

Teen Mothers' Experience of Intimate Partner Violence

A Metasynthesis

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Pregnant and parenting teens suffer higher rates of intimate partner violence (IPV) than older mothers. This qualitative metasynthesis explores teen mothers' experience with IPV during pregnancy and postpartum. Organized by the metaphor of a web, findings highlight how pervasive violence during childhood contributes to teen pregnancy and the risk of IPV as violence is normalized. The web constricts through the partner's control as violence emerges or worsens with pregnancy. Young mothers become increasingly isolated, and live with the physical and psychological consequences of IPV. Trauma-informed nursing practice is needed to support teen mothers in violent intimate relationships to spin a new web. **Key words:** abuse, intimate partner violence, poverty, pregnant teens, qualitative metasynthesis, teen mothers, trauma, trauma informed care, violence

Anger and tenderness: the spider's genius to spin and weave in the same action from her own body, anywhere—even from a broken web.¹

INTIMATE PARTNER VIOLENCE (IPV) among pregnant and parenting teens is a significant clinical problem. In a comprehensive review of studies on urban adolescent mothers who are exposed to various forms of violence, Kennedy² reports that prevalence rates for partner violence range from 12% to 50%. Homeless teens³ and American Indian teens⁴ report relatively high rates of IPV. For example, 37.5% of pregnant American Indian teens from the Northern Plains who were served by a teen mother program

over a 5-year period reported IPV.⁴ However, this study reported a poor response rate (26%) to the survey and no comparison group was used. Prevalence of IPV for teen mothers may be substantially higher than reported for several reasons: teen mothers fear that they could lose custody of their children or face their partners' retribution if they report IPV.^{5,6} They also tend to minimize or normalize abuse or believe that their own behavior justifies partners' violent responses.^{7,8} Prevalence also varies across studies as screening methods use different terminology for IPV. For example, higher rates of IPV are identified when more specific behaviors are referred to, such as "have you ever been hit or kicked."⁹ Kennedy et al's⁹ review further highlights that urban pregnant and parenting teens are at high risk for multiple forms of violence, including IPV.

Research also documents the health effects of IPV for women in general and pregnant women in particular, but health effects are rarely differentiated by age groups. Health effects include direct injury and trauma-related problems such as depression, anxiety, internalizing problems, aggression, posttraumatic stress disorder, drug abuse, and externalizing

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Statements of Significance

What is known or assumed to be true about this topic:

Intimate partner violence (IPV) in teen relationships leads to significant clinical problems such as depression, anxiety, posttraumatic stress disorder, drug abuse in the mother, and poor neonatal outcomes and infant health. Homeless and American Indian teens experience higher rates of IPV than the general population. IPV is underreported for fear of retribution from partners and fear of losing custody of their children. Frequently, the partner's behavior is minimized and normalized. Across the age range pregnancy and birth can precipitate IPV. Pregnancy and birth can also be a catalyst for the mother to leave an abusive relationship.

What this article adds:

IPV tends to occur in pregnant and parenting teens who have been exposed to multiple forms of violence across their childhoods, and therefore it is difficult to identify early warning signs of an abusive relationship. Help-seeking can be counterproductive as the young mothers are often blamed or disbelieved. Coming out of a violent relationship can take several attempts and building a new life requires community resources. Trauma-informed staff who assess for cumulative trauma and ask specifically about IPV can validate the experience, offer education and practical support. Health professionals should also advocate for social policies that mitigate the social determinants of teen mothering and violence.

issues. Silverman et al^{10(p140)} refer to IPV as a "pervasive public health concern." They explore the physical health consequences for women enduring IPV both before and during pregnancy noting chronic pain, gastrointesti-

nal problems, heart and circulatory problems, and poor sexual and reproductive health outcomes. Neonatal outcomes, infant health, and women's pregnancy-related morbidity are also a concern.¹⁰ Pregnancy and birth can precipitate IPV^{11,12}; conversely, pregnancy can be a catalyst for women to leave an abusive relationship.¹³

This growing literature is complemented by qualitative reports on teen mothers' perspectives on IPV. Qualitative approaches are particularly valuable in uncovering aspects of the IPV experience that may be hidden or taken for granted in variable-focused studies.¹⁴ Illuminating the human experience of IPV has the potential to trouble the assumptions of researchers, clinicians, and policy makers. When sufficient qualitative studies are available in a substantive area, a metasynthesis of primary studies is recommended. Described as a research method that overcomes the limitations of small-scale studies, metasyntheses have the potential to offer a fresh interpretation.¹⁵ Metasynthesis is defined as "the theories, grand narratives, generalisations, or interpretive translations produced from the integration or comparison of findings from qualitative studies."^{14(p366)} A metasynthesis is based on the findings from qualitative reports rather than on the data collected from the original studies, and is therefore potentially limited by the fact that it is an interpretation of other researchers' interpretations.¹⁶

Relevant to the project reported here, Kearney¹⁶ synthesized 13 qualitative studies on IPV in adult women; however, the experience of IPV in young and older mothers may vary in important dimensions.^{8,17} Given the clinical importance of IPV in teen mothers, the broad purpose of this study was to synthesize the growing number of qualitative studies on teens' experiences with IPV during pregnancy and after giving birth. A second goal was to describe the trajectory of IPV, including the ascendance of partner violence in their lives and the circumstances and contexts for leaving abusive partners.

