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ORIGINAL ARTICLE

Parenting and Mental Health needs of Young, Maltreated parents: implications for Prevention of intergenerational child maltreatment

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Abstract

Purpose Children of young parents are at elevated risk for child abuse and neglect due to myriad challenges. Despite the dual need for parenting support and mental health support, most literature and programs separate these and do not address maltreated parenting youths' intergenerational context. The current study explores parenting and mental health needs as intertwined, uplifting experiences of young adult mothers with child maltreatment histories, professionals serving them, and mothers' own caregivers.

Method Through a community-engaged research process, this grounded theory study was co-conceptualized and conducted through a university-community-based organization partnership. We conducted in-depth interviews with 23 participants: nine young, maltreated mothers aged 18–25 (M 20.9) years, 14 professionals and two caregivers. Data were collected in the community and analyzed using grounded theory methods. We transcribed each interview and analyzed the transcripts using a structured process of open, focus, axial, and selective/theoretical coding. Rigor was enhanced through several strategies including reflexivity and member checking.

Results Grounded theory analysis produced a detailed model of the process of accessing and receiving mental health and parenting support among young, maltreated mothers, including (1) Reckoning with the Impact of Childhood and Adolescent Trauma on Mental Health and Parenting; (2) Reaching Out; (3) Receiving Parenting Support; (4) Receiving Mental Health Support; and (5) Seeking a Change.

Conclusions Findings support a comprehensive approach for supporting young parents in improving the trajectories of their families through integrated approaches to parenting and mental health intervention.

Keywords Child maltreatment prevention · Teen parenting · Mental health · Teen pregnancy

Introduction

Children of young parents are at elevated risk for child abuse and neglect (Putnam-Hornstein et al., 2015). Young parents face myriad challenges, including gaining autonomy and parenting skills in a supportive environment, balancing educational demands while caregiving, and ongoing surveillance of child welfare and other systems (Aparicio et al., 2015; Hoffman & Maynard, 2008). In addition, adolescents who give birth to one or more children are more likely than those who do not have children to have a child maltreatment history (Putnam-Hornstein et al., 2015), thus have unique mental health needs during the often stressful pregnancy and early childhood phase. Despite the dual need for parenting support and mental health support, most research and interventions separate these and often inadequately address

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the intergenerational context within which maltreated parenting youth are embedded. The current study explores parenting and mental health needs as intertwined issues requiring intertwined intervention, uplifting and analyzing experiences of young parents, professionals serving them, and caregivers to create a conceptual model to guide further research and attuned intervention.

Intergenerational Patterns of Child Maltreatment

Among parents who experienced maltreatment as children, most do not go on to later maltreat their own children (Greene et al., 2020; Madigan et al., 2014; Yoo & Abiera, 2020). Those parents who do tend to have a number of potential risk factors, such as being more likely to have experienced child sexual abuse and later to struggle with substance use (Capaldi et al., 2018; DiLillo et al., 2000; Martoccio et al., 2020). Contextual factors in parents' lives that increase stress and risk of intergenerational transmission of child maltreatment include poverty (Hughes & Tucker, 2018), housing instability, lack of affordable high-quality childcare, and food insecurity (Panisch et al., 2020). These factors can lead to a state of chronic stress, which is a more consistent cause for child maltreatment than a learned behavior or traumatic response framework (Ben-David et al., 2015).

Pathways to children's victimization vary depending on the type of child maltreatment the parent experienced. When mothers have a history of child physical abuse, they are at increased risk of developing interpersonal aggressive response biases, but when mothers have a history of child sexual abuse, they are more likely to develop substance use problems - both lead to increased risk of intergenerational transmission of child maltreatment by the time their child is 3.5 years old (Martoccio et al., 2020).

Given societal inadequacies in providing tailored supports for young families, having a teen parent, or a parent who was a teen at their first birth, also heightens child maltreatment risks. A study on intergenerational continuity of child maltreatment among adolescent mothers found increased risk when mothers had higher exposure to community violence and, specifically among African American families, lower rates of authoritarian parenting attitudes (Valentino et al., 2012). Young, maltreated mothers who became a teen parent while in foster care report using many strategies to break the cycle of child abuse and neglect, including intentionally treating their children well, actively working to parent differently to avoid their children entering foster care, reducing social isolation, and reaching out for support to trusted adults such as former foster parents, mentors, therapists, and family members (Aparicio, 2017).

Young Parents' Parenting Needs and Interventions

Studies on early parenthood suggest that many young parents struggle to provide positive and sensitive care for their children. Compared to older mothers, young mothers tend to be less attuned to their children, make fewer positive remarks to and about their infant, use more punitive discipline, and perceive their child's temperament as more difficult (Demers et al., 2010; Savio Beers & Hollo, 2009). In addition, children of teen mothers with a history of child maltreatment are two to three times more likely to be formally reported for child maltreatment than those born to teen mothers without such histories (Putnam-Hornstein et al., 2015).

Whereas such findings may suggest young parents' inadequacy in parenting, studies have also shown variability across individuals: various psychosocial and environmental factors have been identified that make healthy parenting more challenging for young parents. For example, adolescent parents are less likely to be knowledgeable about children's developmental milestones and parenting strategies, leading them to hold unrealistic expectations about their children and exhibit potentially abusive parenting styles (Brooks-Gunn & Chase-Lansdale, 1995; Letourneau et al., 2004). Teen mothers have also been shown to experience higher levels of depressive symptoms than adult mothers. One study of adolescent mothers found that 57% of the sample had moderate to severe depressive symptoms (Schmidt et al., 2006). Critically, the dual crises of taking on the responsibility of parenthood while dealing with age-appropriate developmental tasks adds significant burden on young parents, and such taxing circumstances are associated with parenting stress, coping difficulties, and limited emotional availability for their children (Letourneau et al., 2004). Young parents with a history of childhood maltreatment are at an even higher risk for parenting stress, as many of them are also coping with residential instability, substance misuse, and limited social support (Aparicio, 2017; Pereira et al., 2012). These findings suggest that many young parents are in dire need of informational, psychological, and relational support.

