The Institute for Clinical Social Work

Reflective Functioning in Young-Adult African American Mothers

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By

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Abstract

Parent-child relationships have been researched in many ways. This study is unique because it focused on understanding the experiences of early childhood adversities, social supports, and the reflective-functioning capacity of young-adult African American mothers and their children. In this study, the researcher interviewed 11 mothers from urban and suburban areas of Minnesota, using a qualitative methodology. The researcher used the concept of reflective functioning to frame the study.

This research resulted in the following major findings: (a) participants did not perceive adversities as bad, but as part of a daily norm, (b) participants demonstrated that they have social support and know how to access it, and (c) participants showed the ability to be reflective of their children's emotions and experiences, as well as the parent-child relationship. Participants talked about transmitting good things to their children, while simultaneously protecting the children from negative experiences. Thus, parents were able to change patterns that could affect their children's well being.

Thank you, with love and the utmost appreciation, to all of you who supported me

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Chapter I

Introduction

General Statement of Purpose

This study intended to explore the reflective capacity of young-adult African American mothers who experienced abuse, neglect, inadequate relationships, and / or household dysfunction during early childhood. Reflective functioning is defined as "the parent's capacity to hold and reflect upon her own and her child's internal mental experience" (Slade, 2005, p. 269). It is "the overt manifestation, in narrative, of an individual's mentalizing capacity" (Slade, 2005, p. 269). Mentalizing is "the capacity to understand one's own behavior and that of other people, in terms of underlying mental states and intention—and, more broadly, as an intrinsic human capacity crucial for affecting regulation and productive social relationships" (Slade, 2005, p. 269). Thus, this study aims to shed light on how young African American mothers who had difficult childhoods now understand, connect with, and relate to their own children and help them manage their feelings and behaviors—with or without help from others.

The researcher was curious about the types of childhood adversities experienced in the sample study and how, if at all, these experiences affect parents' ability to be reflective in their relationships with their children. Adverse childhood experiences are defined as

childhood exposure to multiple types of adversity as outlined by Redding (2003), including:

1. Abuse …
2. Neglect …
3. Domestic violence …
4. Other serious household dysfunction, such as substance abuse and mental illness …

During conversations with participants, the researcher listened for themes and patterns related to: (a) mothers' experiences and behaviors, the parent-child relationship, and (b) reflective-functioning capabilities. The researcher also explored the role of social supports in participants' lives. In this instance, support is defined as "… a network of family, friends, colleagues, and other acquaintances one can turn to in times of crisis or simply for fun and entertainment" (Mayo Clinic, 2013, p.1). If the mothers had support, the researcher examined how they engaged that support, and whether the support impacted the mothers' reflective-functioning capacity and their relationships with their children.

The parent-child relationship is crucial to child development because it helps shape the child's sense of self. The ways in which parents respond to their children's needs and cues impacts how children (a) feel about themselves, (b) learn to handle and express emotions, and (c) how they relate to others. Therefore, understanding parents' ability to be reflective, and potential challenges to that ability, helps us understand how children feel about themselves and get along in the world.

Statement of the Problem Studied and Specific Objectives

A high proportion of young-adult African American mothers experienced adverse experiences in childhood, according to numerous researchers, including (a) Randolph and Koblinsky (2011), (b) Sterrett and others (2015), and (c) Sadler and others (2016). Parents' history impacts parent-child relationship, whether the parents' history is healthy or characterized by adversity.

Randolph and Koblinsky (2003) link together psychological distress and reduced quality of parenting. For example, the stress of a demanding job may lessen the amount of time a mother interacts with her children. Parents with emotional problems might push infants' needs into the background during times of stress, resulting in inconsistent care. African American families tend to include younger mothers, and a percentage of single mothers higher than the national average. "Living in a low-income family and neighborhood may increase the probability of parents' emotional distress because of exposure to negative situations" (p. 33).

According to the 2014 U.S. Census Bureau ACS study, 46.1% of African American mothers age 18-64 who head households with children under the age of 18 are single parents. By comparison, only 37 percent of all mothers nationwide are single parents (http://blackdemographics.com/households/poverty/, September 28, 2016). The number of African American youth who come from an African American female-headed household is 67%, compared to 23% for the U.S. general population (Sterrett, et al., p. 455, 2015).

> Those African American youth from a female-headed household range in age from 10 to 19 years old. These young people have shown an elevated risk for externalizing problems compared to European American counterparts, respectively. Externalizing difficulties in children are linked to negative functioning in occupational, familial, parenting, and societal roles in the adults who care for them. This externalizing impact is more serious and long-standing among African Americans. (Sterrett, et al., p. 455, 2015)

These externalizing adversities are transferred inter-generationally when interventions are not put into place.

The researcher examined concepts of "young-adult parenting" and "young-adult African American parenting." There is ample literature on the teen-parenting population, but nothing focused specifically on parents in their early twenties. There is also an abundance of literature on the effects of adverse experiences (e.g., abuse, neglect, trauma, exposure to violence, and family dysfunction) and on the concept of reflective functioning, but not in the context of how adverse experiences may affect young mothers' reflective-functioning capacity with her child, and more specifically young African American mothers. The researcher explored other major topics, including:

1. African American women as mothers …
2. African American parenthood …
3. African American resilience …
4. African American young-adult women …
5. African American parents who have histories of abuse and neglect …
6. African American mothers and trauma …
7. African American females and reflective functioning …

The author researched these topics via Google Scholar and Ebsco, Ebsco Host, ERIC, PsychInfo, and other journal listings and online textbooks. The term "African American families," per mention in these searches, mostly referenced the family as consisting of a female, who has the following characteristics:

1. African American …
2. At times young …
3. Heading the household …
4. Usually with informal social support networks that consist of extended kinship, or community members who are considered like family …

One article discussed the importance of having specific and better-focused research on African American family dynamics between parent and child. This research, the article suggests, might produce more findings on the potential impact of cultural norms on the following dynamics, as discussed by Randolph and Koblinsky (2001):

1. Parent-child behaviors …
2. Attitudes towards mental well-being …
3. Children mental-health outcomes via intergenerational poverty …
4. Behaviors that may appear negative to the dominant culture, yet are internally evaluated by the African American mother as a protective stance, rather than what may appear to be a favorable stance towards the child according to dominant cultural norms …

The African American family might find that safety and survival (and teach related skills to children), is more important than demonstrating purposeful, engaging, and expressive behaviors towards the child. As noted by Randolph and Koblinsky (2001, p. 32), "Parents from different cultural groups may differ in their views concerning the fragility of newborns, their perception of a response to crying, and the importance of encouraging specific developmental skills." These skills encompass three types of growth: (a) psychological, (b) emotional, and (c) social. Several factors can help shift unhelpful cultural views related to child development. These factors include the child's and parent's mental health and African American parent-child behaviors. However, as noted by Randolph & Koblinsky (2001, p. 30):

> … there is a paucity of research examining how African- American families raise young children within a socio-cultural context. Researchers also know relatively little about the normative development of African American children, the parenting values, or behaviors of their parents. In particular, there are relatively few studies exploring the strengths and resources of African American families that reduce risks, protect

children, and contribute to optimal development.

Given the lack of research data on young-adult African American mothers with histories of neglect, poverty, abuse, and being misunderstood, parenting engagement might be better understood from a cultural perspective, rather than an assumptive perspective. In such a case, it would help the research community (and programming efforts as well), to measure and write evidenced-based research data about this group. This research would hopefully provide a substantial evaluation of this parent population in terms of their mental, reflective, and environmental states.

A mother can be more aware of her child's need for engagement and purposeful parent-child relating if she is aware of her ability to show mental and physical availability to the child, given her capacity to hold the child's mind and her mind in reflection. This ability can exist despite the mother's potential history of adversities and external negative experiences.

Little research focuses on young-adult African American mothers with experience of abusive, neglectful, or sub-optimal upbringings. As a result, the researcher aimed to specifically look at this parent population. This study explored the concepts of young-adult African American mothers and adverse early-childhood experiences. Additionally, this study examined the impact of those concepts on (a) mothers' relationships with their children, (b) mothers' capacity for reflective functioning, and (c) the role of social supports in the parent-child relationship

The overall objectives of this study were as follows:

1. To learn about the adverse experiences of the young adult mothers in the study sample …
2. To examine each mother's reflective-functioning capacity …
3. To explore the dynamics presented within the parent-child relationship and how they shape the parent and child's connectivity …
4. To look at social-support systems and whether these play any role in the mothers' Reflective Functioning abilities or the parent-child relationship …
5. To gain an understanding of the young-adult African American mothers' awareness and comprehension of their children's minds and being as separate from their own …
6. To consider cultural, class, and racial aspects of parenting and Reflective Functioning …

Research Questions Explored

Primary research question.

What is the effect of adverse childhood experiences on the reflective-functioning capacity of young-adult African American mothers?

Secondary research questions.

1. How do young African American mothers with adverse backgrounds understand their children's emotions and help them manage those emotions?

2. How do these mothers understand their own emotions and experiences, and how these experiences affect the parent-child relationship?

3. Do these mothers have social-support systems, do they use them, and what is the impact, if any, on the parent-child relationship?

Theoretical and Operational Definitions of Major Concepts

Reflective Functioning: The parent's capacity to hold and reflect upon her own and her child's internal mental experience (Slade, 2005, p. 269).

Capacity: For the purposes of this study, "capacity" means the ability to do something (Merriam Webster Dictionary, 2014), e.g. "reflective-functioning capacity."

Adverse Childhood Experiences: According to the Center for Disease Control (CDC) definition, adverse childhood experiences are defined as childhood exposure to multiple types of (a) abuse / neglect, (b) domestic violence, and (c) serious household dysfunction (Redding, 2003).

Social Support: A network of family, friends, colleagues, and other acquaintances that one can turn to, whether in times of crisis or simply for fun and entertainment" (Mayo Clinic, 2013).

Young-Adult Mother: For the purposes of this study, “young-adult mother” is defined as any participant between the ages of 20 and 25 who is parenting a child. According to Munsey (2006), a young adult is described as "… one who is interested in exploring the possibilities of her identity, who is at the age of instability, who is also at the age of self-focus, coupled with the reality of existing between adolescence, ages 18-29, and still having dependence on family ties" (p.68).