DEFINING IPV

It is essential to define IPV and how it might differ from other similar terms. For example, IPV is often used interchangeably with domestic violence, yet international definitions of domestic violence vary. According to the UK Home Office,¹⁸ domestic violence applies to intimate partners, family members:

Domestic violence is . . . any violence or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, sexual, financial, emotional.

This definition was recently amended to decrease the age to 16 years in recognition of the increasing "domestic violence" experienced in younger groups. The experiences of even younger children with partner violence are ignored in this definition.¹⁹

The US Department of Justice,²⁰ definition of domestic violence focuses on intimate relationships only:

We define domestic violence as a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic Violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure or wound someone.

This US document further states that domestic violence can affect people of any race, sexual orientation, religion, or gender and occurs across all socioeconomic and educational levels. Couples of the opposite or same sex, and those who are married, living together or dating are affected. Because of international differences in definitions of domestic violence, we use the term "intimate partner violence" for this metasynthesis as defined by the World Health Organization²¹:

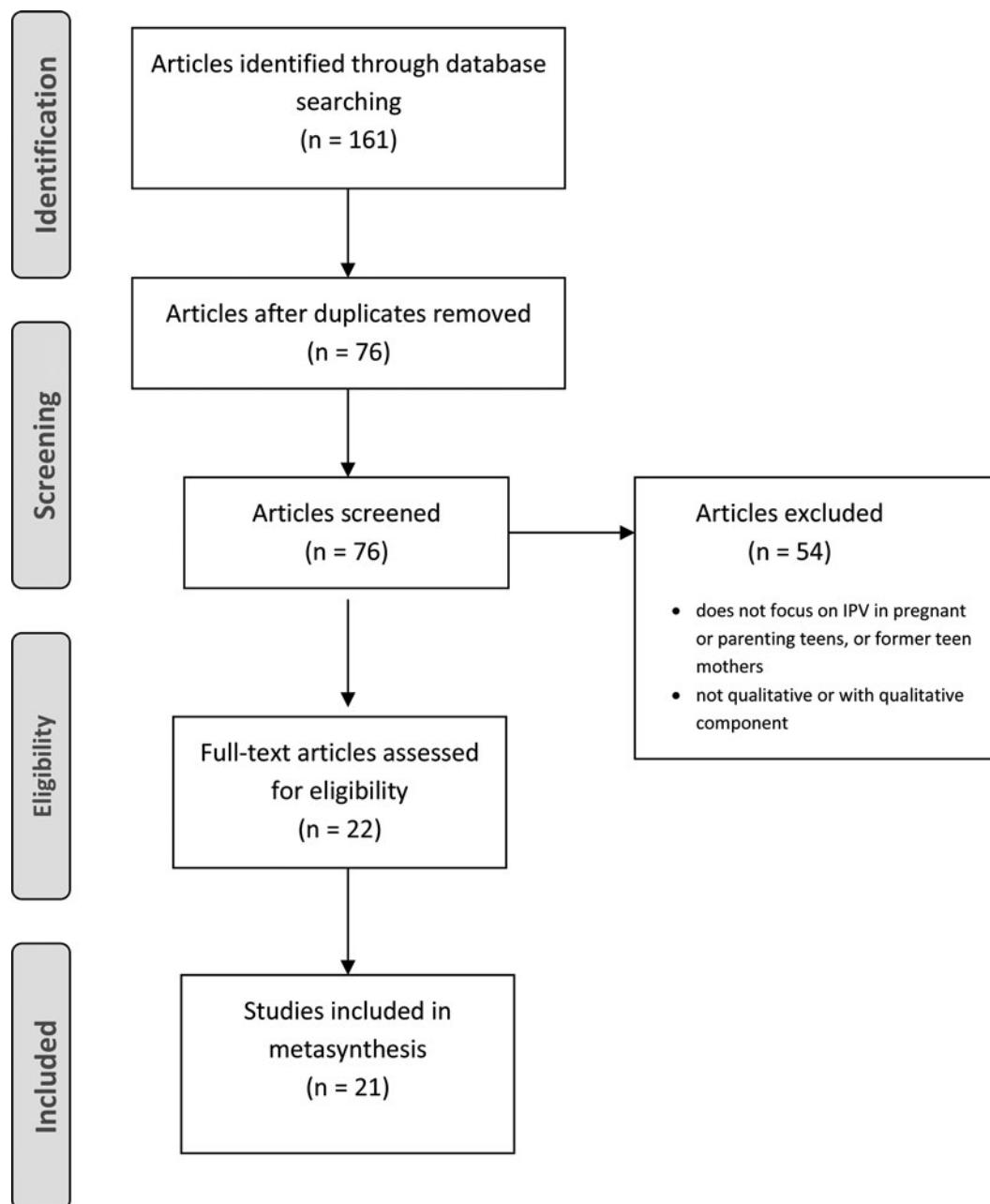
Any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.

METHODS

The research team undertaking this meta-synthesis included a seasoned and novice qualitative researcher from the United States and the UK; both researchers brought their extensive clinical experience with teen mothers to the project. We followed the approach to metasynthesis described by Sandelowski and Barroso.¹⁵ We conducted an exhaustive search of the literature with the assistance of an information specialist. In March 2015, a systematic literature search was conducted in 10 electronic databases for qualitative research studies relating to adolescent mothers and intimate partner violence. The databases searched were *CINAHL*, *Ovid MEDLINE*, *Scopus*, *Web of Science*, *PsycINFO*, *Social Work Abstracts*, *Sociological Abstracts*, *Social Services Abstracts*, *Cochrane Library*, and *Women's Studies International*. The search strategy consisted of text words and controlled vocabulary terms appropriate to the individual databases for the concepts of *adolescent mothers* AND *intimate partner violence* AND *qualitative research*. Publications were limited to English; no publication date limits were applied. Qualitative reports were included if they addressed IPV of pregnant or parenting teens, or former teen mothers. Studies on the basis of mixed methods or longitudinal designs were included when a qualitative component was reported. The second author reviewed the titles and abstracts of 161 articles from the electronic search. Seventy-six duplicates were removed. Twenty-one studies, represented in 22 articles (2 articles reported on different aspects of the same study), met the study criteria (Figure 1).