Interventions designed to enhance positive parenting and improve maternal mental health have been delivered to young parents (mostly mothers) in the form of individual and group sessions, and home visiting services. Several programs have shown positive results; mothers who participated in the programs demonstrated increases in parenting sensitivity and decreases in mental health symptoms (e.g., depression and posttraumatic stress disorder [PTSD]), parenting stress, and parenting helplessness (Bohr & BinNoon, 2014; Jacobs et al., 2016; Muzik et al., 2015; Rosenblum et al., 2017). One study found the impact of the intervention

was more pronounced among women with a history of interpersonal trauma, as they showed marked decreases in mental health symptoms and parenting stress (Rosenblum et al., 2017). However, interventions have also been challenged by high attrition rates and negative results. Only 4 out of 11 participants remained for the duration of the entire study in one study (Bohr & BinNoon, 2014), and another study found a decline in maternal self-esteem and caretaking ability in both the intervention and control conditions, although the worsening effect was less in the intervention group (Cox et al., 2019). Such findings highlight the complexity of what young parents are experiencing as they are adjusting to parenthood while coping with challenges present before they became pregnant. Qualitative findings on the expressed needs of young parents underscore the critical role of support characterized by open communication and non-stigmatizing interactions with both the professionals and other trauma-exposed young mothers, warranting more intervention efforts incorporating such relational needs (Aparicio, 2017; Muzik et al., 2013).

Young Parents' Mental Health Needs and Interventions

Young mothers are more likely to experience adverse mental health outcomes. They are more likely to experience depression, both prenatal and postpartum, and have higher rates of suicidal ideation when compared to their peers and older women (Hodgkinson et al., 2014). Although depression is prevalent among adolescent mothers, those who have more social support are less likely to be depressed postnatally (Brown et al., 2012). Young mothers are also more likely to live with violence and have longstanding struggles with depression, self-sabotage, and attempting suicide due to the continual cycles of violence in their lives re-exposing them to trauma (Lucas et al., 2019). These experiences impact physical and mental health and may lead to PTSD symptoms (Hodgkinson et al., 2014; Lucas et al., 2019). Young women report feeling unable to describe and disclose their feelings of depression or mental health problems for fear that they will be perceived as ineffective parents (Lucas et al., 2019). They also tend to describe their feelings as ways of dealing with difficult circumstances rather than mental health struggles (Lucas et al., 2019).

Currently, programs targeting mental health for adolescent parents predominantly focus on postpartum depression. Effective programs for postpartum depression include home visiting interventions, pre- and post-natal education programs, interpersonal therapy, cognitive-behavioral therapy, and infant massage (Sangsawang et al., 2019). Another successful strategy in postpartum mental health treatment has been to provide multidisciplinary care that includes maternal mental health in pediatric primary care (Hodgkinson et al., 2014). Interventions designed to improve parenting skills have also found a decrease in depression symptoms through increasing the participants' feelings of effectiveness and decreasing negative parent-child interactions, as well as teaching reflectivity about their own parenting and childhood experiences (Stirtzinger et al., 2002). One example is SafeCare, which focuses on anticipatory awareness of child development, parenting skills, and safety; it has been found to decrease young parents' depressive symptoms (Hubel et al., 2018).

Study Aim and Research Questions

There is a growing body of literature on mental health needs among young parents with maltreatment histories and their respective parenting support needs. However, few if any studies seek to explicitly examine how mental health and parenting needs are related among young families. This study sought to fill this gap, exploring parenting and mental health needs among young parents with histories of child maltreatment as intertwined issues. We aimed to develop a conceptual model to inform integrated intervention, supporting young families and preventing intergenerational transmission of child maltreatment. The study was guided by the following research questions: *What are the parenting and mental health needs of young mothers who have experienced child maltreatment? How can these needs be conceptualized to inform prevention of intergenerational child maltreatment?*

Method

Participants and Setting

The Institutional Review Board approved the study methods and procedures at the University of Maryland, College Park. This study used in-depth interviews to understand the parenting and mental health needs of young mothers with their own history of child maltreatment. Eligibility criteria for the study were: (1) 18-25-year-old mothers who had given birth to one or more children when they were 19 years old or younger and who have a history of their own experiences of child abuse and neglect. The child needed to be currently or previously residing with their mother, and the mother had to have been the child's primary caregiver at least once; (2) caregivers and professionals who work with (or supervise work with) the above-described mothers. Caregivers refer to foster parents who are currently working with maltreated parenting youth. Professionals refer to employees such as group home staff, independent living program staff, social

Table 1 Characteristics of the sample of young mothers (n = 9)

Variable	%, Mean (SD), or Median (Range)
Age (M, SD)	20.9 (1.5) years
Ever in foster care	55.6%
Age entered foster care, if applicable[a] (M, SD)	12.2 (5.4) years
Race and Ethnicity[b]	
Black or African American	77.8%
Hispanic	22.2%
Sexual Orientation	
Bisexual	11.1%
Heterosexual	66.7%
WIC Recipient	100%
Number of Foster Care Placements, if applicable (M, SD)	8.8 (11.9) placements
Age at first consensual sex[c] (M, SD)	15.4 (1.4) years
Age at first birth (M, SD)	17.8 (1.7) years
Number of children (M, SD)	1 (0) children
Child's current age (M, SD)	3.0 (2.3) years
Number of miscarriages (Median, Range)	0 (0–1) miscarriages
Number of abortions (Median, Range)	0 (0–2) abortions