Early Childhood Development: For the purposes of this study, early-childhood developmental concepts will be used to demonstrate the importance of using a developmental lens to examine the full lifespan of the child, the parent, and their relationship. These concepts will be used to better explain what children need to grow and develop from their relationships with caregivers.

Parent-Child Relationship: This term encompasses the mental, physical, and psychological connection that exists between a parent and a child.

Attachment: Attachment is a bond that connects mother and child together across mental states, affectivity, physical proximity, safety, environment, and symbolic interaction (Davies, 2011).

Statement of Assumptions

The primary assumption of this study is that young-adult African American mothers have greater challenges reflecting on the parent-child relationship when they have experienced adverse childhood experiences, and have little to no supportive relationships.

The mental, physical, and psychological connection that exists between a parent and a child may become disrupted because of the mother's inability to read her child's cues accurately and reflect upon them. As stated by Soderstrom and Skarderud, (2009, p. 53):

> Minding the mind of the baby is a necessary precondition for the development of the infant's own self, affect regulation, and interpersonal understanding. This is intuitively understood by most caregivers, as the early interaction with the infant to a large extent consists of face-to-face and mind-to-mind interactions.

The study assumes that exposure to early adverse experiences will affect a mother's development of self and can be later brought into the relationship with her own children. If unresolved adversity prevents the mother from reflecting on her child's needs, there might be challenges to the parent-child relationship, which will leave the child more vulnerable to adverse experiences.

> The ability to understand other minds rests on the experience of having been understood as an individual with a mind. The child learns the dynamics and logic of the mind in safe and intimate interaction with caregivers, and the hoped-for result is a well-functioning interpersonal interpretive mechanism or misreading, mentalizing competence. (Soderstrom & Skarderud, 2009, p. 53)

The mother's ability to separate her child's mind from her own is ideal for the parent-child relationship. However, if she cannot do so, the child's mind and relational experiences may be thwarted.

> There is strong evidence to support the theoretical notion that parents' mentalizing capacity plays an important role in the ability to provide care and comfort to a child,

> which points towards reflective functioning as a central mechanism in the intergenerational transmission of attachment. (Katznelson, 2014, p. 115)

If the mother is not psychologically, physically, and emotionally connected to her child, this may lead to a less than desirable outcome for the child, thus repeating a generational transmission of adverse experiences and the child's inability to reflect on self and others. As Katznelson states, "Evidence suggests that being able to make sense of both one's own, as well as one's child's mental state can serve as a protective buffer in relation to child development" (2014, p. 115).

The incapacity to reflect on the child may be the mother's way of unconsciously keeping her own painful experiences away from the child. Fonagy (2011) suggests that attachment in early infancy has the primary evolutionary function of generating a mind capable of inferring things about other people's minds, namely, their thoughts, ideas, motivations, and intentions (p.427). The mother is not psychologically available to infer things about her child when she is consumed with her own opposing history and experiences. It is assumed that a social-support system can impact mother-child relationships.

Epistemological Foundations

This study used a constructivist viewpoint, which embraces the following multiple realities: (a) participants, (b) previous literature, and (c) the researcher (Creswell, 2007). Constructivist researchers "… often address the processes of interaction among

individuals. They also focus on the specific contexts in which people live, in order to understand the historical and cultural setting of the participants" (Creswell, 2007, p.21).

From a constructivist viewpoint, "… researchers understand their own backgrounds shape their interpretations, and they position themselves in the research to acknowledge how their interpretations flow from their own personal, cultural, and historical experiences of what other people say" (Creswell, 2007, p.21). This approach is also at times referred to as "interpretive research." This study sought to interpret and construct the multiple realities of young African American mothers and their relationships with their children, while also examining how parental reflective functioning, adverse childhood experiences, and social supports influence one another.

Each mother told her story within the context of a dyadic interview session with the researcher. Patterns of meaning were developed through told stories (Creswell, 2007). These patterns were then constructed into an overall meaning of each mother's situation and of the mothers as a whole. As this study sought to gain an in-depth understanding of how mothers' life experiences can affect the parent-child relationship, the study addressed participants' histories, as well as social and cultural contexts, depending on the relevancy of each.

Chapter II

Literature Review

This research looked at the following:

1. Young-adult African American mothers and the concepts of adverse early childhood experiences …
2. The impact of those concepts on the parent-child relationship …
3. Mothers' reflective-functioning capacity …
4. The role of social supports in the parent-child relationship …

To understand young adult mothers and the effects of adverse early experiences and social support on their parenting relationships with their children, the research explored several areas in existing literature, including:

1. Reflective functioning …
2. Parent-child relationship and attachment …
3. Adverse experiences …
4. Social support …

The author looked at concepts in various pairings by using search engines. The following concepts were combined, looked at separately, and paired throughout the search:

1. Young adult …
2. African American mothers …
3. Parenting young children …
4. Adversities …
5. Reflective capacity / functioning …
6. Social support …

Researching these topics involved numerous publications, including:

1. Cultural Models For Early Caregiving (Finn, 2003) …
2. Emerging Adults: The In-Between Age (Munsey, 2006) …
3. Transactional Relations Across Contextual Strain, Parenting Quality, and Early Childhood Regulation and Adaptation in a High Risk Sample (Yates, Obradovic, & Egeland, 2010) …
4. Bridging the Transmission Gap: An End to an Important Mystery of Attachment Research (Fonagy & Target, 2005) …
5. Mindful Parenting: A Group Approach to Enhancing Reflective Capacity in Parents and Infants (Reynolds, 2003) …

6. The Parent's Capacity to Treat the Child as a Psychological Agent: Constructs, Measures and Implications for Developmental Psychopathology (Sharp & Fonagy, 2008) …

7. The Impact of Adverse Childhood Experiences on an Urban Pediatric Population (Burke et al., 2011) …

8. Adverse Childhood Experiences: Towards a Clear Conceptual Meaning (Kalmakis & Chandler, 2013) …

9. Prevalence and Relationship Between Adverse Childhood Experiences and Child Behaviors Among Young Children (Freeman, 2014) …

10. Does Early Caregiving Matter (Shifren & Kachorek, 2003) …

11. Youth Functioning in the Co-parenting Context: A Mixed Methods Study of African American Single Mother Families (Sterrett et al., 2013) …

12. Having a Baby Changes Everything: Reflective Functioning in Pregnant Adolescents (Sadler, Novick, & Oliver, 2016) …

13. Intergenerational Transmission of Attachment in Abused and Neglected Mothers: The Role of Trauma-Specific Reflective Functioning (Berthelot et al., 2015) …

14. The Effects on Young Caregivers' Adult Mental Health …

15. The Socio-cultural Context of Infant Mental Health in African American Families by Randolph & Koblinsky (2001) …

Reflective Functioning

Reflective-functioning capacity looks at how the parent-child interaction is reflected upon in the beginning stages of development, which sets the tone and foundation for connecting relationally throughout the parent-child relationship. It also sets the tone for the capacity to reflect within the relationship, from the mind of the parent to the mind of the child. As Slade wrote, "Early relationships create the opportunity for the child to learn about mental states, and determine the depth to which the social environment can ultimately be processed" (2005, p. 271). Those mental states influence how the child further explores the social environment.

The concept of reflective functioning served as a tool to explore and understand a parent's capacity to integrate two things: (a) what she internally knows, remembers, and understands about her own childhood care, and (b) her ability to hold the idea of her child (and the child's experience of understanding its own mind) as separate from her own. The child's ability to relate to self and others is determined by its ability to utilize the caregiver's mind, which depends on the psychologically availability of his caregiver's mind.

Parent-child relationship.

The conditions surrounding the development of early relationships can influence the capacity to form and maintain healthy relationships throughout life. The parent-child relationship is the first and most important relationship that exists in any person's developmental lifespan. This sentiment is agreed upon by theorists specializing in object-

relation, attachment, and infant mental-health, respectively, specifically Klein (1994), Bowlby (1988), Slade (2005) and Lieberman (1998).

> Deep emotional bonds develop between the baby and a variety of people who have a regular role in his life. These emotional bonds influence each other and come to form a matrix of interpersonal connections that in normative conditions build the earliest foundations for mental health by helping the baby feel loved, valued, and competent, as opposed to feeling unwanted, burdensome, and ineffective." (Lieberman, 1998, pp. 3-4)

Healthy relational patterns result from successful relationships. The opposite holds for dysfunctional early parent-child relationships. (Davies, 2011).

The parent and child have separate minds, and the parent-child relationship helps facilitate the connecting, reading, and understanding of those minds, in the process of "mentalization." According to Katznelson (2014), "… mentalization is a proposed mechanism of change" (p. 115), from one mind to another. The construct of mentalization was introduced more than 10 years ago by a team of psychoanalytically oriented attachment researchers (Peter Fonagy, Miriam Steele, Howard Steele, and Mary Target), and it indicates the parent's capacity to reflect upon and hold the inner life of her child in her mind (Slade, 2005). Parental reflective functioning is described as "… the parent's capacity to reflect upon her and her child's internal mental experience. It is an overt manifestation, in narrative, of an individual's mentalizing capacity" (Slade, 2005, p. 269).

Reflective functioning involves the capacity to "… understand one's own mind and others' behaviors in terms of underlying mental states and intentions, and more broadly as a crucial human capacity that is intrinsic to affect regulation and productive social relationships" (Slade, 2005, p. 270). Holding the other's mind internally requires the capacity to reflect, understand, and correctly read cues within the dyadic relationship. The mother's capacity to reflect on the mind of her child is an important psychological tool to separate her needs and experiences from that of her child's needs and experiences. This capacity is important within the parent-child dyad to assure that the mother can meet the needs of her child without compromising her child's needs with needs of her own.