Primary studies were coded independently by both researchers. We first extracted the characteristics of the original studies (ie, sample size and demographic characteristics, methodological approach, and discipline of

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**Figure 1.** Flowchart of the articles reviewed.

researchers) and placed this data in matrices. We then extracted the key findings of each study and placed them on coding sheets. Coding sheets included a complete list of thematic or interpretive statements. After all stud-

ies were coded in this way, we compared findings across coding sheets and reconfigured them into a larger "mosaic." We used a dropbox account to revise the matrices and communicated by e-mail to review sampling

decisions and coding sheets as needed. Differences in coding were minor and were settled by mutual agreement.

RESULTS

The 21 studies identified for the metasynthesis represent the experiences of approximately 850 pregnant or teen mothers who experienced IPV (Table 1). Because 2 studies followed up teen mother participants for 6²² or 15 years,⁵ participants' ages ranged from 15 to 37 years. Fourteen of the 21 studies included 2 or more ethnic groups, and 3 focused on a specific ethnic group: Navajo, black African, and Latino. Four studies did not report the ethnic background of study participants. One study focused on homeless teen mothers' experience of IPV.²³ No studies addressed IPV in teen mothers in foster care or from sexual minority groups. Two reports interviewed teen mothers who had participated in an educational intervention to improve communication with their partners.^{24,25} The majority of the studies ($n = 18$) originated in the United States, with 2 studies from the UK and 1 from Uganda. Data collection for 12 of the studies included individual interviews only; 4 studies conducted focus groups only; 5 used a mixed-method approach combining either focus groups and interview or survey and interview. Where stated, a grounded theory (5), ethnographic (2), and case study (1) approach was used. Thirteen studies did not state a methodological approach. The disciplines of the authors were predominantly from health and social work, and 1 from law. The articles span 2001 to 2014, suggesting a recent focus on teen mothers and IPV.

We included all relevant studies irrespective of their quality. Because there is no consensus on excluding studies on the basis of methodological quality,^{15,26} we chose instead to evaluate studies using Kearney's²⁷ taxonomy, which categorizes qualitative studies on the basis of their level of complexity and discovery. Kearney identifies 5 levels; level 1 involves no discovery and little complexity

because a priori frameworks are imposed on the data. In contrast, studies at level 5 provide thick descriptions and variations that are contextually grounded. As Kearney points out, even studies at levels 1 to 2 may be methodologically sound but do not offer clinically useful insights. Studies at higher levels are more likely to have clinical significance. The majority of studies for this project clustered at levels 1 to 3 (Table 2). These ratings were not surprising because studies at level 5 are typically published in books, not in journals with strict page limits.²⁷

The results of this metasynthesis are organized by the metaphor of a web, as inspired by Adriene Rich's poem *Integrity*,¹ which appears at the beginning of this article. The metaphor was considered only after all studies were coded by both researchers. The lines of the poem conjure up a range of emotional responses and teen mothers' resilience in coping with the assaults to their bodies and personhood. The visual image of a web implies being suspended by tensile threads; the connections (broken and otherwise) that are spun and rewoven over time; and the long-term repercussions of violence, even for those who extricate themselves (Figure 2).

[T2]

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FINDINGS

The findings from the metasynthesis demonstrate how the experience of IPV among teen mothers is woven into a larger web that is often formed by the insidious effects of poverty and multiple forms of violence.² When acts of aggression occur across multiple settings and with various actors, teen mothers respond with fear, mistrust, anger, and hopelessness; they may withdraw or lash out, hurting themselves or others.^{25,28,29,30} As teen mothers and their partners cannot easily remove themselves from the web without viable alternatives, habits and sentiments that are learned in the web may be transmitted from one generation to the next. The key findings are presented in temporal order under the following

Table 1. Demographics of Study Participants

Study	Location	Sample Size	Age Range at Time of Interview, y	Ethnicity	Pregnancy Status
Brown et al ³⁸	UK USA	26; 9 young mothers T1 = 29	Not stated T1: 16-20 T2 = 28-37	Not stated Navaho	Teen mothers Former teen mothers
Dalla et al ⁵		T2 = 21			
Herrman ³⁴	USA	26	Mean age 16.5	7 Latina 10 black 6 white	Pregnant and parenting teens
Kaye et al ¹³	Uganda USA	16 10	Not stated 16-20	3 mixed Black African 7 Latina	Pregnant teens Pregnant and parenting teens
Kennedy et al ²³	USA	14	18-22	3 black 9 black 4 mixed	Teen mothers
Knight ³⁷	USA	16		1 Native American 7 white 2 black 2 Latina 4 mixed	Teen mothers
Kulkarni ³⁵	USA	13 of 30 with violence exposure ^a	18-22	1 Asian American Not stated	Teen mothers
Kulkarni ¹²	USA	24 (of the 30 in author's 2007 study)	18-22	10 Latina 9 black 4 white	Teen mothers
Leadbeater et al ²²	USA	93 at 6-7 y follow-up	20-26	1 Asian 59 black	Former teen mothers
Lesser et al ²⁸	USA	21 mothers 19 fathers	18-23	34 Latina Latina	Teen mothers
Lesser et al ⁴⁷	USA	18 mothers 15 fathers	15-23	Latina	Teen mothers
					(continues)