Note

[a] Four participants (44.4%) responded they had not been in foster care

[b] This measure combines race and ethnicity information so the percentages sum to 100

[c] One participant did not answer this question

Table 2 Characteristics of the sample of caregivers and professionals (n = 14)

Variable	% or Mean (SD)
Age	38 (15) years
Gender	
Woman	86%
Man	14%
Sexual Orientation	
Heterosexual	93%
Self-identified: Queer	7%
Race and Ethnicity[a]	
Black or African American	41.7%
White Non-Hispanic	58.3%
Number of parenting youth served/cared for	
5–15	33.3%
20+	49.9%
Missing	16.6%

[a] This measure combines race and ethnicity information so the percentages sum to 100

workers, mental health therapists, and program administrators or supervisors.

Tables 1 and 2 show the demographic characteristics of the current sample of young mothers and staff/caregivers, respectively. The young mothers' average age was 20.9 years (SD = 1.5). All were Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) recipients and had one child. Five mothers (55.6%) had been in foster care. The average age for professionals was 33.9 years (SD = 11.3), 91.7% were female, and 49.9% had served or cared for 20 or more parenting youth. The average age for caregivers was 65.0 years (SD = 0.0), 50.0% were female, and both had served or cared for 5–15 parenting youth. Professionals and caregivers worked with young, maltreated parents in a variety of settings, including Department of Social Services, Early Head Start, and in their own homes.

Data Collection

Interview participants were recruited through purposive and snowball sampling by leveraging existing relationships with local community organizations and stakeholders in the District of Columbia (D.C.) and Maryland area. Co-authors one, two, and three approached potential participants via phone or email. Following an informed consent process, co-authors one, two, and three conducted interviews in person, in a private, quiet location of the participant's choice for 90–120 min.

Semi-structured interview guides were developed for each of the three participant types. The guides were drafted based on an extensive literature review and in collaboration with our main community partner, [blinded]. The guides were revised accordingly, pilot tested, and finalized. The interview guide for the young mothers consisted of questions on parenting needs and mental health needs. The caregivers and professionals were also asked corresponding questions on the young mothers' parenting and mental health needs. The study team provided a health resources guide to each young mom participant after the interview. A total of 23 participants were interviewed including 9 young mothers, 2 caregivers, and 12

professionals. The study team continued recruitment until theoretical saturation was reached (i.e., no new information emerged during analysis of later interviews). Each interview was audio-recorded and transcribed verbatim, using participant pseudonyms. Participants were provided $50 as compensation for time spent during the interview.

Data Analysis

In this constructivist grounded theory study, we iteratively analyzed the data using four steps: open coding, focus coding, axial coding, and selective/theoretical coding (Charmaz, 2014). First, co-authors two, three, five, and eight open-coded a randomly selected set of $n = 8$ interviews. Open coding involves assigning a tag, or code, to sections of raw transcript text that capture the meaning of the text relevant to the research question. Co-authors two through five, seven, and eight organized the open codes into focus codes, which are slightly broader, less idiosyncratic tags, or codes, used for multiple sections of text that have a similar meaning. We developed a codebook for the focus codes based on this open coding, including an operational definition for each focus code and guidance for when to use and not to use the code. We used the focus codebook to code the remaining transcripts, updating the codebook if an important issue relevant to the research question arose that required an edit to our coding structure. Next, we organized the focus codes into broader concepts. Finally, we organized the concepts into theoretical categories, properties, and dimensions that characterize the process by which young, maltreated mothers access and receive mental health and parenting support.

Ethical Considerations

This study included a particularly vulnerable population: young mothers with experiences of maltreatment. Co-authors who interacted with the participants took extra precautions to mitigate any potential risk to the participants. These included distributing a comprehensive resources guide following interviews and having emergency protocols in place in case participants experienced any distress during or following the interviews. The comprehensive resources guide included links and phone numbers related to reproductive health, parenting, and mental health. Participants were also given the Principal Investigator's (first author) contact information in case they needed additional support.

Strategies to Enhance Rigor and Researcher Positionality

Strategies to enhance rigor included peer debriefing, member checking, triangulation, reflexivity, and coding by multiple coders. The research team completed peer debriefing at every stage of the research process, from interviews to analyzing the findings, to enhance the trustworthiness and credibility of the research. Findings were presented to participants of the study for member checking. Their feedback was integrated into the findings to ensure that they authentically reflected participants' experiences. Co-authors one through eight, who completed data collection and analysis, maintained reflexive journals throughout the research process to reflect on their own experiences and potential biases and their effects on the study.

Our research team was made up of university and community partners. We are majority cisgender women, with several cisgender men, of diverse sexual orientations and racial and ethnic identities. Our disciplinary training and experience include social work and public health. Together, we have several decades of experience working directly with young, maltreated mothers and conducting research with them.

Results

Grounded theory analysis produced a detailed model of the process of accessing and receiving mental health and parenting support among young, maltreated mothers. The model has five categories, representing a facet of the process and composed of multiple properties (see Table 3 for a summary). The process of accessing and receiving mental health and parenting support among young, maltreated mothers includes (1) Reckoning with the Impact of Childhood Trauma on Mental Health and Parenting; (2) Reaching Out; (3) Receiving Parenting Support; (4) Receiving Mental Health Support; and (5) Seeking a Change.