If the caregiver is not connecting with the child psychologically or emotionally, the child may go psychologically and emotionally unnoticed by the caregiver, and the child's needs may go unmet and its cues misread (Davies, 2011). "The child may progressively internalize a sense of self as unworthy and undeserving of love that can derail the course of healthy development," as stated by Lieberman and others (2005). The parent's ability to connect with the mind of her child and understand the separateness of the two minds evidences her capacity to think about the needs and experiences of the child as being different from her own.

By examining the mother's state of mind, we can learn how she processes the external world to make it coherent, and how her subsequent understanding of the world influences her interaction with her child, mentally and physically. According to Winnicott (2002), when a caregiver physically holds the baby well, it fosters growth and development from the inside out. "The baby's personality is being laid down well if the baby is held well

enough. Babies do not remember being held well, what they do remember is the traumatic experience of not being held well enough" (p. 50).

A caregiver's state of mind impacts the development and behavior of the child. Whether a caregiver is stable and accepting (or unstable and non-accepting) of her psychological wellbeing, her interaction with others demonstrates her state of mind. If a caregiver's psychological functioning is diminished, she will have difficulty attending to her own needs, and will therefore be unable to fully attend to her child's needs. Thus, dysfunction related to unresolved events within the caregivers may be transferred to the mind of the child (Ordway et al., 2015).

Unconsciously, the caregiver may begin to use defenses to keep psychic pain from becoming conscious. The resulting internal conflict and struggle can make the mother ill, thereby impacting the parent-child interaction, and transferring the conflict to the child. Thus, the health of the caregiver-child relationship depends on the caregiver's ability and capacity to deal with what is already present in her mind, prior to becoming a caregiver. "In every nursery there are ghosts," as Fraiberg and others explain. "They are the visitors from the unremembered past of the parents. The parent, it seems, is condemned to repeat the tragedy of her childhood with her own baby" (1975, p. 101). If these ghosts are not detected and exorcised, the caregiver will suffer while providing care to the child, and thus the child suffers as well. Extending the theme of specters, Lieberman and others say, "Ghosts and angels coexist in dynamic tension with each other, at times actively struggling for supremacy and at other times reverting to a quiescent state that allows the person to temporarily inhabit a conflict-free ego sphere" (2005, p. 506). Exorcising these ghosts calls for intervention.

Intervention is used as a way of intercepting a disturbed transmission and interjecting healthy transmission from one state of mind to the next, across generations (Grienenberger, 2005). If a mother has a foundational understanding of how relationships are formed and transmitted from caregiver to child, she can increase her purposefulness in parenting and relating across generations. When the caregiver has recognized, acknowledged, or uncovered past internal challenges of received care, the care-giving experience is guarded, and a healthy course of development is transmitted from mother to child. Alicia Lieberman and others termed this dynamic "angels in the nursery" (2005, pp. 504-520) As Lieberman writes, "Angels emerge from childhood memories deeply connected to the phenomenology of care-receiving experiences that are characterized by intense shared affect between parent and child and provide the child with a core sense of worth and security" (p. 506). The caregiver must recognize the patterns of relation within her own mind, and understand how these patterns were transmitted from her own care-giving experience to the care-receiving experience of her child.

Reflective functioning has been studied in parent-child relationships in pediatric care, home-visiting programs designed for mothers and children, and chemical-dependency programs aimed at the enhancement and promotion of healthy emotional and interpersonal connectivity between parent and child (Ordway, et al., 2015; Soderstrom & Skarderud, 2009; Katznelson, 2014).

One 2015 study monitored mothers, aged 14 to 25, who received intervention-care via a program called Minding the Baby (MTB). Each MTB relationship consisted of the professional, the caregiver, and the child. The goal was to provide intense interdisciplinary home-visiting to assist mothers in "… becoming more reflective in their

interactions with her child, (thereby) promoting a learning experience to foster the management of multiple demands in their lives" (Ordway, 2015, p. 327). Mothers who participated in the MTB study showed better "… life course outcomes such as lower rates of subsequent childbearing. Mothers were less likely to have a child referred to child protective services, the infants were more likely to have secure attachment to the mother, and lastly, the teen and young adult mother-child interactions were less likely to be disrupted during the intervention group time together" (Ordway et al., 2015, p 327).

Soderstrom and Skarderud conducted a 2009 study with mothers being treated for substance-use disorder. The treatment model centered on mentalization and hoped to achieve the following: "… study, treat, and support high-risk families in breaking down the burden of intergenerational transmission of internal representations of caregiving experiences, and, to ultimately promote good enough care for infants" (2009, p. 48). In this case, interventions addressed substance use and how it impairs the parent's reflective-functioning capacity while under stress, at times causing

"… absent mindedness, thus imposing risk of impaired interactions between caregiver and child, including the extra vulnerability of the child being vicariously exposed to substance" (Soderstrom & Skarderud, 2009, p. 47).

Soderstrom and Skarderud define "minding the baby" as "… the promotion of sensitive care, which serves as a buffer, and protective shield for the infant, and the immature brain, from potentially dangerous adverse experiences and physiological arousal, brought on through substance use and misattunement between parent and child" (2009, p. 47). The two authors claim that the misreading of minds can result in

misunderstanding, disruption, and frustration in social communication and parent-child interactive experiences (p. 50).

According to Slade (2005), if the child's innate sense of exploration is threatened by the caregiver, the child will develop internal alarms, or the lack thereof. These alarms will either be hypersensitive or hyposensitive to other people and environmental stimuli. These sensitivities can create flat affectivity and an inability to exhibit or correctly express proper affectivity and emotional states that match object connectivity.

Now we will look at how reflective functioning derives from attachment history and concepts.

Attachment.

Attachment theory derived from the joint work of John Bowlby and Mary Ainsworth. Bowlby's direction was to "… revolutionize our thinking about a child's tie to the mother and its disruption through separation, deprivation, and bereavement" (Bretherton, 1992, p. 759). Ainsworth provided "… the conceptual contribution of the attachment figure as a secure base from which an infant can explore the world and maternal sensitivity to infant signals and its role in the development of infant-mother attachment patterns" (Bretherton, 1992, p. 759).

Bowlby (1988) believes children develop a natural bond with their caregivers. Bowlby looked at ethology and evolutionary literature to better understand the patterns of attachment an infant has to his caregiver. Evolutionary literature says attachment

behaviors are "… species-specific behavior patterns that are instinctive and are activated in the service of survival" (Palombo et al., 2009, p. 292). In other words, each species has its specific pattern of relating. Bowlby determined that parent-child connectivity is driven less by the need for nourishment and more by the desire for the intimacy of the parent-child relationship, thus describing attachment (Palombo et al., 2009).

Attachment theory, through all its revisions, has led to a few pivotal studies that demonstrate a better definition and description of the connectivity that exists between a parent and child. Bowlby continued to reconfigure the mother-child attachment theory, aspects of the relationship, and conceptual language to describe attachment. Meanwhile, Ainsworth, Bowlby's former student, worked to make sense of the theory as it relates to the attachment pattern between mother and child. Both theorists were working towards a better understanding of the dynamics of attachment. Their work happened separately, and unbeknownst to one another (Bretherton, 1992). Ultimately, they collaborated to provide the ultimate defining moment of attachment theory. Then, as Slade writes, "A decade later, following the work of Bowlby and Ainsworth, Mary Main was to redefine the field of developmental psychology, and affirm many of the principles of psychoanalytic developmental theory" (2005, p. 284). Main's work also explored the relationship between psychoanalytic development theory and attachment.

The Strange Situation is a pivotal study that clarified the theory of attachment and its patterns of connectivity. Described as a "… miniature drama with eight episodes of the mother and infant within a laboratory room" (Bretherton, 1992, p. 765), each 20-minute portion of the study included toys and a stranger leaving and re-entering the room. The outcome of the study found that infants explored the playroom and toys more vigorously

when alone with their mothers, as opposed to when a stranger entered or the mother was absent. Researchers observed the mother-child dyad from outside the playroom through video recording and a two-way mirror. The three changing conditions of the Strange Room—(a) the mother present and absent, (b) a stranger present and absent, and (c) all adults absent —were set at intervals. The researchers arranged these conditions to observe the child's signals in response to the mother's presence and absence.

Ainsworth became more interested in "… the unexpected patterns of infant reunion behaviors" (Bretherton, 1992, p. 765). Prior to the Strange Situation, Ainsworth worked on a study project in Uganda and Baltimore that included elements of the work previously done with Bowlby on attachment. These combined studies, and all relevant data previously acquired on attachment, would later contribute to the existence of what we today know as attachment theory.

The Uganda study developed aspects of infant-mother attachment connectivity. Through the data-collection aspect of this project, Ainsworth "… began to think about the meaningful aspects of Bowlby's earlier theories on attachment theory" (Bretherton, 1992, p. 764). This study included 26 families with infants ranging from 1 to 24 months of age. Ainsworth was interested in "… the onset of proximity-promoting signals and behaviors, noticing carefully when these signals and behaviors became preferentially directed toward the mother" (Bretherton, 1992, p. 764). This data remained inactive and undeveloped for years prior to the Baltimore Project, the Strange Situation, and Bowlby's theoretical work and publications.

The Baltimore study looked at 26 prenatal families via extensive home visits, during which researchers collected narratives and observed the family to collect "… meaningful behavior patterns between the caregivers and the infant" (Bretherton, 1992, p. 765). As Bretherton explains, "Ainsworth observed how sensitively, appropriately, and promptly mothers responded to their infant's signals. Finding that infants' expectations are based on prior satisfying or rejecting experiences with the mother" (1992, p. 765).

Through Ainsworth's Uganda and Baltimore project-data findings, specific patterns of attachment emerged. Bretherton explained how infants were classified, beginning with those who seen as "securely attached" to their mothers. These infants "… cried little and seemed content to explore in the presence of their mother." The "insecurely attached" infants were those who "… cried frequently, even when held by their mothers, and explored little." Finally, the "not yet attached" were those who "… showed no differential behavior to the mother" (Bretherton, 1992, p. 764).