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Table 1. Demographics of Study Participants (Continued)

Study	Location	Sample Size	Age Range at Time of Interview, y	Ethnicity	Pregnancy Status
Miller et al ⁴³	USA	53, 14 in-depth analysis	15-20	20 Latina 11 black (assume 22 white American)	Young women
Moloney et al ³¹		65 mothers; subset 350 female gang members	13-31	32 Latina 21 black 8 mixed	Young mothers
Raphael ⁴¹	USA	Subset from 474 girls on welfare; n not stated	≥15	4 Pacific Islander	Teen mothers
Renker ³²	USA	Subset of 40 teens from larger sample of 139 teens	18-20	18 white 17 black 5 other	Teen mothers
Renker ⁴⁴	USA	20	18-20	Black/white Numbers not stated	Teen mothers
Renker ⁶	USA	20	18-20	Black/white Numbers not stated	Teen mothers
Rosen ⁴²	USA	35	Mean age 18.2	23 white 12 black	Teen mothers
Toews and Yazedjian ²⁴	USA	148	14-20	130 Latina 18 other	Teen mothers participating in educational program to improve communication skills with partners
Toews et al ²⁵	USA	199	14-18	173 Latina 14 black 6 white 6 biracial	Teen mother participants in educational program to improve communication skills with partners
Wood and Barter ⁸	UK	16	13-18	Not stated	Teen mothers

^aAge range is based on the participants' ages at the time of being interviewed for the current study. In some studies, participants were no longer teens but either provided retrospective accounts of their IPV experience or were participating in longitudinal studies of teen mothering.

Table 2. Methodological Considerations of Studies

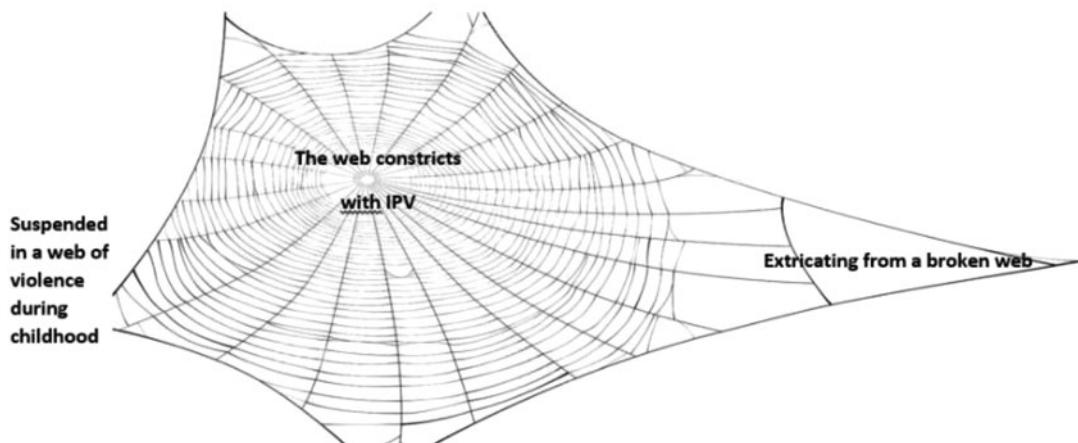
Study	Discipline	Purpose of Study	Method	Kearney's Level
Brown et al ³⁸	Sociology	Young mothers' experience of power, control, and violence within intimate and familial relationships	Interview; constant comparative analysis	2
Dalla et al ⁵	Family studies	Focus on Navajo adolescent mothers and intimate partner relationships	Interview: thematic analysis	2
Herrman ³⁴	Nursing	How teen mothers describe dating violence	Focus groups; descriptive/qualitative analysis	2
Kaye et al ¹³	Public health/women and gender studies	Coping strategies of pregnant adolescent survivors of domestic violence	Interview; grounded theory	3,4
Kennedy ³⁶	Social work	Exploring resilience among urban adolescent mother living with violence	Mixed methods; grounded theory	2,3
Kennedy et al ²³	Social work	Risk chains over the life course for homeless teens	Interview; grounded theory	3
Knight ³⁷	Social work	Describing the experience of pregnant and parenting adolescents and IPV abuse	Interview; grounded theory	4
Kulkarni ³⁵	Social work	Partner violence at the crossroads between adolescence and adulthood	Ethnographic interview; thematic analysis	3
Kulkarni ¹²	Social work	The relational consequences of IPV for adolescent mothers	Ethnographic	3
Leadbeater et al ²²	Psychology	Escaping domestic violence (chapter 9)	Longitudinal; mixed methods; content coding and case study analysis	3
Lesser et al ²⁸	Nursing	Developing insight into multiple struggles with violence	Focus groups; analytic approach not stated	1

(continues)

Table 2. Methodological Considerations of Studies Continued (Continued)