Category I: Reckoning with the Impact of Childhood and Adolescent Trauma on Mental Health and Parenting

At the foundation of the process of accessing and receiving mental health and parenting support is reckoning with the impact of childhood and adolescent trauma on mental health and parenting. This category includes several properties, including child maltreatment and mental health, domestic violence and mental health, child maltreatment and parenting, and domestic violence and parenting. Mothers' experiences of child maltreatment and domestic violence spanned their entire lives, with compounding impacts on their mental health and parenting.

Property a: impact of child maltreatment on mental health. Study participants explained that child maltreatment perpetrated against young mothers in the past had

Table 3 Grounded theory model categories and properties

I. Reckoning with the impact of childhood and adolescent trauma on mental health and parenting	II. Reaching out	III. Receiving parenting support	IV. Receiving mental health support	V. Seeking a change
Child maltreatment and mental health	Access	Formal support	Managing mental health needs (Self-regulation, therapy, medication, additional supports)	Desired parenting formal and informal support
Domestic violence and mental health	Trust	Community support	Navigating mental health systems	Desired mental health formal and informal support
Child maltreatment and parenting	Pitfalls	Benefits and challenges		
Domestic violence and parenting				

a profound impact on their mental health and well-being, particularly if, as one participant explained, they had not yet been able to "process that and understand that." Young mother participants expressed an awareness of the impact of child maltreatment on their everyday behavior and feelings; social workers shared that these impacts frequently manifest in either the same negative behaviors they had seen in their parents or in new behaviors that are also "not helpful or healthy". For example, Leah, a mother, said, "Me being, like I said, I've been through it, and I know that that has impacted my life today….and I know why. That impacted some of the things I've done or felt." Another participant shared:

> I believe that your past really impacts who you are today and if they don't process that and understand that, then you know they will repeat things that happened to them in the past or they will behave in a manner that is not helpful or healthy, but it's because they have not processed what's gone on. (Megan, social worker)

Property b: impact of domestic violence on mental health. For some young, maltreated mothers, the dangers of their childhoods persist into adolescence and adulthood through relationships with intimate partners. Participants commented on how young mothers often experience a recapitulation of childhood violence through these relationships, often further complicated by sharing a home or a child. As one mother shared regarding experiencing intense fear both of her partner and the outside world after her former partner broke their door in a rage: "I was scared. Somebody was gonna come in, and I had my child. But they ended up fixing the door, so it made me feel real better to be in the house" (Brooklyn, mother, 20).

Mothers shared the complications of extracting themselves from these dangerous relationships, which often involved getting support. The process of getting out and protecting themselves from their abuser was often prolonged and particularly emotional, as getting engaged or setting up a home together felt like an opportunity to settle down and start the next chapter of their lives. One mother explained her process for getting out:

> 'Cause one time I was feeling down, and I was going through a time where I was being—my child's father was hitting me, and that wasn't good for me in that environment or my child, so I had to get out of there as soon as possible. That's kind of why we're not engaged together anymore. I just called the hotline one day or [local domestic violence agency], something like that. It was a phone number I called, and they were giving me—telling me basically, just giving me an idea what to do and I did it. Now, my life is healthier. 'Cause that was very unhealthy for me and my child. (Leah, mother, 21)

Property c: impact of child maltreatment on parenting. Participants described how young mothers are embedded in an intergenerational context where they are not entirely in control of what their children are exposed to daily. These exposures include the mothers themselves experiencing continued abuse at the hands of their parents as adolescents and young adults. One mother shared:

> I was holding my hand up like this because he was drunk. He was spitting in my face. So I just put my hand up like this, like, "Dad, okay. I understand." And he smacked me. And my acrylic nails broke off. And so now my thumb's bleeding, my lip is swollen. I'm just so disgusted. You know what I mean? I'm like, "I cannot wait to get away from this man." Like, this is not what I want my child to see, to feel. (Angel, mother, 22)

Young mothers shared struggling with finding a pathway forward when all they had learned from their prior experiences was what *not* to do, how *not* to discipline their children. These challenges were heightened by intrusive thoughts about their own experiences in the midst of

managing the day-to-day needs of their children. Holly, an infant mental health specialist, shared, "It's really hard to be the parent you want to be if you have this stuff that's, like, just impacting you. It's, like, right behind the front of your brain." Another participant shared:

> And my sister's like "stand in the corner" [when disciplining her kids], like, you know, something like that. I don't like doing things like that to [my daughter] because my dad used to do it to me. So I try to shy away from discipline in all areas. (Angel, mother, 22)

Professionals and caregivers echoed these challenges, noting that mothers' determination to do things differently with their children is usually not in itself enough to change intergenerational patterns of child maltreatment. As one professional shared, young mothers' attempts to make changes happen through sheer will without external support can create barriers:

> They think that they're ready to conquer the world. They think that they got this. 'I'm never gonna be anything like my mom. I'm never gonna neglect my kids. I'm never gonna abuse my kids.' And oftentimes, it's their own stuff that creates that neglectful environment or that abusive environment. And they don't see it that way, so letting someone [a helping professional] into their life is scary, especially if it's not voluntary. (Megan, child welfare social worker)

Property d: impact of domestic violence on parenting. The impact of domestic violence affected young mothers' parenting experiences in a multitude of ways. Young mothers described seeking legal action against their abusers. They explained how it was imperative to model for their children to demand safety in their relationships. Mothers often identified their part in abusive relationships: how they, too, had been abusive to their partners. Ultimately, mothers were committed to change for the sake of both themselves and their children. One mother shared, "I'm in a process of getting a peace order against him and full custody of my son, because he threatened to kill me and him" (Brooklyn, mother, 20). Other mothers also shared:

> I can't let my daughter go through it [domestic violence] because she has to know, like, when you love somebody or someone loves you, that's not the things that y'all do to each other, or that's not the way you should feel about somebody that you're supposed to love. (Rose, mother, 21)
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> I could seriously hurt him or he could seriously hurt me. That's not something that needs to be happening. So, yeah, I'm trying to change that around, stay more focused because I feel like I was losing myself and losing me being a mom. (Brianna, mother, 19)

Category II: Reaching Out

Mothers' process of beginning to reach out for mental health and parenting support has several key properties: access, trust, and pitfalls.