Bowlby and Ainsworth wrote three volumes of papers titled "Patterns of Attachment." The trilogy describes the evolution of attachment theory. All data, history, collaborations, and revisions related to the trilogy ultimately established the foundation of attachment theory. Additional concepts emerged via discussion and understanding of attachment theory and framework, including internal working models, mental representations, and intergenerational transmission of attachment patterns (Bretherton, 1992). Reflective functioning and mentalization later came from the concept of attachment and attachment patterns as well (Slade, 2005). Parents are encouraged to help create autonomy in the child by creating the ultimate environment for safe, secure, and healthy patterns of attachment between the parent and the child (Bretherton, 1992).

Attachment can be described as the bond that connects mother and child together across the following:

1. Mental states …
2. Affectivity …
3. Physical proximity …
4. Safety …
5. Environment …
6. Symbolic interaction …

As Davies (2011) describes, "… the goal of the infant's behavior is to keep close to a preferred person in order to maintain a sense of security" (p. 7)." According to Bretherton (1992), the definition of attachment theory is based on the child growing up to be mentally healthy, as a result of experiencing a warm, intimate, and continuous relationship with its mother during childhood.

If attachment patterns are unhealthy, the mental state of the child is at risk for interruptions, disturbances, or the hindrance of basic developmental skills. Additionally, unhealthy attachment patterns can diminish the ability to secure, sustain, and maintain connections with others. In turn, the child might develop the following: (a) an unhealthy or uncertain sense of self-esteem, (b) a lack of confidence, and (c) feelings of inadequacy.

Attachment begins with and expands through the early developmental stages of life. These relational patterns create lasting foundational stability or instability within the

parent-child relationship. The patterns also create representations of the caregiver that the child internalizes. The child might reference these internalized representations to determine the predictability of parent's actions, affects, and behaviors. The relational patterns then transfer to other relationships throughout the child's life. The child's stability is contingent on many other factors, including (a) how the caregiver regulates the child, (b) how the caregiver holds the child, and (c) how the child dyadically interacts with the caregiver (Benoit & Parker, 1994; Bretherton & Munholland, 2008).

During infancy, the mother is connected to the child and the child is connected to the mother. Winnicott (1966) describes the infant as "the self-experiencing being" and the mother-child dyad as "… oneness between two persons who are in fact two and not one" (p. 13). The mother-child experience works well together when the mother guides the child, and the child accepts the guidance. "This allows for the moments during which the interaction may unfold as if in an effortless dance where each partner unselfconsciously anticipates and responds to the moves of the other" (Lieberman et al., 2005, p. 509).

Winnicott (1966) describes the mother-child relationship this way: "She, the mother, is the baby and the baby is her" (p. 13). A child does not function properly without a close bonding experience with his mother. Indeed, the child cannot survive without the caregiver or the environment—meaning that the child can physically be present in the world, but psychologically, socially, environmentally, and emotionally, it depends a great deal on its caregiver. The caregiver provides for every need until the child can manage important internal and external tasks of survival on its own. As Winnicott says, "After all, she, the mother, was a baby once, and she has in her memories of being a baby. She also

has memories of being cared for, and these memories either help or hinder her in her own experiences as a mother" (1966, p. 13).

An attachment will always be present in a parent-child relationship, whether the relationship can be classified as secure, insecure-avoidant, insecure-ambivalent, or disorganized. The classification will all depend on the interactions and experiences that take place between the caregiver and the child, which begin during infancy (Davies, 2011). If attachment is secure, it fosters a healthier way of relating, connecting, being, and securing healthy attachments throughout life. Davies (2011) states that a person is not exempt from adversities because he has had a secure attachment from the beginning. That individual may experience blows to the self, to security, to the psyche, which might threaten the ability to relate to others. However, the individual who started with a secure attachment has a better chance at being resilient in the face of adversity, and coping with and better dealing with a given situation. This is in comparison to the individual with an insecure attachment, characterized by minimal or inconsistent parental connectivity.

If attachment patterns are negatively experienced, the individual's basic developmental platform may have a disturbance or a misunderstood pattern. In this instance, ways of relating with the parent might present as one way externally, while the child has another experience internally. The external behavior may be misread and / or misunderstood by the caregiver, therefore hindering the child from getting its needs met. Additionally, the child will re-experience the adversity each time cues are perceived incorrectly by the caregiver (Slade 2005; Davies, 2011; Ordway et al., 2015).

When the child internalizes this type of negative parent-child interaction, it may experience internal conflict. This conflict is displayed externally and may be misunderstood by the parent as negative behavior. In the parent's attempt to connect with her child, she may miss the child's cues. This is especially true if she has previously experienced similar situations as a child, through her own care-receiving experience. Internally, the caregiver never fully understands the dynamics of her childhood care-receiving experience. Therefore, she unconsciously transmits these encounters to her child.

If attachment patterns are healthy, purposeful, and intentional, the parent-child interaction is internalized as a sense of security, a regulatory function, a promotion of expression, and a base for exploration (Davies, 2011). This, in turn, promotes (a) increased sensitivity and reflection within the parent-child dyad, (b) healthy self-esteem, confidence, and competence in self-exploration, and (c) healthy interaction between the child and others. In all, these factors foster healthy development for the child starting at birth.

If the attachment patterns are insecure, the mental state of the child is at risk for (a) interruptions, (b) disturbances, or (c) hindrance of basic developmental skills of the self. This jeopardizes the completion of tasks needed to secure, sustain, and maintain current and future connections with others. This in turn promotes unhealthy or uncertain self-esteem, a lack of confidence, and feelings of inadequacy.

Ideally, a person's earliest relationships help to shape the internal self and external expectations of the world. The infant internalizes interactions that take place between

itself and its earliest caregivers. This explains the critical importance of bonding (including the parent's mental capacity to reflect with the mind of the child), in terms of child development and the experience of parent-child attachment and relational experience.

Attachment has an extensive and broad historical context that permeates developmental and psychotherapeutic practices, ranging from early childhood through late adulthood. The theory has been used and researched to better understand the following:

1. Areas in developmental context (Davies, 2011) …
2. Developmental psychopathology (Carlson and Sroufe, 1995; Schore and Schore, 2007) …
3. The implications of attachment theory and research on adult psychotherapy perspectives (Slade, 2005) …
4. Reflective functioning (Slade, 2005) …
5. Psychoanalytic theory in relation to separation and loss in attachment (Scroufe, 1986) …

In relation to attachment, Katznelson mentions "… empirical studies conducted on reflective functioning" (2014). These studies, like the 1991 work of Fonagy and others, demonstrate that the mentalizing capacities of parents have important implications for infant attachment. However, through previous measurements of data collection, results were implied, not specifically derived from real-time, moment-to-moment parenting

experience. Fonagy's 1991 study suggests that mentalizing capacities were merely derived from inferred responses from the parent's childhood memories, and not solely focused on the intentionality of the current parent-child relationship. Due to shortcomings in tools that measured parent's capacity to visualize her parenting experience and interaction with her child, additional study measures were created to add depth and promote the capacity for reflective thinking (also known as "mentalizing") between parent and child.

The Adult Attachment Interview (AAI) consists of 20 protocol questions, conducted with adults over a conversation-style interview. As explained by Hesse (2008), "There are two speakers involved in the exchange." Those two people are the interviewer and the interviewee. Carol George, Nancy Kaplan, and Mary Main initially created the AAI in 1984.

> Main followed children longitudinally from 1 to 6 years of age. She was specifically curious about links between parental attachment experiences and their children's attachment organization. In order to explore this complex question, she developed the Adult Attachment Interview (AAI)." (Slade, 2005, p. 284)

According to the AAI protocol, "Individuals are asked to both describe their attachment-related childhood experiences, especially their early relations with parents or parenting figures, and to evaluate their influences of these experiences on their development and current functioning" (Hesse, 2008, p. 552). Individual responses are then categorized into adult-mind-state classifications, and researchers look for "… any major contradictions, inconsistencies in the narratives" (Hesse, 2008, p. 553). The AAI

has been widely used for a variety of purposes, including an examination of the "… parent's state of mind and to estimate the extent to which parents in high risk samples are willing to involve themselves in the intervention process" (Hesse, 2008, p. 553).

Addendum measurements were created to complement the Adult Attachment Interview. One addendum was created by Arietta Slade and others in 2004 and named the Parental Development Interview (PDI). In 1995, Charles Zeanah and Benoit created the Working Model of the Child Interview, a similar tool to reach a similar outcome. These tools, based on early study results, inferred responses and reactions of the parent on the lack of reflectiveness of parent-child interaction. This is as opposed to the parent describing her own parented experience within the AAI. The goal was to assist the parent to tune into the specific focus of parent representations of their children, through questions provoking reflective thoughts and reflective parenting experiences.

Fonagy and others conducted a study on the capacity for understanding mental states in 1991. This study used the Adult Attachment Interview to link attachment to reflective capacity in parents with their children. The study was titled the Parent Child Project. The aim of the study was to "… replicate Mary Main's study, with modifications, looking at the prenatal assessment of adult attachment" (Slade, 2005, p. 286). This study sought to assess and link the parent's attachment security during pregnancy to the child 's attachment organization within the first year of life. The study found "… mothers whose attachment narratives were rated as secure were more likely to have children who themselves were secure in relation to attachment" (Slade, 2005, p. 286). Fonagy and his colleagues used this research to reframe the notion of attachment theory.

Attachment relationships evolve and revolve around the regulation of intense, often negative effects. The internal processes necessary for secure attachment and intergenerational transmission must include a capacity to think about feelings and their relation to behavior. These mechanisms for processing intersubjective and interpersonal experience were referred to under the general rubric of the "reflective function" (RF) (Slade, 2005, p. 286).

A 2005 study linked attachment to reflective functioning. The study assessed 78 first-time pregnant women, who were seen during and following pregnancy. Psychopathology was assessed, along with Adult Attachment and Parent Development, to measure maternal Reflective Functioning. The Strange Situation was also used to conduct this study through observation of the mother and child. Slade (2005) hypothesized that "… the attachment classification for the mother would be linked to maternal reflective functioning within the child" (p. 289). Slade's findings explain that "… a person's capacity to describe and contain complex mental status within the context of a relationship that is full of current feelings is particularly crucial for a range of later developments in the child. Mothers who were able to coherently describe their own childhood attachment experiences were more likely to be able to make sense of their children's behavior in light of mental states" (p. 293).