Study	Discipline	Purpose of Study	Method	Kearney's Level
Lesser et al ⁴⁷	Nursing	Latino adolescent mothers and fathers in South Texas managing violence	Mixed methods; focus groups and individual interviews; grounded theory	1
Miller et al ⁴³	Medicine/not stated	Male partner pregnancy promoting behaviors	Interview; content analysis	1-2
Moloney et al ³¹	Sociology	Gang girls negotiation of new identities with motherhood	Mixed methods; interviews; analytic approach not stated	3
Raphael ⁴¹	Law	The role of domestic violence in teen pregnancy and parenting	Survey followed by interview; analytic approach not stated	1
Renker ³²	Nursing	Exploring strategies for dealing with perinatal violence	Interview; content analysis	2
Renker ⁴⁴	Nursing	Exploring outcomes of perinatal violence for teen women	Interview; content analysis	2
Renker ⁶	Nursing	Teenagers rationale for denying violence when asked	Interview; content analysis	3
Rosen ⁴²	Social work	Exploring partner violence with teen mothers	Interview; grounded theory	3
Toews and Yazedjian ²⁴	Family and child development	Adolescent mothers' perceptions of a relationship education program	Focus groups; constant comparative method	2
Toews et al ²⁵	Family and child development	Conflict resolution strategies in adolescent mothers' dating relationships	Focus groups; thematic analysis	1-2
Wood and Barter ⁸	Social work	Teen mothers' experiences of intimate partner violence	Interview; analytic approach not stated	3

Abbreviation: IPV, intimate partner violence.



[AQ2]

Figure 2.

3 themes: suspended in a web of violence during childhood, the web constricts with IPV, and extricating from a broken web.

Suspended in a web of violence during childhood

IPV tends to occur among pregnant and parenting teens who have grown up in toxic environments. Vulnerable families and dangerous neighborhoods expose youth to multiple forms of violence beginning in childhood. Pregnant and parenting teens may have witnessed parental IPV or were themselves emotionally, physically, or sexually abused by a family member or the mother's partner.^{23,29} They may have also witnessed school fights, stabbings, shootings, and police action or brutality. They may have exchanged sex for material goods, joined a gang, or become romantically involved with a gang member, and then participated in violence by fighting with peers or hiding partners' guns.^{28,31} Childhood losses and traumas accumulate further from foster care placement, gun violence, and incarceration and murders of family members.^{23,32} These multiple traumas place teens at risk for early sex, pregnancy, and risky behaviors; they also contribute to symptoms of depression and trauma and self-medication with drugs or alcohol.^{12,29} When

violence becomes normative in family and community contexts, teen mothers tend to cope by emotionally sealing off the past.²⁹

Pervasive violence becomes taken for granted,^{8,23,28,32,34-37} with those in the web "tolerating" or becoming numb to microaggressions (coercion, intimidation, manipulation) and overt violence.^{25,38} Dependence and control course through the web of relationships, reinforcing powerlessness, mistrust, and social isolation.²⁵ Codes of silence are maintained by fear, guilt, shame, social isolation, and lack of trust in authorities.²⁹ Young mothers learn to act tough. Lacking skills for negotiating or deescalating conflicts, situations that convey disrespect can quickly become volatile.^{23,32}

Against a background of family disruption and community violence, teens form intimate relationships seeking attention, security, and love.³³ Some become involved with gangs and older partners.^{31,39} Romance offers a hoped-for escape from a grim past and an impoverished future.^{29,31,40} Girls often welcome pregnancy, believing a child will strengthen the relationship with the partner and offer fulfillment that is often lacking when teens are disconnected from school.²³ In a web that offers few pathways to a promising future, relationships with partners and children fill an emotional void, while increasing girls' vulnerability to abusive partners, substance

abuse, and other personal and interpersonal problems.^{8,29,31,37,41}

The tensile threads of a spider web allow little room for maneuver as control and domination by the partner are mistaken for love.⁴⁰ As teens are entrapped by a partner's control and jealousy,⁴² other relationships wither. Family relationships are particularly vulnerable if parents disapprove of the partner or the pregnancy.³⁶

The web constricts with IPV

Within a context of pervasive and normalized violence, young mothers are vulnerable to abusive partners, but the trajectory of IPV varies. Some teens leave an abusive relationship with the first physical assault but return when a pregnancy is confirmed so the child will have a father. Many girls welcome mothering but also hope that a child will cement their relationship with the partner.^{22,30}

However, their dreams and hopes for love and security unravel as the threads of the web constrict. Although girls may assume that pregnancy will decrease the partner's violence, it often intensifies abuse and feelings of entrapment.³⁶ Stress related to the pregnancy, the partner's denial of paternity, and drugs and alcohol play a role in exacerbating violence.^{5,34} Teens report being pushed, slapped, choked, punched, beaten, raped, or threatened with death by partners.³⁷ They also report verbal and emotional abuse (yelling, arguing, belittling, and humiliation) and stalking.^{34,42} Partners sabotage mothers' use of birth control,^{11,41,43} undermine their efforts to attend work or school, and disrupt ties with family members or friends.^{34,41} Cell/mobile phones and social media entrap mothers further by providing more effective technological tools for stalking and monitoring or controlling their behavior.³⁴

Caught in the threads of the web, pregnant and parenting teens rarely recognize early warning signs of IPV; they also tend to minimize IPV.^{13,32,37} The unpredictability of the partner's behavior, which may vacillate from being supportive to emo-

tionally and physically abusive, creates an emotional roller coaster that includes hopelessness, helplessness, shame, self-blame, and emotional numbing.^{12,43} As threats and violence escalate, and as teens become more isolated, they may avoid "pushing his buttons" to reduce the partner's assaults.⁴⁴ Their efforts at self-protection also include self-imposed silence, distracting or placating the partner, withdrawing from the partner, sneaking away for short periods, feigning illness, and resignation.^{13,32} They may also ask friends to the home, hoping that the presence of others will curtail the partner's abuse.^{6,44} Some mothers retaliate in response to the partner's violence even though this response may result in their own arrest.^{5,23} Mothers also report using their child as a shield during fights with the partner.⁴⁴