Property a: access. The first part of reaching out was mothers' knowledge of and access to parenting and mental health support. Participants noted several critical considerations regarding access, including: locating classes and other services (particularly with the depth that young, maltreated parents need), distance and transportation to services, flexibility as to where and how services are offered, payment for services, applying for vouchers (e.g., for childcare), continuity of support, and assessing continuing eligibility as a youth in foster care to age out of the system. Professionals, caregivers, and young parents worked hard to address or overcome these access issues, and many provided helpful suggestions for addressing them:

> The biggest thing has been finding parenting classes. It's really hard. I'm a social worker and I have trouble finding parenting classes that these kids can go to. It's rough because one of my kids is court ordered to go to a parenting class, [but it's] 30–45 min away and she got really annoyed with it, understandably. But there was no other option, really. (Bethany, clinical case manager)
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> I've had the best situations with in-home therapy, or some kind of DSS [department of social services] transported therapy. (Bethany, clinical case manager)
>
> My therapist keeps it interesting. Like, sometimes we drive around and do our therapy. And sometimes he comes to the house and we do our therapy. And sometimes we walk, or we go out to eat. Like, we do different things in therapy. We don't just sit in a room with a couch. (Angel, mother, 22)
>
> And then my other big thing that I have with a lot of the providers that we use in the community is when you make a referral […] sometimes it takes two weeks for our referrals to process, and then after those two weeks, you get assigned an intake worker. […] Then, an intake person goes out and […] does the intake, so they go out, they talk to this mom, they ask all their intake questions, whatever their intake assessment might look like, and then they say, 'Okay, you'll be assigned a therapist in two weeks and then somebody'll be out.' That's a long time, [and] it's yet another new

> person you have to share your story to. Why isn't the intake person, you know, the person that's gonna be who you're with. So that's a huge break in service, I think, and it definitely impacts how that service continues with a lot of our families. (Megan, social worker)

Property b: trust. A central component of Reaching Out for parenting and mental health support was trust. Study participants repeatedly emphasized the importance of trust in the process of accessing and receiving mental health and parenting support. Participants explained that young parents need to feel they can trust a provider or other support person in order to want to engage. The sheer number of providers and instability in helping professional-youth relationships across roles and sectors were identified as perennial issues impacting trust-building. Participants shared many ways by which initial trust was broken, which had implications for the relationship in which the breach of trust has occurred and future relationships. For example, young mothers shared about their therapists disclosing information they had thought was confidential but resulted in their foster parents and caregivers taking them to an inpatient unit to be admitted when they did not need intensive treatment.

> It depends a lot on the kid, but kids that I work with have had so many workers, so many therapists, so many…*people* just coming in and out of their lives and you really need to… Each kid, you need to make sure that you are at a good ground with them because otherwise they're not gonna open up to you and the idea of therapy doesn't really work. (Bethany, social worker)
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> My foster mother, she wasn't really in the room with me, but [my therapist] would always have to go back to tell her what we talked about [in therapy]. Which is another thing people don't like. You need confidentiality, so yeah. (Chloe, mother, 19)

Property c: pitfalls. Participants spoke extensively about pitfalls in the process of reaching out for parenting and mental health support. Pitfalls stymied efforts to get support at multiple levels, including mothers' social isolation and anxiety, interventions being very "heavy" and "serious" without being much fun, pressure to participate in individual and group therapy, the power differential between young parents and potential helping professionals, and creation and enforcement of extremely rigid rules within group homes that made young mothers distrust staff. Anna, a social worker, shared that parenting youth "see us as this authoritative figure, which we are. And that really makes them distrustful." Other participants also shared:

> [Attending therapy would be easier by] not making them feel pressure, because that was one of the biggest challenges for me when I was in the group home, I just felt pressure to, like. participate. I felt like, uh—I mean I'm ready, I'm going to, but forcing somebody to do it, it's not gonna help them open up or anything. Like, it was a mandatory thing. When they feel like they're ready to talk, they will. (Chloe, mother, 19)
>
> When you engage and interact with [young parents] in a way that they don't know that you're being therapeutic, I think that works for them. So, like, even if, you know, we're on a car ride. You know, to them, I think, it's just the maybe the sitting down face to face like this [like we are now in this interview] that probably bothers them or it feels so formal that they're like, 'I know that you're listening' or you have pen and paper out and you're taking notes, like, all of that makes—I can tell it makes them share enough, but not as much as they'd want to, versus, like I said, if we're going on a car ride or, like one of my girls that took yoga and meditation. (Ariel, social worker)

Category III: Receiving Parenting Support

Once young, maltreated mothers reached out for support, they received parenting support in varied ways. These included formal parenting support, such as through evidence-based programs, as well as informal community support, such as instrumental and social support from their foster parents, biological family, and other mothers in the community. There were both benefits and challenges to receiving these supports. Participants emphasized how committed young mothers were to changing the trajectories of their families; as one participant shared:

> I think that's, like, a common theme, is that our [young client] moms and dads, they don't want their children to have the same lives that they did. So it's like, how can you educate them on how to change that cycle. (Wilma, social worker)

Property a: formal support. Participants identified several formal parenting supports being used by young, maltreated parents. These supports include formal evidence-based parenting programs (e.g., the Circle of Security parenting program) and parenting classes offered by community-based child welfare organizations. Participants emphasized the importance of parenting support programs helping young parents to identify "what your triggers are and why that's maybe not reasonable to [react to] your child [the way that you were reacting to them]" (Carrie, family advocate).