Attachment in the parent can predict attachment styles used by the parent to help create attachment patterns in the child. This can be done by looking at the parent's own attachment history and how that history affects the child's world (Hesse, 2008). According to Slade, "… it is the mother's capacity to understand the nature and function of her own, as well as her child's mental states that will allow her to create both a

physical and psychological experience of comfort and safety for her child" (2005, p. 284).

When awareness and understanding take place, unhealthy patterns can be detected by the caregiver and intervened upon, thus stopping the cycle of unhealthy relating that stems from an unhealthy state of mind. When operating from an unhealthy state of mind, patterns continue to go unrecognized, therefore unaddressed, and unknowingly transmitted within the care-giving and care-receiving encounter, thus challenging the mother's ability to healthily reflect with her child.

> The reflective function refers to an adult's capacity to hold complex mental states in mind which will allow her to hold her child's internal affective experiences in mind; even more important, it will allow her to understand her child's behavior in light of mental states such as feelings and intentions. (Slade, 2005, p. 286)

When early relating goes well, future patterns of reflecting can be generalized and transmitted to others. However, when things go wrong, disturbances may occur within an individual, leading to undesirable patterns of relating, reflecting, and an undesirable state of mind.

Social Support

According to Seeman (2008), the term "social support" indicates assistance that people receive from others. Social support is a multi-dimensional concept. According to

several groups of researchers, (Hiles, Moss, Wright, & Dallos, 2013; Panzarine, Slater, & Sharps 1995; Seeman, 2008), social support encompasses assistance in areas including:

1. Emotional …
2. Instrumental …
3. Informational …
4. Appraisal resources …

Social support moderates the relationship between stress and mental health (Manuel et al., 2012, p. 2015). The Mayo Clinic (2014) describes social support as a network of friends, family, and peers—and one's comfort in knowing that these people are there in times of stress. For example, according to Seeman (2008) and the group of Manual, Martinson, Mansori, and Bellamy (2012), gestures that help one feel better are classified as emotional support, e.g., talking over a problem with someone and providing encouragement or positive feedback. Instrumental support is described as tangible acts, such as helping with child-care, providing transportation, and assisting with financial resources. Social support also includes the ability of key providers to influence mental and physical health.

The key providers of social support to young people, according to Hiles, Moss, Wright, and Dallos (2013) are "… parents, relatives, other adults, peers, and siblings" (p. 2060). Social support is "… an individual's social network that impacts psychological wellbeing and social functioning" (Panzarine, Slater, and Sharps, 1995, p. 114). The benefits of having social support include having (a) a sense of belonging, (b) an increased

sense of self-worth, and (c) a feeling of security. Research shows those who "… enjoy high levels of social support stay healthier and live longer" (Mayo Clinic, 2014, pp.1-4).

Social support may be viewed as supportive or stressful. Yates, Obradovic, and Egeland (2010) note that early intervention and prevention determines whether an individual has a negative or positive outcome in relation to stressors in and outside of the family, as well as the child's capacity to regulate psychosocially.

> Social support is one of the critical protective factors affecting the way a child is treated due to its stress buffering or stress alleviating effects … Informal support can enable families at risk to manage the demands from their life stress. (Kang, 2012, p. 933)

According to Fonagy and Target (2005), in bridging the generational transmission gap from mother to child, social support looks like this:

> … each person having access to more than one adult with sufficient interest in the emergence of mental capacities in an attempt to treat one another as potential minds through a process of attunement and sensitive scaffolding, promoting in one another the emergence of affect regulation, selective attention and mentalizing capacities. (p. 335)

Social support starts during the early infancy stages of life, initially (and ideally) through caregiver support. A sense of well-being, and the impression that others around care, have a positive effect on how the infant grows up to approach the world and others in the world. According to Chia-huei Wu and Cheng-Ta Yang (2012), "A person's

attachment relationship with others influences his willingness to learn and to master his environment" (p. 346). Furthermore, as stated by Hiles, Moss, Wright, and Dallos (2013):

> Early relationships with caregivers lead to the development of an internal working model of beliefs and expectations in relation to self and others. Theoretically, this way of thinking underpins the infant's earliest relationships, and leads to the development of characteristics or patterns of relating which are designed to ensure essential needs are met." (p. 2060)

Wu and Yang believe that "a caregiver's responsiveness fosters the infant's sense of a supportive world" (2012, p. 348). The infant who learns secure support from her caregivers and grows up to be an adult (and perhaps, a mother) can call on others as support agents for the following:

1. Resources …
2. Reliability …
3. Information …
4. Emotional sharing …
5. Connectivity …

When a caregiver has certain knowledge that she was cared for by others as an infant, she can maintain this knowledge as she grows into adulthood, primitively and instinctively knowing how to find safe and secure support. This mother will have the innate sense to seek and access someone safe and who is willing to be called upon in various situations. If the mother, as an infant, does not experience secure support

connectivity, she may grow up without knowing how to use and access her support. She may not recognize that she has support, or even know what support looks like.

A qualitative research study using a review of the literature, conducted by Hiles et al., looked at 47 studies involving young people's experience of social support (meaning teenagers and young adults) during the process of leaving care, e.g. state care. Young people between the ages of 16 and 19 were viewed as needing support around identity, social-emotional connectivity, and family relationships. The study states that young people need social relationships to improve physical and mental health, specifically by reducing stress. Researchers detailed the resiliency that mentorship and strong supportive ties to adults can instill within the young person—including those adults who hold professional roles in the young person's life. Additionally, the study examined the quality of multiple relationships in terms of social support to promote overall well-being in young people. It also reports that young people tend to rely on themselves for support, and that this may stem from (or lead to) difficulty in trusting others, which may ultimately lead to problems involving (a) potential and supportive connections, (b) the ability to reach out for help, and (c) future instances where support is desired or needed (Hiles et al., 2013).

A study by Pazarine et al., on coping, social support, and depressive symptoms in adolescent mothers looked at how such symptoms may differentiate maternal outcomes, social support, and coping mechanisms. This study determined that social support is multifaceted and social support maximizes psychological well-being. This is said to minimize depressive outcomes that may get transferred during the adjustment time-period needed between parent and child postpartum (Panzarine, 1995).

Manuel et al., conducted a more recent study on the influence of stress and social support on depressive symptoms in mothers with young children. This study looked at outcomes pertaining to both adolescent and adult women in relation to depressive symptomology. This study reports that "… being a mother of young children places women at particular risk for depression with estimates of 10 to 48 percent" (Manuel et al., 2012, p. 2013). This percentage is in comparison to women who do not parent young children. This study also reports that depressive symptoms typically begin during adolescence with a high probability of reoccurrence during young adulthood. The prevalence is greater when the young adult faces poor social-support systems, such as low-income housing, financial instability, chronic stressors, and reduced social support. This study reports that depression compromises optimal mothering by negatively effecting mother-child interactions and poor support systems.

Manuel and others refer to social support as a protective factor for mothers of young children.

> … women who are younger, economically disadvantaged, defined as unemployed, low income, limited education, or being single, have a greater number of children under the age of five, have physical health problems, and have a high number of stressful life events, coupled with poor social support … are more at risk for higher levels of depression than those ladies without these risk factors. …
>
> There is likely to be a reduction in useful parent-child interactions due to increased risk factors such as depression and multiple adverse experiences, described in this

study as chronic stressors, and not enough protective factors, also described in this study, as social support systems (Manuel et al., 2012, p. 2014).

A final study on pathways from social support to service use among at-risk caregivers looked at pathways from social support to service-use among caregivers of both African American and Caucasian American women who are biological mothers, and who are at risk of maltreatment. This study begins by stating, "Various factors such as domestic violence, substance abuse, mental health problems, and poverty can put a caregiver at risk for child maltreatment" (Kang, 2012, p. 933). However, this study shows social support is a "… well-known protective factor for physical and mental health as well as for child safety because of its distress-alleviating and stress buffering effects" (Kang, 2012, p. 933). The study looked at caregivers and the risk of child maltreatment if there is little to no social support available to the caregiver. It found that social support reduces distress across populations at risk of distress from the various risk factors in question. This study reports that, to caregivers, "Family is an important resource" (Kang, 2012, p. 934). Kang states that a greater number of social-support interventions effectively reduces postnatal depression, which can affect parenting experiences, and has a direct "… linear relationship with family functioning" (p. 934). The study purported to show that, "Rather than a mere amount of social support, the function of social support is a good predictor of service use" (Kang, 2012, p. 934).

Over time, this sense of support becomes an internal working model (Wu and Yang, 2012) to understand whether other people are reliable.

> People with higher secure relationships are more likely to perceive support from family and friends, which encourages them to seek support from others when facing stressful events compared to people with lower secure attachment scores." (Wu and Yang, 2012, p. 348)

In relation to social support and its effect on child development, Yates and others (2010) wrote, "An array of contextual factors, both inside and outside the family, affect child development, including negative life events" (p.540). In other words, the quality of parental social support determines better attentiveness from parent to child. Parental support also enhances the child's ability to seek and rely on support throughout its developmental trajectory. As stated by Yates, Obradovic, and Egeland, "Social support encompasses the availability of meaningful and consistently nurturing relationships that communicate a sense of interpersonal security and commitment" (2010, p. 546).

Adverse Childhood Experiences

According to Lawson, Davis, and Brandon," Incidences of trauma typically begin in childhood and are prolonged by caregivers and other adults who are expected to provide safe, secure, and predictable care" (2013, p. 331). According to a report from the Center for Excellence in Children's Mental Health, "Trauma is not only defined by the nature of the event, but also the person's perception of it as overwhelming to the psyche (2010, p. 1). Elsewhere, the same report claims, "Trauma is experienced when a person is subjected to direct or witnessed physical or psychological injury or threat of injury" (Center for Excellence in Children's Mental Health, 2010, p. 10).