In some instances, calls to the police are effective in obtaining restraining orders or the partner's arrest,^{13,32} but help-seeking is counterproductive when mothers are subjected to shame and blame, and partners retaliate.⁵ Teen mothers describe many reasons for not seeking help from authorities and community services: they assume they will not be believed; fear losing custody of the child (especially if they fight back); and fear the partner's retaliation if their allegations are dismissed.⁶ Their ambivalence about severing emotional ties with the partner and the child's ties to the father also constrain help-seeking.⁶ They continue to hope that the partner will change his behavior, and fear the unknown.^{30,34}

Teen mothers are also reluctant to disclose IPV to professional caregivers.^{5,6,32} Their mistrust is reinforced when their fears and concerns are dismissed, when professionals do not explain the limits to confidentiality, or do not fully explain the implications of reporting abuse. When help-seeking leads to unexpected hardships or further violence, mothers' trust in professionals is eroded further. They are more likely to seek the help of family and friends to leave the partner. However, these relationships may be strained if teens submitted to the partner's demands, or if families pressured them to remain with the

partner. Family members, for example, may have encouraged the teen mother to "stand by your man" to ensure the child's ties to the father.^{12,35,45,46} In some cases, family ties may have been severed years earlier for those who were placed in foster care.

The effects of IPV reverberate throughout the web. The chaos and unpredictability of a toxic environment create an unstable ground for mothering and establishing a promising future.^{12,30,44} Teen mothers link episodes of IPV to fetal deaths, miscarriages, abortions, and premature births.^{32,44} They also report poor school performance, suicide attempts, self-mutilation, and drug use abetted by the partner.^{36,37,44} As symptoms are dismissed, symptoms of trauma and depression fail to be recognized by teens and professional caregivers. The ultimate impact of recurrent IPV in the context of cumulative violence is a loss of self. Feelings of helplessness and worthlessness erode confidence,³⁰ isolation grows,²³ and teens are immobilized as cumulative exposure contributes to mental health problems, disability, homelessness, serial relationships with abusive partners, and the removal of children from their custody.^{22,23}

Extricating from a broken web

When violence is normalized and past help-seeking has been ineffective or counterproductive, extricating oneself from a dangerous web takes strength and courage and may involve multiple attempts.⁴⁴ Mistrust of professionals and the police, symptoms of trauma and depression, and the lack of personal or social resources immobilize teen mothers and create formidable barriers to leaving partners.²² The lack of stable housing and a reliable source of income are additional barriers to leaving an abusive partner, especially because returning home to their families is often considered a last resort.^{31,37}

In spite of these emotional and practical challenges, abusive relationships with partners come to an end when partners are arrested for unrelated crimes or mothers take action on their own behalf.²² Some mothers

sever relationships when abuse or drug and alcohol use become intolerable,^{22,37} or when they fear that their child's exposure to IPV is repeating what had happened to them as children. This fear often coexists with the fear that reporting IPV may jeopardize their custody of the child, especially if mothers are using drugs or have a history of retaliating and going to jail.^{37,44} In spite of these fears, protecting the child often provides a more compelling reason to leave the partner than concerns for their own safety.^{30,38}

Growing self-awareness of abuse and its insidious effects on their lives is promoted when teen mothers' prior tolerance is challenged by peers, trusted professionals, and educational programs.^{24,25,37} Leaving an abusive partner is generally considered the first step in disentangling from the threads of the old web and spinning a new one. Without consciousness-raising, mothers' understanding or memories of IPV remain submerged in the shadows and are poorly integrated into the present.³⁸ Old habits and survival skills that developed in response to a dangerous web contribute to ongoing fears, pervasive mistrust of men (and others), and hypervigilance about being self-sufficient.²² Until new habits and skills are developed, mothers may continue to present a tough and defiant façade to prove their invulnerability.^{23,29,47} Bravado and cynicism are engrained forms of coping; any show of weakness is avoided at all costs. Without repairing the past and gaining new coping skills, mothers remain at high risk of returning to an abusive partner or repeating the cycle of abuse with subsequent partners.^{22,25}

Teens with few prospects for a positive future find meaning and purpose in mothering.^{8,39} This metasynthesis shows that those with trauma histories face special landmines related to parenting. They may be hyperprotective of their children and committed to *avoiding* becoming the kind of parent they do not want to be.²⁹ Their intentions to not repeat what had been done to them, including exposing their child to violence and IPV, may be insufficient to learn new skills

and habits consistent with becoming a parent who disciplines without recourse to threats and abuse and knows how to settle conflicts with partners. Self-sufficiency also takes high priority after leaving an abusive partner, but building a new web requires community resources that are often in short supply and difficult to navigate without an advocate.²³ Safe housing, legal assistance, reproductive and mental health care, and educational and vocational resources are critical supports if mothers are to come to terms with the past and create a more hopeful future.