Mothers found it helpful to normalize how challenging parenting is, as one participant shared:

> [It's important for moms to know] we have different stages of parenthood, and you can see growth. [We need to let moms] know that it's a process. No one has a book on how to be a perfect parent, and we're in this story together. (Darryl, social work administrator)

Participants discussed the power of integrating didactic and experiential learning regarding trauma and parenting when receiving formal parenting support. For example:

> We'll do hands-on discussion-based activities, or I really like to have them speak from their experience […] And they'll, like, speak from their own experience as a mother, and I feel like that gives more of a discussion-based feel, instead of us just reading the book to them. […] So we'll have handouts […] and then we do the hands-on activities, we'll do something on the white board or whatever, and we'll have someone come up and discuss what they've been through as a parent. (Bethany, clinical case manager)
>
> We have done what's called separation practice […] Where especially for, um, children who've had a lot of trauma and parents who've had a lot of trauma, that idea of separating is really complicated. So, um, a formalized practice of separating for 30 s with somebody—a clinical support on the parent and a clinical support with the child and then separating for a minute. So, reinforcing, every time, mommy or daddy is coming back. […] And then reinforcing that there's always a good goodbye. That that parent does that every time they leave. That the child realizes that they're coming—the parents are coming back. (Bonnie, social worker)

Participants felt differently about the value of ongoing parenting classes. Some shared: **"**All young moms need parenting classes. It doesn't matter how old you are. You need parenting classes" (Whitney, caregiver). Others felt classes had limited utility: "I mean, it could be really informative for somebody who, you know, has no knowledge of kids. […] But again, I had been doing it for so long that it was just like, 'Why am I here?'" (Angel, mother, 22).

Property b: community support. Participants emphasized that parenting support comes most often in the form of community-based support provided in less formal ways, such as modeling from other caregivers, advice, emotional support, and instrumental support from trusted friends, family, and foster parents, and support from churches and other religious groups. Young parents particularly appreciated hearing from other parents who, themselves, had been through parenthood. As one participant explained,

> I think it comes from the perspective of, like, especially if [you're] not a parent. You're telling me what to do, but you don't have children. So that's why I feel like I haven't found a [formal] program per se that maybe my [young parenting clients] have preferably liked. I have seen that if they don't enjoy the program, but they have a good relationship with their foster parent, they respond to that [foster parent] so much—so, so much better. (Ariel, social worker)
>
> I became a mother at 14. And my sister has—from that moment that we found out I was pregnant, she's always been by my side. She's always supported me. […] Oh, I wouldn't be able to go to work if it wasn't for my sister. She watches my daughter. (Angel, mother, 22)
>
> They need someone who they can speak with. Because a lot of the ladies want to open up, but they need someone who's willing to be there by their side. So if they have questions or they have concerns, or they are not sure about something, they can pick up the phone and/or go see someone. That's someone that they actually trust and know that that's not going to judge them. And who is going to be willing and wanting to help them. (Veronica, social worker)

Property c: benefits and challenges. Receiving parenting support had many benefits and challenges. Participants expressed that parenting classes helped young parents to "learn how to take care of their children because they [themselves] may have not been taken care of [well]," and that "their way of taking care of their child, not to say that it's wrong, but they could see it in other ways instead of [just doing] what they already know [from their own families]" (Veronica, social worker). Having parenting support allowed young parents to experience "just having someone that's by their side, [which] helps them a whole lot" (Veronica, social worker). Young mothers benefitted from having non-judgemental, helpful people in their lives who could support mothers' autonomy while providing suggestions, "step[ping] in and say[ing], 'hey, you can do it this way or you can keep it this way'" (Veronica, social worker).

Challenges to receiving parenting support included when young mothers were unwilling to accept the support offered, and the clash between young mothers' desire to have time with their friends or "party all the time" and foster parents' perceptions of asking for childcare for this purpose. Participants explained that young mothers can be "very sensitive to the idea that they're doing something wrong…and new moms are scared in general so, like, it isn't only them" (Britney, social worker). Often, young mothers expressed that

the manner in which advice was given got in the way, as Angel explained:

> But it was just overbearing, like, 'This is what I want you to do, so you should do it.' It's like, but this isn't the best choice for me, because I actually have—you know, I actually—I'm one of those people who looked into my life. I'm not just gonna do something because you think that's best for me. (Angel, mother, 22)

Another challenge to receiving parenting support was unhealthy relationships between young mothers and their own parents:

> So in my line of work, we call them the grandparents—they're still, you know, playing a role in the trauma that the young moms have faced, themselves having mental health and substance abuse issues. They are not supportive of the young moms getting the help that they need. I've seen so many different dynamics of parents who keep their kids kinda under their wing, and keep them unhealthy and not thriving, because then it still makes them feel like they're healthier than like their kids. Seeing their kids succeed would be detrimental to their own self." (Megan, social worker).