The Center for Disease Control and Prevention (CDC) describes adverse childhood experiences as including abuse, neglect, and household dysfunction. Abuse can be emotional, physical, or sexual. Neglect is placed into two subcategories: emotional and physical. Household dysfunction is described as (a) violence towards a caregiver or child, (b) substance abuse or mental illness, and (c) parental divorce, separation or incarceration (CDC, 2014). As Steele states, "The landmark Adverse Childhood Experiences (ACE) study found that exposure to four or more categories of child abuse, neglect, or household dysfunction predicted significantly higher risk for physical and mental health problems" (2016, p. 36).

"Adverse childhood experiences" can be understood as unfavorable events a person experiences and describes as harmful during the first 18 years of life. A mother who has been "… exposed to adverse experience during the first 18 years of life carries an independently significant influence over how they parent" (Steele et al., 2016, p.36). Exposure to adverse childhood experiences brings unfavorable outcomes to children who then grow up to become adults and may potentially become parents. "Trauma involves repeated incidence of maltreatment over extended periods of time, including emotional abuse, physical abuse, sexual abuse, neglect, and witnessing family violence" (Lawson et al., 2013, p. 331). According to Steele and others, "Parenting stress in the earliest years predicts internalizing and externalizing behaviors in young children" (2016, p. 33). By understanding this dynamic, we can encourage positive and purposeful parent-child interactions, even given exposure to such adversities.

The Adverse Childhood Experiences (ACE) Study (Felitti et al., 1998) was conducted with Kaiser Health members during a standard medical evaluation. According to the

study, “Patients who were exposed to at least one category of childhood abuse or household dysfunction were also exposed to at least one other (category)” (Felitti et al., 1998, p. 251). The study also states, “Retrospective reports of childhood abuse are likely to underestimate actual occurrences” (p. 252), and, “High levels of exposure to adverse childhood experiences would expectedly produce anxiety, anger, and depression in children” (p. 253). Bowlby said, “A society that values children must cherish their parents” (1951, p. 84). The converse is also true. The parent affects the child, and the child affects the parent in the parent-child relational experience.

In 2016, a study on adverse childhood experiences, poverty, and parenting stress looked at mothers between the ages of 19 and 50 years old. These mothers either identified themselves as having income below the poverty threshold (less than $30,000 of annual income), or as middle class (having income over the $30,000 threshold). Mothers within the poverty classification reported four or more adversities experienced during childhood, while mothers who classified themselves as middle class did not. This study showed increased evidence “… of the impact adverse childhood experiences have on adults’ experiences of parenting” (Steele et al., 2016, p. 36).

According to Steele, “While stress of any kind impacts parent-child relationships and children’s social emotional development, high levels of parenting stress are particularly problematic because of their direct influence on parenting behavior and consequent child outcomes” (2016, p.32). The higher level of adversities experienced by a parent during childhood increases the level of impact that adversities may have during the parenting process, which can complicate the dynamics of caregiving and receiving. Steele and other link parenting stress to a “… higher likelihood of child maltreatment, as well as more

punitive, less responsive, and less stimulating parent-child interactions" (2016, pp. 32-33).

According to Lawson and others (2013):

> Trauma, which occurs in childhood within the caregiver system, is associated with overwhelming perceptions of severe traumatic experiences often related to survivor adaptations such as: self-harm behavior, social isolation, aggression, dissociation, adversely affecting normal and healthy development. (p. 331)

This adversity may also affect the presence of and capacity to psychologically reflect within the parent-child relationship. Adversity may transfer to the caregiving experience, unbeknownst to the parent. As Steele noted, "In a sample, over 100 African American mothers who had been exposed to physical and verbal abuse were more than likely to report spanking their infants than those who did not have such experiences" (2016, p. 33).

According to Pereira (2012) and Steele (2016), mothers who reported greater childhood maltreatment were observed to be less sensitive with their infants. This relationship was mediated by the parents' level of parenting stress according to the Childhood Trauma Questionnaire.

The trauma that mothers feel may be familiar and not perceived as a bad experience. This can insert patterns of unconscious dysregulation into the parent-child experience, and as Lawson explained, "A disruption in the caregiver-child relationship negatively impacts a secure attachment and a coherent and stable sense of self, leading to a general distrust of self and others" (2013, p. 331). Meanwhile, Steele says:

> Parent's early exposure to early childhood experiences may indirectly impact parenting, parenting attachment, and patterns that tend to shape both their representations of their children and parenting behavior, namely sensitivity and responsiveness. (2016, p. 33).

Looking at the early exposure to adversities in a parent's life can help support the parent-child dynamic, specifically by helping uncover how these adversities have been internalized and then externalized into the parent-child relationship. Parents' ability to identify their own trauma can activate parental cues, despite the parents' early exposure to experiences that can detract from sensitive and purposeful parenting experiences.

Conceptual Framework

Reflective functioning provides a conceptual framework for this study, which emphasized the curiosity of the parental reflective-functioning experience. Reflective functioning is "… the parent's capacity to hold the child's mental state in mind" (Slade, 2005, p. 269). Mental experiences are referred to as all thoughts, feelings, desires, beliefs, and intentions (Soderstrom & Skarderud, 2009). Reflective functioning is a way to observe and listen to the mother's capacity to psychologically reflect on the child. This concept examines the mother's capacity to intentionally connect with her child reflectively, helping the child to regulate, relax, and feel safe by using his mother's mind for support and mental organization.

Reflective functioning looks at the psychological availability of the mother's mind and intentionality while caring for the child. "Parental reflective functioning promotes

sensitive care, which again serves to protect the infant and the immature brain from potentially dangerous stress and physiological arousal" (Soderstrom & Skarderud, 2009, p. 62). The child uses the mother's mind to understand and explore its own mind. In observing the mother-child dyad, the researcher may have questions such as: (a) Is the mother's mind available to the child, (b) Can the mother recognize that her child's mind is separate, and (c) Does the mother understand that the child has needs outside her own thoughts? Also, can the child use the mother's mind in a way that helps to feel regulated and organized?

Arietta Slade and her colleagues introduced the concept of parental reflective functioning (Slade, 2005; Slade, Grienenberger et al., 2005). According to Slade (2005), Fonagy and his colleagues originally measured the reflective functioning of adults using a scale developed for use with the Adult Attachment Interview (AAI). This tool is used to measure the "… adult's capacity to reflect upon memorialized childhood relationships with their parents"(Slade, 2005, p. 270). Researchers were curious about the transfer of mental states and experiences from parent to child, which made it necessary to observe and measure the capacity to reflect upon the parenting experience. Thus, the Parent Development Interview (PDI) was created as an addendum to the AAI, specifically to reflect on the mother and child's emotional experience through the parent-child relationship (Slade, 2005).

Soderstrom and Skarderud claim that reflective functioning includes sensitive caregiving, secure attachment patterns, and mentalizing competence in the child. The two authors state that the caregiver's capacity to make sense of her own mental state (and that of her child) plays a crucial role in helping the child develop flexible and adaptive means

of self-regulation, as well as establishing productive and sustaining relationships with others. The authors state, “It is the parent’s capacity to tolerate and regulate these experiences in the child” (Soderstrom & Skarderud, 2009, p. 56).

The concept of reflective functioning fits well with the parent-child relational narrative that has been examined in this study. Through the mother’s capacity to reflect on the relationship she has with her child, she can retrospectively tell her story through the experience of caregiving, as well as through her experience of being cared for as a child. According to Soderstrom and Skarderud, without a lifeline to the caregivers’ mind, the development of self-regulation and social competence is endangered. “High-risk families need substantial support to navigate the burden of intergenerational transmission of internal representations of caregiving experiences, and to promote good enough care for the infant” (Soderstrom & Skarderud, 2009, p. 48). While the mother cares for her child, she remembers being cared for (Winnicott, 2002), whether her experience was good or bad. Her presence, both psychologically and physically, is affected by the capacity in which she remembers receiving care.

The concept of reflective functioning suggests that the parent-child relationship is vital to the child’s mental experiences. “Misreading minds leads to misunderstandings, disruption and frustration in social communication (between the mother and her child)” (Soderstrom & Skarderud, 2009, p. 50.) Parents have the responsibility of being available to the child. That availability includes perceiving, noting, discerning, and reading internal and external cues, along with the intentions of the child. Soderstrom and Skarderud state that being with the child and recognizing how the child feels during various experiences, coupled with managing to set aside one’s own emotional experiences and needs to attend

to the child's needs, will assist the child in feeling regulated. This feeling will help regulate the parent-child relationship as a whole. "The parent must be skilled in understanding their own mental states in general, and their own feelings of parenthood" (2009, pp. 56-57). Elsewhere, Slade (2006) writes that parental reflective functioning consists of helping the parent keep the child in mind.

Mentalization

According to Slade (2005), reflective functioning is an overt manifestation, in narrative, of an individual's mentalizing capacity. Soderstrom and Skarderud (2009) describe mentalizing as a concept that represents conceptual and empirical bonds between brain and mind. Further, the "… mentalizing tradition aims to combine psychodynamic hermeneutics with evidence-based medicine" (Soderstrom & Skarderud, 2009, p. 62). To Fonagy and others, mentalizing is "… the capacity to understand one's own and others' behavior in terms of underlying mental states and intentions" (Fonagy, Steele, & Higgitt, 1991; Fonagy et al., 1995).

According to Soderstrom, mentalization was introduced by French psychoanalysts in the late 1960s, and is used today in the studies of cognition and interpersonal understanding. Soderstrom describes mentalization as an individual's competence to envision mental states in self and others, and to understand behavior in terms of mental states (2009, p. 49). "Mentalization thus implies a competence to identify mental states and to interpret one's own as well as others' inner states. The concept of 'reflective functioning' is usually used referring to the measurement of a mentalizing capacity

(Soderstrom & Skarderud, 2009, p. 49). Fonagy and Target's 1996 work posits that mentalization is derived from the joining of theory and knowledge from different disciplines, such as infant mental health, attachment theory, neuroscience and psychodynamic theory.

Fonagy and Target (2005) suggest that mothers who can reflect with their child have greater capacity to regulate a baby's experiences, by interacting with the child without frightening or otherwise disorganizing the child. Mentalization serves the parent-child dyad as a regulatory function of the attachment stance once the mother-child relationship has been ruptured. The mother is called upon to give voice and understanding to the child's internal and external experience. The key conceptual implication is that consistency of being present and understanding the infant's internal working model is achieved through repair following rupture.