As leaving the partner appeared to be the preferred response to IPV by researchers, alternative approaches were rarely described. An educational intervention to improve communication skills primarily among Latina teen parents with their partners provides an exception.^{24,25} Although experience with IPV was not a criterion for participation in the program, teen mothers revealed that they were both victims and perpetrators of emotional and/or physical partner abuse. Although numbers were not reported, teen mothers shared that they gained self-awareness from the program and implemented conflict resolution strategies that deescalated conflicts; a few reported leaving abusive relationships. The researchers recommended that the program be extended to reinforce and practice new communication skills.²⁵

DISCUSSION AND IMPLICATIONS

The primary goal of this study was to synthesize qualitative studies on teen mothers' experiences with IPV and to describe the trajectory of IPV in their lives. The threads of the primary studies were woven together to provide a more complete understanding of IPV as the most recent expression of violence in teen mothers' lives.

Findings from the original studies generally complemented each other but varied on the basis of study aims. For example, some studies focused on violence during pregnancy

whereas others focused on teen mothers' experience with health care providers or leaving abusive partners. As the aims of this meta-synthesis were broad, we "pulled" findings together from the 21 studies to highlight the temporality and social embeddedness of IPV in the context of cumulative trauma, even though (a) IPV among teen mothers is sometimes studied in relative isolation of exposure to other forms of violence, including childhood experiences of violence; (b) studies may neglect teen mothers' mutual participation in aggression, and (c) researchers may assume that the unqualified best response to IPV is to leave the abusive partner.

As teen mothers tend to be poor and from minority ethnic groups, IPV often intersects with other forms of violence that cluster around poverty, occurs across many settings, and includes micro-aggressions associated with racism and discrimination.^{8,48,49} These intersections translate into substandard schools, high unemployment rates, unsafe housing, dangerous neighborhoods, health disparities, and systems of unequal justice. In this toxic mix children absorb grim lessons and practices and norms of submission and domination in their bodies and relationships. Traumas accumulate early, contributing to early cognitive and behavioral problems, school disruption and alienation, academic underachievement, early sex, substance abuse, and violence.⁵⁰⁻⁵² Mistrust, isolation, and gender norms reinforce aggressive ways of coping with frustration, fear, and hopelessness.^{24,26}

In volatile situations where few models for solving conflicts exist, young people may perpetrate violence for their self-protection, to gain a sense of belonging, or to cope with powerlessness.⁵³ Youth, including teen mothers, engage in mutual violence^{23,29,34,54} and may be further traumatized or retraumatized in homeless shelters, or by child welfare and justice systems.

The embeddedness of violence in the web makes it difficult for teen mothers to recognize early warning signs of IPV or symptoms of psychological distress. They may not seek

help or disclose IPV because of their mistrust in authorities, fear of retribution, and fear of the unknown. Leaving an abusive partner creates serious concerns because there is no guarantee that mothers will find safety or stable housing, and will be able to financially support themselves and their children. These well-grounded fears and concerns about the future contribute to their vulnerability and ambivalence in leaving abusive partners. Even extricating themselves from a violent web may increase already high levels of psychological distress as mothers are retraumatized by untrained staff in homeless shelters, or by child visitation orders and custody battles.⁵⁵

Nurses miss many opportunities to address trauma in teen mothers, as they are often hesitant to ask, and teen mothers are often reluctant to report abuse. Specific "red flags" include a large age gap between the young mother and her partner, repeat requests for pregnancy tests or emergency contraception, or erratic contraception use.⁴³ Nurses should ask specifically about IPV, with unambiguous questions like "Has your partner ever slapped, hit, or threatened you, or wants to know your whereabouts at all times?". Because of mistrust of statutory services, young women initially may not wish to disclose IPV, which can be exacerbated by ethnic or racial differences between service users and providers. However, by building trusting relationships through dedicated and long-term services, these barriers can be overcome. Nurses should also be aware of wider community resources for young mothers who are experiencing IPV.

Trauma-informed health settings train all staff to recognize multiple forms of trauma and to respond with sensitivity so that mothers can disclose sensitive issues without being retraumatized. Clinical services that adopt a trauma perspective implement policies and procedures in line with trauma-informed principles of safety, trustworthiness, transparency, peer support, collaboration, and choice.⁵⁶ Nurses trained in these principles create a safe haven by validating mothers' traumatic experiences

and their strengths and aspirations to be good parents; educate them about the effects of trauma; offer practical support; and become trusted mentors.^{22,23,32,57}

When traditional mental health treatment is indicated, referrals are discussed in advance so that mothers' preferences and barriers to care are identified. Barriers to treatment are most effectively reduced by locating mental health providers at clinical services and by offering group approaches, which are generally preferred by teen⁵⁶ and low-income mothers.⁵⁹ Group therapy has shown promise in promoting teen mothers' mental health⁶⁰ and offers the added benefit of promoting peer support as mothers are encouraged to learn from each other and integrate stories of violence.⁵⁷

Screening for IPV is recommended but remains relatively low in reproductive health settings.⁵⁹ Excellent guidelines are available and are consistent with study findings.^{62,63} In keeping with trauma-informed principles of trust, choice, and safety, and to avoid a sense of betrayal, mothers should be informed of mandatory reporting obligations before screening begins so that they can decide what is in their best interest. Mothers who do not disclose IPV, and mothers who disclose but remain in contact with an abusive partner, should command respect in their efforts to cope with complex situations.⁶⁴ Teens who remain with abusive partners should be asked about their efforts to maintain their safety.⁴⁴