Category IV: Receiving Mental Health Support

Maltreated young mothers similarly had varied experiences of receiving mental health support. At the individual and interpersonal level, managing their mental health needs included self-regulation, medication, therapy, and community support. System level factors were particularly important, including several aspects of navigating mental health systems, such as receiving mental health diagnoses, therapy benefits, and therapy challenges.

Property a: managing mental health needs (dimensions: self-regulation, therapy, medication, additional supports). Maltreated young mothers used a number of strategies to manage their mental health needs, including working on their own self-regulation, participating in individual, group, and family therapy, taking medication, and seeking additional support when they needed it. Mothers described a process of always looking out for the interests of themselves and their children, working to become aware of and vocalize their feelings. They described a number of activities for coping, including listening to music, writing, art, going for a walk or jog, getting outside for fresh air, walking dogs or interacting with other animals, breathing exercises, yoga, meditation, taking breaks, using stress balls, and, overall, as young mother Catherine shared, working on "nurturing yourself." Mothers also described use of substances to regulate their emotions, including alcohol, marijuana, and smoking. Mothers described a desire to move from less healthy to more healthy ways to build self-regulation skills. Veronica, a social worker, noted that when seeking mental health services, providers should help "them see that they're empowered" explaining that the youth should be able to say:

> I've [the youth] been through this, I'm resilient, I got through that. I'm going through something right now and I can still move forward, and moving forward I can use these tactics, I can use these skills to help me maneuver continuously through life. (Veronica, social worker)

Participants expressed concern that medication to manage mental health conditions may not be helpful for everyone. As Bonnie, a social worker, shared: "I have seen people really thrive by using psychopharmacological tools to support them. And I have seen a lot of people drugged."

Property b: navigating mental health systems. Participants described significant challenges with navigating mental health systems. Both young mothers and providers described mixed feelings about mental health diagnoses. They shared particular concerns about receiving a diagnosis early in life and not being reevaluated regularly to see if the diagnosis was still valid. Some participants felt as though diagnoses led them to being prescribed medication that was not really needed, particularly if the diagnosis no longer applied. As one caregiver explained:

> I don't know if mental health is the way the kids are thinking…. Because some of the kids that were on medication, they really didn't need it. I think it was a way to, I guess, diagnose these kids with something. Some of them weren't even tested, um, when they got older. It's just like, 'Well, I was tested at five years old.' Well, how do you know you have whatever? … 'I have ADHD. I have Asperger syndrome. I have this,' and they went all down the line. I said, 'You can go on down the line like that with me. You ain't had much of nothin'. They're just telling you that.' I said, 'Well, when did they tell you that?' 'Oh, I was, like, five years old.' I said, 'Five years old, and you remember all of that?'(Whitney, caregiver).

Providers explained that diagnoses can be helpful to normalize what therapy clients are going through. They also expressed concern that diagnoses may be inaccurate - for example, symptoms associated with a diagnosis of attention deficit hyperactivity disorder (ADHD) or bipolar disorder being, instead, trauma sequelae:

> It's a label, really. I mean, it's for billing purposes. But at the same time, I think that it also kind of normalizes it for clients. […] I just don't like when clients get a diagnosis when they're, like, 12, and then 20 years later, they're, like, yep, I'm diagnosed with this, this and this. But they haven't ever—they haven't, like, continued to get evaluated […] When you think about depression, there's so many different types of depression. And it really is just, like, a label that, like, follows you forever. Same with ADHD […] I get very concerned with how many kids are diagnosed with ADHD, when I feel like, again, it's, like, trauma symptoms just, like, playing out. (Wilma, social worker)
>
> And, you know, I know a lot of people who had traumatic childhoods who were diagnosed very young with bipolar, and who have been working really, really hard, you know, into their 30s to extricate themselves from those diagnoses that do things like prohibit them from driving and, you know, medicate them in ways that they don't need to be medicated. So, I mean, you know, I think - I think it's all hand in glove with for-profit healthcare and pharmaceuticals. (Bonnie, social worker)

Participants expressed both benefits and challenges of seeking therapy. Benefits included how healing therapy can be, particularly when therapists are creative in how they work with clients, such as integrating basketball or other activities, and how therapy can serve as an important "sounding board" (Sam, caregiver) that "provides [young parents] with a lot of insight" (Wilma, social worker). Shelley, a young mom, described therapy this way: "It's helping me with my well-being." As helpful as therapy could be, participants described a number of structural challenges to its access. Barriers included waitlists and delays in receiving mental health care, disruptions in continuity of care when changing providers, childcare, transportation, stigma, and past negative experiences with other therapists and mental health care systems.

Category V: Seeking a Change

Throughout their interviews, participants identified ways to improve parenting and mental health supports for young, maltreated mothers. Participants discussed desired formal parenting and mental health programs, as well as family and community supports.

Property a: desired parenting formal and informal support. Participants described a number of formal and informal parenting supports that would be helpful to young maltreated parents, including individual home-based parent coaching, group parenting sessions, and receiving instrumental support to address basic needs (e.g., diapers, housing, and food). Participants expressed the importance of holistically addressing basic needs as well as psychological and parenting needs. Young parents shared again and again their desire to support one another, either through group sessions or through hearing from parents who had been through similar struggles and overcame them. Providers and caregivers echoed this sentiment:

> I think the same should work with parenting programs for our young girls so they can see…that that person overcame, I think that speaks volumes to the girls that I work with versus having the social worker come in or, you know, even if it's just a regular mom, but the fact that there's a mom that's coming in, it's like, 'Hey, I've been in foster care, I've dealt with abuse, and here I am now standing in front of you.' (Ariel, social worker).