Soderstrom and Skarderud (2009) suggest that the distorted mind of the parent influences the patterns of interaction over time. The child becomes increasingly unable to successfully regulate its own affects, thus creating the inability to make sense of its mind, and that of its mother.

> Hence, psychological and social development are endangered. Systemic failure in caregiver's sensitivity for the child endangers the child's neurobiological development. Normal brain development depends on sensitive care and protection from enduring stressful arousal to develop the prewired potential for an interpersonal interpretive mechanism. (Soderstrom & Skarderud, 2009, p. 57)

Slade says, “The human capacity to relate and process interpersonally is linked to meaningful, predictable ways of understanding underlying, unobservable, changing dynamics, feelings, and intentions” (2005, p. 271). The child becomes able to discover its own mind by observing and accessing the mother’s mind. If the mother’s mind is blocked, not accessible, ill, or distressed, the child inherits the mother’s incapacities, which are unseen and unobservable to the mother, and unbeknownst within the child’s mind. For the mother to observe, allow access, and connect with the child, she must put aside her own experiences and tend to the needs of her child, which are ultimately separate from her own. Minding the mind of the baby means initially minding the mind of the self, and learning to separate the two.

Reflective functioning helps us explore parent-child relationship because it promotes parent-child interaction and the “reflective stance” (Ordway et al., 2015, p. 328). Ordway and others refer to the reflective stance as an effort to assist the parent to take a reflective approach to the mind of the child, and to her own mind as separate from the child. This approach helps the parent recognize (and better understand) the child by being in tune with the child, and recognizing the child’s mind as separate from her own. The parent can thus be curious about the mind and actions of the child, from moment to moment. The reflective stance between mother and child “… acknowledges the underlying mental states, understanding them as behaviors that will shift” (2015, p.328). Further, these states will tell a narrative of what the child may be thinking, and experiencing, versus the parent’s intrusion of self-thoughts projected onto the child.

Reflective functioning has also been used as a concept to frame the parent-child relationship, because it suggests strong basic principles that help the parent make sense of

her child's signals and communication via non-verbal responses, interactions, and interpersonal experiences within the dyadic and interactive parent-child encounter. As Ordway states, "Parental reflective functioning is crucial to promoting healthy parenting" (2015, p. 327).

Parental reflective functioning promotes more secure and correctly implicit cues from the child. The parent must recognize that she can determine how an interaction goes with her child based on how she either views, misreads, or ignores her child's mental state, and how that mental state interacts with her own. "When the parent does not recognize her own and her child's individual and separate emotional state, and subsequent effects on behavior, there is a risk for miscuing one another, resulting in miscommunication that can lead to poor emotion regulation and an elevated stress response" (Ordway et al., 2015, p. 327).

In summary, the researcher looked at three concepts in relation to young-adult African American mothers: (a) reflective capacity, (b) social support, and (c) adverse childhood experiences. The researcher used several search engines to gain a better understanding and to provide definitions for each concept. Reflective capacity is used to both define the experience of the concept and to frame the research.

The research tells us that a parent's ability to reflect sets the tone and foundation for connectivity within the parent-child relationship. The research also states that if reflective capacity is thwarted, the child's sense of exploration and sense of self may be offset, resulting in miscues between parent and child. Attachment is used in this section to complement the concept of reflective capacity. The research on social support states that

parents with supportive relationships better encourage additional relational connectivity with others, which increases an individual's capacity to encounter stressful events.

Lastly, the research on adverse childhood experiences defines traumatic experiences that overwhelm the psyche. The research supports the notion that childhood traumas may carry forward into caregiving experiences. Traumas are referred to as adversities, and the adversities are broken down and explained in three categories, with subcategories to better define the experiences. Adversities that occur in childhood may ultimately carry over into the caregiving and care-receiving experience of the parent and child.

In conclusion, a child's personality is characterized by an inborn desire to connect with others. If a mother's way of relating to the child remains healthy, she can maintain a healthy sense of self and a healthy pattern of relating to her child. The author proposed to study this dynamic by listening to young-adult mothers describe their early experiences of receiving care and current experiences of providing care. It was thought that if the mother did not have (a) healthy attachments, (b) limited reflective capacity, or (c) little to no supportive relationships, she might transmit unhealthy reflection and relating as a caregiver.

Chapter III

Methods

Introduction

This study involved collecting stories of young-adult African American mothers about their relationships with their children. Early childhood adversities were explored with each of these mothers. The researcher sought to find out how each mother may have faced adversity and identified the availability of social supports—and how both of those dynamics affect the mothers' capacity for reflective functioning. By design, this research was exploratory and qualitative. Data were collected through interviews using structured but open-ended questions. Also, the researcher endeavored to gather preliminary and descriptive information. Themes and patterns emerged from these mothers' narratives. The researcher has examined and interpreted the findings from clinical and developmental theoretical perspectives. These efforts sought to understand the dynamics of reflective functioning within the mother-child relationship and how, if at all, adverse experiences and social supports play a role.

According to the literature, a qualitative approach allows researchers to listen to the voices of an understudied, overlooked group (Creswell, 2007). In the case of this study, the overlooked group was young-adult African American mothers. The qualitative

approach allowed for increased curiosity and dialogue between the researcher and the research group. Additionally, it provided a platform for subjects to tell their stories, in their own words. This ultimately gave the researcher a heightened awareness and greater understanding, which will hopefully contribute to a more clinical and professional approach to working with this caregiver population. According to Patton, "In new fields of study where little work has been done, few definitive hypotheses exist. Little is known about the nature of the phenomenon, qualitative inquiry is a reasonable beginning point for research" (1990, p. 131). Given these factors, qualitative research was appropriate for this study, as there few studies look at young mothers beyond their teenage years. Moreover, virtually no studies explore the concepts of reflective functioning and social supports among young mothers.

Throughout this study, the researcher was interested in gathering the perspective of each participant through interviews. In addition to hearing the voice of the participant, the researcher used observation to capture the actions, and recognize the emotions, that were present during the interview process (Denzin, 2001). This modality served as a pathway towards interpreting a larger meaning of each participant's story (Creswell, 2007), bearing in mind that, according to Denzin, "… thick description creates the condition for thick interpretation" (2001, p. 117).

Denzin described participating, interviewing, and listening as a way the researcher can "… attempt to live their way into the lives of those they investigate" (2001, p. 65). To do this, Denzin stressed the importance of "… thick descriptions, rich detail, interpretations, and performance texts, as a way to generate meaning out of these stories" (p. 26).

According to Denzin, “Meaning is anchored in the stories persons tell about themselves” (p. 80).

Thick descriptions are described by Denzin as “… an intersection of people’s conception of themselves and their worlds” (2001, p. 99). Thick descriptions were introduced to capture attention by giving the reader a “… space to imagine his way into the life experiences of another. Thick descriptions captured and recorded the voices of lived experiences” (Denzin, 2001, p. 99).

Thick description does more than record what a person is doing. It presents detail, context, emotion, and the webs of social relationships that join people together. It enacts what it describes. Thick descriptions evoke emotionality and self-feelings. They insert history into experience, and establish the significance of an experience or sequence of events for the persons in question. The voices, feelings, actions, and meanings of interacting individuals are heard and made visible (Denzin, 2001, p. 99-100).

In this study, the researcher used thick descriptions to “… make the world of lived experiences visible to the reader” (Denzin, 2001, p. 34). The researcher was able to capture the interactions of participants’ life story to better understand their interior experiences. Creswell (2007) describes this approach as “… present narration of the essence of the experience. Developing textual descriptions of what happened” (p. 157).

Interpretation is the attempt to explain meaning (Denzin, 2001). An interpreter translates the unfamiliar into the familiar. The act of interpreting gives meaning to experience. Meaning refers to "… that which is in the mind or the thoughts of a person" (Denzin 2001, p. 119).

According to Denzin, interpretation is the clarification of meaning. Understanding is the process of interpreting, knowing, and comprehending the meaning that is felt, intended, and expressed by another. Interpretation precedes understanding. It is an interactional process that dissects units of experience. It is relational and dialogical, requiring that one person enters into the life of another and experiences the same or similar experiences as the other (2001, p. 137).

The two types of narratives to be interpreted, as described by Denzin, are personal-experience stories and self-stories. A personal experience story is described as "… a narrative that relates the self of the teller to a significant set of personal experiences that have already occurred" (2001, p. 61). A self-story is a "… narrative that creates and interprets a structure of experience as it is being told" (p. 61). For this research study, both personal and self-stories were collected, assessed, interpreted, coded, and analyzed based on data provided through participant interviews.

Research Sample

The study sample consisted of 11 young-adult African American females, ranging in age from 20 to 25 years, who identified themselves as parenting a child between the ages of 1 to 5. The child was described being between the ages of 1 to 5 years of age, or 12 to 60 months. Infancy, or birth to 1 year of age, was not purposefully included within this research study. This omission meant to ensure that the mother experienced at least one full year of caregiving experience with the child.

Research announcements were posted and distributed by local agencies specializing in working with this population and age group. Potential participants contacted the researcher via electronic messaging, email, social media, and face-to-face interactions. This differed from the researcher's expectation that potential interested participants would call the researcher. This did not happen once.

Following the initial contact from participant to researcher, the researcher asked each participant for permission to telephone her to give information, ask questions, and set up the next point of contact. After each participant gave the researcher permission to call, the researcher called to give information, introduce the study, and do pre-screening. During the initial prescreening process, participants were asked their age, their child's age, and their identified race. This assured that participants met the requirements to move forward with the research.

By reviewing the criteria with the participant over the phone, the researcher assured that the participants understood the overall intent of the proposed study. Then, the researched informed each mother whether she met the criteria to move forward. All potential participants fit the criteria, so no potential participants were turned away. Participants who expressed an interest in further participating in the study were invited to meet on a date and time that best fit their schedule. One participant chose not to move forward with the research after a date was scheduled. This participant rescheduled and then ultimately cancelled the appointment and said she would call if she became interested again. Another participant was scheduled to be interviewed in her home, but on the day of the scheduled interview, the participant's phone number was no longer in service. The researcher showed up to the participant's home, but was not able to get into

the building because of the phone issue. The researcher did not hear back from this participant.