This synthesis strongly suggests that screening for IPV alone disregards cumulative trauma from multiple sources. On the basis of the findings reported here, teen mothers should be assessed for childhood traumas, polyvictimization, and mutual aggression. The Adverse Childhood Experiences (ACE) tool may serve this purpose.⁶⁵ The tool includes 10 items related to household dysfunction (eg, physical and sexual abuse, household members who abuse alcohol or drugs or have a criminal record); mothers mark items that occurred before age 18 years. Because each item receives 1 point, a total ACE score ranges from

0 to 10. Waite et al⁶⁵ describe the tool and the clinical skills for responding to trauma. A limitation of the ACE tool is that many forms of trauma are excluded. Nurses should therefore consider screening for childhood and current traumas that reflect the experiences of the teen mothers they serve. Forms of violence perpetrated in child welfare and juvenile justice systems should also be considered. A more recent tool for children that addresses these concerns is now available.⁶⁶

Nurses should consider additional mental health screenings when caring for teen mothers. Because symptoms of depression, anxiety, and trauma tend to co-occur,^{67,68} screening for depression alone is inadequate. Clinical services need to carefully consider which screening tools are most appropriate for assessing the full range of psychological distress in teen mothers. Mothers' responses to individual items may alert the nurse to suicidality or substance abuse. Nurses should also be aware that psychological distress may remain high even after mothers leave abusive partners because of the potential loss of housing and financial security.⁵⁵

These results confirm that teen mothers are vulnerable parents because of cumulative trauma from multiple forms of violence and high levels of psychological distress.^{2,22,69} If trauma is not addressed, mothers are vulnerable to revictimization and poor mental health outcomes.⁶⁹ Research also documents that toxic environments and multiple traumas change physiology and contribute to the leading causes of chronic disease in adulthood.⁷⁰ Research into the neurobiology of chronic stress and trauma demonstrates wide-ranging effects on the inflammatory response, metabolism, and the architecture of the brain.⁷¹ Significant stressors in childhood stimulate the hypothalamic-pituitary-adrenal axis to release elevated levels of corticosteroids that play a role in developing cancers, heart disease, and immune disorders. These and other stress responses also contribute to premature aging and disparities in rates of morbidity and mortality among low-income groups.^{72,73}

Cumulative trauma also exacerbates parenting difficulties. Research documents that teen mothers are remarkably resilient in coping with adversity when growth-promoting emotional support and practical resources are available to support their strengths and aspirations.^{73,74} That the most vulnerable teen mothers often defy the odds when provided with emotional and practical support⁷⁶ offers a clarion call for nurses to promote their resilience and avoid focusing on their presumed deficits and incompetencies.^{77,79} The implications are clear: therapeutic and corrective relationships support teens' strengths, concerns, aspirations, and the transformative potential of mothering.^{78,80} Emotional support must be complemented with material resources including legal assistance, safe housing, substance abuse treatment, and educational and vocational programs. Assisting teen mothers to create a new web with emotional and material support offers the best chance for mitigating health and social disparities over the life course and interrupting the intergenerational transmission of trauma and distress.

Moving upstream

Upstream conditions related to poverty create social problems (eg, crime, substance abuse, and violence) and private troubles that are sedimented in teen mothers' bodies and relationships. Downstream effects of social disadvantage are deeply rooted in systemic inequities and restricted pathways to adulthood.^{8,81,82} When youth are marginalized into dangerous webs with few meaningful options, the future holds little promise.^{78,82,83} A teen mother in Gubrium et al.'s^{84(p121)} study captures this stark reality in an offhanded but insightful remark: "When nothing matters, things just happen." What "just" happens is a volatile mix of poverty, violence, and teen parenting. Targeting the social determinants of teen parenting and violence, which exist upstream, would go a long way to reduce early life adversities, high rates

of teen parenting, and the many forms of violence that are part of the lived reality of vulnerable youth.⁸⁵

STRENGTHS AND LIMITATIONS

The results of this study offer a more thorough understanding and explanation of IPV in teen mothers than primary studies alone, and this broader picture has the potential to enrich clinical services and programs serving teen mothers in ways suggested by Kearney.¹⁶ For example, results sensitize nurses to teen mothers who endure IPV in the context of cumulative trauma, and highlight the need to conduct relevant screenings and to provide anticipatory guidance and coaching from a trauma-informed perspective. Findings also highlight the imperative to work upstream to challenge the systemic inequities that fuel teen parenting and violence. The lack of primary studies on how teen mothers recover from IPV and cumulative trauma represents a limitation of this project. At this point, we simply do not know how the experience of IPV may differ for subgroups of teen mothers; future studies should therefore investigate IPV among rural or immigrant teens, teens in foster care or with gang affiliations, and teens from various class and racial/ethnic

backgrounds. Additional studies should investigate the challenges of creating a new web, and how teen mothers' relationships with their children, family members, and partners evolve in the context of interpersonal support, material resources, and interventions to strengthen relationships and reduce IPV. Thick descriptions of the factors that contribute to setbacks and positive turning points would be particularly useful for developing nursing interventions.

CONCLUSION

This metasynthesis of 21 qualitative studies highlights the temporality and social embeddedness of IPV in the context of cumulative trauma. Using the metaphor of a spider web, the pernicious effects of poverty and violence course through the lives of vulnerable young mothers. Habits and norms that are learned in such webs are difficult to alter without personal courage, material resources, corrective relationships, and social support. Nurses play a pivotal role in helping teen mothers create a new web when they assess teen mothers for IPV and cumulative trauma, and provide emotional support and material resources. Nurses must also move upstream to advocate for social policies that mitigate the social determinants of teen mothering and violence.

[AQ3]

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