Property b: desired mental health formal and informal support. Participants emphasized the need for interactive support that engages young parents as active participants in therapy. Participants had many different ideas for how to create an interactive experience through various treatment modalities, for example Anna, a social worker, said: "having an app for social groups where they could, when they're not in the group, they have an app that they can chat with each other if they're feeling stressed out or something;" and Ariel, a social worker, said: "not necessarily like a sit-down, there's someone like lecturing to you;" integrating physical activity into the appointment; and involving the children in therapy where appropriate. Participants identified preferring to have options to meet where the client feels most comfortable and it is most convenient for them, whether via telehealth, in the office, in the home, or in the community, such as meeting at a park. Without the option to bring their children and either have childcare available or have them in the session with somewhere to play, young parents would likely have difficulty attending. Participants further emphasized the importance of scheduling flexibility, given that young parents' days are often unpredictable and can change due to work schedules and children's needs. They recommended having flexible arrival times and providing grace regarding rescheduled appointments. Participants recommended offering transportation to sessions to further reduce barriers to attendance.

Discussion

This study highlights the importance of an integrated, multilevel approach to parenting and mental health support for young maltreated parents in order to give young families a

strong start and prevent the intergenerational transmission of child maltreatment. Due to the way services are designed and billed for - particularly mental health services - parenting support and mental health support are often separated. Yet, mental health and parenting are conceptually and experientially intertwined, particularly for young parents with a trauma history. Study findings echo prior research on the heightened parenting stress and mental health challenges experienced by young, maltreated parents (Aparicio, 2017; Schelbe & Geiger, 2017). Parents' exposure to emotional stressors and other adversities mediates the relationship between parents' own child maltreatment and experiences of maltreatment among their children, leading to adolescents' depression, anxiety, PTSD, and externalizing symptoms (Negriff et al., 2020). Thus, mitigating exposure to and impact of young parents' emotional stressors and other adversities is critical to prevention of intergenerational maltreatment and mental health problems. In this study, participants' experiences emphasized the importance of taking a systems approach to addressing the needs of young, maltreated parents. In particular, it is critical to understand that young parents will necessarily be attending appointments with their young children.

In practice, some organizations and programs have found ways to successfully address parenting and mental health together in order to support families and prevent maltreatment, including addressing basic needs and integrating a family-focused prevention approach. The Healthy Generations Program at Children's National Medical Center includes a two-generation comprehensive approach to health care for teen parents and their children, including medical and mental health care, parenting support, diapers provided at every well child visit, and referrals for legal services, WIC, and other support services (Children's National Hospital, n.d.). The Damamli Program at Hearts and Homes for Youth is an independent living program and treatment foster care program for teen mothers in foster care that provides mental health treatment, parenting support, case management, and housing (either with a specialized foster home or supportive independent living program) (Hearts & Homes for Youth, n.d.). These and other programs, while not necessarily explicitly designed for the prevention of child maltreatment, demonstrate the kind of integrative approach young parents and their supporters are requesting. There are some mental health interventions focused on infant mental health and parent-infant relationships that could be expanded or integrated with evidence-based mental health treatment for parents in order to enhance a dual focus on both young parents' own mental health care and parenting, for example the Attachment and Biobehavioral Catch-up (ABC) Program (Dozier & Bernard, 2019) and Child-Parent Psychotherapy (Lieberman et al., 2005). It is important for model developers to be responsive to the integration of parenting and mental health programming so that the model fidelity (i.e., evidence-base) is maintained as the programs are adapted to meet the complex needs of young parents.

Study Limitations

The current study offers an in-depth and innovative analysis of the parenting and mental health needs of young, maltreated mothers in order to inform an integrated approach to child maltreatment prevention in partnership with young families. There are several limitations to consider prior to assessing study implications. The study was conducted with a focus on young mothers, yet many young fathers also have child maltreatment histories and are navigating the challenges of parenting young children and may have different needs than those found in this study. This study was conducted in the mid-Atlantic region of the United States; it is always possible that other young mothers, their caregivers, and professionals serving them would have other experiences if living elsewhere. For example, young parents living in rural areas might have a greater need for telehealth and other technology-mediated interventions to bridge the distance between young parents and providers of services. Despite these limitations, this study offers a clear contribution to the literature with regard to informing an integrative mental health and parenting approach to intervention.

Implications for Child Maltreatment Prevention Practice and Research

There are a number of important implications, with public health impact, from this study. Young, maltreated mothers are often met with considerable barriers to accessing mental health and parenting supports critical to preventing intergenerational transmission of child maltreatment including internalized stigma, transportation needs, balancing time required to meet their children's and their own needs, and waitlists for treatment. When designing services for young, maltreated mothers, referral and intake processes should be made as simple as possible to reduce barriers to engagement. Accounting for basic parenting needs while providing mental health services is critical, including housing, diapers, food, and safety; young, maltreated mothers are likely to need intensive wraparound support that addresses both mental health and parenting needs in a comprehensive, integrated manner in order to ensure they are able to successfully avoid maltreating their children. Because so many factors are stacked against young parents, it is imperative that systems be mobilized to support them as too often child maltreatment is attributed to individual failures of parenting

rather than systemic failures to support young families so that they can thrive. Designing new or adapting existing programs that recognize and address complex multilevel needs of young, maltreated parents and their children can be further strengthened by employing a reproductive justice framework that recognizes the inherent right of people to their own reproductive planning and decision-making. Testing integrated parenting and mental health services, and paying particular attention to issues of implementation fidelity, will be important in future research. Finally, further research is needed on the experiences of young, maltreated fathers, so that services can be specifically developed and marketed for them.

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Declarations

Conflict of interest The authors declare they have no conflict of interest.

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