like to be emotionally attentive and sensitive to her child’s needs and stress.
This intervention would also include opportunities to model and role play appropriate interactions between the mother and child on how to create a nurturing environment that helps foster a sense of well-being for her child. By intervening during the infant’s most critical years of brain development, the opportunity for healthy brain development can be enhanced and increase the probability of the child developing healthy boundaries and decision-making skills.

**Prevention of Additional Unintended Pregnancies**

Another stage of intervention would focus on the mother and breaking the cycle of ACEs by preventing additional unintended pregnancies. It is imperative to educate the mother about how the adversity she experienced in childhood may have interfered with her brain development. This would help her to understand how her brain may have gotten hard wired and stuck in the fight or flight mode and give her insight into her behavior. It would also help her to see patterns of unhealthy decision-making regarding relationships and risky sexual behavior.

Because the mother may not have healthy role models who have not experienced ACEs themselves, it would be important to provide a safe therapeutic relationship where she can seek help under stress and develop cognitive reasoning.

Through psychotherapy, the therapist would help the mom to move into her logical brain by understanding her private logic and mistaken beliefs set in place in early childhood. It would be very important for the therapist to create a relationship that is non-judgmental, and affirming allowing the client to build trust in the therapist. By offering her safe and supportive environment, she would have the opportunity to learn how to access the help she needs to process and understand. Therapeutic interventions, such as challenging her private logic, and would help her move from her limbic brain to her logical mind so she can begin to make reasonable choices.
According to Adlerian theory, human beings all have one basic desire and goal: to belong and to feel significant (Adler Graduate School, n.d.). Because of this, a person will find a way to belong. One can do this in a socially useful or useless way. “Psychological motivations to engage in risky sexual behavior that have been identified include the need to belong, the need for intimacy…” (Taylor-Seehafer & Rew, 2000, p. 19). The lifelong consequences of operating in a useless manner are devastating. An early intervention strategy with a mother with ACEs is imperative in the development of her child. Interrupting the destructive inter-generational cycle of abuse and family dysfunction can create a new foundation for her child to flourish as well as opening up new opportunities for mother to move toward a more hopeful future.

Presentation

This material was presented through a power point presentation to the Robbinsdale Women’s Center (RWC) staff and Executive Director. This writer is on staff at RWC and is the Client Services Director. RWC is a pregnancy resource medical center and is a 501(C3) corporation which receives financial support from private individuals, churches, corporations, and private grants. RWC’s mission is to reach out to women who are at risk at aborting their baby and offer options that help her to understand she has choices other than abortion (Robbinsdale Women’s Center, n.d.).

Women who are facing unplanned pregnancies are often scared and make decisions out of fear. RWC offers an opportunity for women to learn the facts about their pregnancy through free pregnancy testing and ultrasound. The center also provides practical help by offering information regarding resources such as education opportunities, housing, material aid, and community resources, as well as adoption options. RWC offers ongoing supportive programming for women who chose to carry their babies and either parent or place for adoption.
The center also networks with post-abortion support services in the community and is an avenue for referral as needed.

The incentive for this research and subsequent presentation was to gain a better understanding of the behavior exhibited by the clientele seen at the center and the possible motivation behind that behavior. The numbers of clients engaging in risky sexual behavior continue to be staggering. Looking for common denominators would give insight and possible intervention opportunities.

At first glance, one could assume that culture or ethnicity had significant impact. However, while the African American population represents approximately 32 percent of clients seen, 28 percent are Caucasian and 26 percent are recent African immigrants. The remaining 14 percent of clients seen consist of those with Asian, American Indian, and Hispanic ethnicity. The significant finding was that more than 87 percent of RWC’s clients lived at or below the poverty level. A significant number of clients have parents, particularly fathers, who were imprisoned at some point during their childhood. Many households consist of family members struggling with substance abuse or mental health issues and domestic violence is commonplace.

This information, coupled with the data from the ACE study, allowed for a broader understanding of the clients served at RWC and opened up dialogue on how the staff could significantly engage the clients in a meaningful manner to help affect change- both individually as well as societal. Using the information gathered in this research, RWC will consider altering the initial intake interview to include information regarding ACEs. There is also consideration of adding programming to include opportunity for mothers to be involved in ongoing supportive group experiences to aid in creating a safe environment for them to experiment with a healthy living environment.
References