As previously stated, the researcher connected with specific agencies that provide programming or educational services to the mothers in this population, or to their children. Local agencies included, but were not be limited to:

1. YWCAs …
2. Head Start …
3. Early-childhood educational providers …
4. Child-care and child-development centers …
5. Transitional Housing Support centers …
6. School districts with early-childhood educational programs …
7. Local community members …
8. Degree-providing institutions …
9. Social-service agencies …
10. Workforce-support and parent-support providers
11. Coffee shops …
12. Individuals in the researcher's professional and personal networks …

Each agency received a verbal and written description of the research study. Research announcements were distributed to agencies in either hard-copy or electronic form, per the request of the agency. Each agency asserted their comfort in sharing this information with potential participants. Each announcement described the criteria for participation and included contact information for the researcher.

Referrals for participants mostly came from community members and agencies. Participants were willing to join the study because someone in their community or at an agency vouched for the researcher. Each participant had a story about how she became interested in the study, and how she came to contact the researcher. The researcher hoped that participants would make contact based on the announcement alone. That was not the case. Participants stated that they may have read the announcement, but ultimately a trusted individual pointed them in the direction of the researcher. Participants also stated that there was a trust factor. Knowing someone who could vouch for the researcher was the deciding factor to participate and share any of "their business." The researcher appreciated hearing these candid comments. The researcher also gained an understanding of how sensitive research might be with this population of parents, as they were not sure of the researcher's intentions in asking them about their parenting relationships with their children.

Research Design

Once contacted, each participant received information describing the voluntary nature of the proposed study. The researcher reminded each participant that at any time she

desired to terminate participation, she could do so without any consequence or prejudice. The researcher explained how to obtain assistance for any harm or risk felt throughout the interview process. It was discussed that this type of interview may stir up memories that were not considered by the participant or the researcher at the time of the interview. To conclude the interview, the researcher asked a final question: "How is it to be asked these types of questions," or, "How is it to be interviewed with these types of questions?" This question brought about the most emotional responsiveness from participants. The researcher did not initially plan to include this question, but did so at the suggestion of her dissertation committee.

This final question brought about deep thinking, curiosity, raised awareness, and statements that were interpreted by the researcher as follows:

1. "No one has ever asked me these questions before" …
2. "No one has ever challenged me to think about my relationship with my child this way" …
3. "No one has ever been interested in me, interested in who I am as a parent, who my child is, or who my parents were to me" …
4. "I can truly see the similarities and differences in my own experience of being parented, and the experience I am having with my child now, but I have never thought about it like this before" …

Data were collected through audio and video-recorded interviews. Participants were told that interviews would take approximately two hours, including the collection of

demographic data. Interviews ranged from 40 minutes to two-plus hours. Participants were given ongoing opportunities to ask questions throughout the entire process. The plan was to travel to each participant's home for the face-to-face appointment, unless the participant chose to meet at the researcher's business office. Five participants were interviewed in their own home. Five participants asked to come to the researcher's office to be interviewed. One participant opted to meet at her children's preschool, where the preschool director provided a secure office for the interview.

During the face-to-face appointment, the researcher reviewed the consent form and asked each participant to sign two forms and to describe an understanding of the study to ensure informed consent. The researcher signed both copies of the consent form. The participant was given a copy of the signed form and the researcher kept the other for record-keeping. Once each participant signed the consent form, the interview proceeded.

For the creation of the interview tool, three instruments were combined into one succinct and cohesive document. Open-ended questions about adverse early childhood experiences and social support were asked. These questions were derived from the Adverse Childhood Experiences Survey (ACES) and the Social Support Circle Questionnaire. Demographic questions were also derived from a combination of ACES and the Social Support Circle questionnaire. The primary interview questions were adopted from the revised Parent Development Interview. (See the "Data Collection" section of this study for an in-depth description of all three instruments, and an explanation of how measured concepts were used to collect qualitative data.) The interview tools were used to guide each participant interview.

During the interview process, the researcher used audio and video to record the interview sessions. The researcher asked permission to use audio and video recording devices during the interview process. No identifying information was intentionally captured on the audio or video devices. All identifying information was obtained by each participant prior to any recording device being used. The participant was reminded that only the researcher would be viewing the video following the interview session, as some participants continued to glance at the video recorder throughout the interview, which alerted the researcher to potential discomfort. Each participant was asked for verbal permission to start the audio and video devices.

The audio recording was used to transcribe interviews. The video was used to review the interview process and dynamics following each interview. Additionally, the researcher used the video files for some of the interview transcription. Specifically, video recordings were used to assist the researcher in viewing the participant while hearing her voice. During the interview, the researcher wanted to make sure to capture the entire essence of the interview and connection with the participant. The video was used to capture missed cues, expressions, affect, and actions present throughout the interview process. Once the transcripts were completed, the researcher used each transcript to write notes about each interviewee while viewing the video, recording all themes within the margins of each transcribed interview. The researcher also observed via the video and audio recordings how the mother viewed and described her child—whether superficially, internally, or via non-verbal cues. Notes were used to help with interpreting deeper meaning of each response.

Once the interview was complete, the recording devices were turned off. The researcher thanked each participant for her participation in the study and offered to answer any questions or concerns. The researcher provided time after the camera was turned off to debrief the participant, letting her know that emotional reactions may be delayed. The researcher gave each participant a handout containing names of three therapists, in case of delayed emotional discomfort, anxiety, or general need to further process the experience. The document also included contact information for mental-health resources in the participant communities. All named therapists listed on the document had previously agreed to meet with the participants. One therapy session would be provided to the participant, free of charge. The document has been included in the appendices of this document. The participants were also given a 15-dollar gift card to Target with a message of, “Thank you.”

To maintain confidentiality, after each interview session, each file (including the signed consent form, interview protocol, electronic audio, and video recordings) was labeled with a participant / interview number representing the mother in question. This number would identify each participant throughout the research project. The files, both electronic and hard-copy files, were placed into a locked file cabinet in a locked office, until the researcher was ready to begin data analysis.

Data Collection

The central research question was, “What is the effect of adverse childhood experiences on reflective functioning of young-adult African American mothers?”

Participants and the researcher engaged in a guided interview to answer this question. Open-ended questions were taken from the research tools. Prompting questions encouraged participants to elaborate on responses, as needed. The researcher asked a pair of final follow-up questions upon wrapping up the interview. Those questions were, "How was it to be asked these questions," and, "What came up as you were being asked to reflect on the questions overall?"

Ideally, these interviews would be conducted in participants' homes, and at least half of the interviews did take place there. Interviewing the mother in her home environment gave the advantage of having the mother answer questions within a setting that was familiar to her, and her child, if the child was present. This also provided the potential opportunity to informally observe how the mother and child interact within their natural environment, when the child was present, during the interviewing.

One disadvantage of interviewing in the home environment came from distractions, which might have interfered with the mother's attention. Also the mother might not feel comfortable answering certain questions in the presence of her child. It was therefore ideal to have the mother answer the interview questions without the child present for increased accuracy and decreased distraction.

All participants were asked demographic information to identify race, age, gender, socioeconomic status, housing status, relationship status, parenting status, and social supports. Three survey instruments were used to frame the qualitative interviews: (a) the Adverse Childhood Experiences Survey (ACES), (b) the Social Support Circle Questionnaire, and (c) the Parent Development Interview, Revised (PDI). Although the

three instruments were quantitative measures, the researcher was only interested in hearing the story behind the questions, versus obtaining a rating. Because these tools already exist, have been validated, and ask questions relevant to the research topic, the researcher chose them as guides to open-ended, qualitative interview questions. The researcher assumed that since the chosen questions were already created within standardized measures using the exact questions, using them for this study, in a qualitative way, would create the potential to increase the validity of this study, as the researcher was not generating any new questions. It was also assumed that using a qualitative approach would provide richer information than a positivist instrument.

A qualitative research design was chosen over mixed methods because the researcher wanted to have access to a collection of in-depth narratives via the mothers' stories. By using a qualitative approach to collect data for this research, participants could respond to interview questions in a narrative, storytelling manner, as opposed to checking boxes, being observed, or answering closed-ended questions. The instruments were used to frame and categorize the research questions to ultimately create the interview protocol for the research study. The questions were seen as fitting for the data the researcher was interested in gathering, although they are all quantitative instruments.

For this study, the ACE and social-support instruments were intended only to present a picture of each mother's history of adverse experiences and social-support systems, as relevant. None of the instruments were scored. The two instruments were used to collect demographic information for each participant. Questions about the participant's parenting experience were asked, including the participant's experience as a caregiver and her own care-receiving experience. This information was gathered as a process to (a) engage with

the parent, (b) have the parent begin reflecting on her experiences of having been parented, and (c) to gain information about the household and parenting status.

The researcher did not score the Parent Development Instrument, Revised (PDI). This quantitative instrument provided a perfect fit of questions to explore and frame the concept of parental reflective functioning. The researcher was interested in obtaining and exploring the parents' stories, not the score or the quantity of parental reflective functioning. The categories used from the PDI are as follows:

1. View of the Child …
2. View of the Relationship …
3. Affective Experience of Parenting …
4. Parent's Family History …
5. Dependence / Independence …
6. Separation / Loss …
7. Looking Behind / Looking Ahead …

These categories helped each participant frame what she would think about next. The categories seemed to work well. The researcher could see the shift in the participants' eyes, body position, and usually with a nod or gesture noting that they were ready for the next thought.

In this exploratory, interpretive experience, the researcher was immersed in the field with participants. Countless hours were spent establishing rapport, and fully capturing

each participant's unique story of parental reflective functioning, including adversities. Participants described adversities as less than desirable, unforeseen, and competing with adult caregivers' attention during childhood. Yet, participants looked at or described these experiences as the norm, or something one could do nothing about. Additional questions captured each participant's view on social supports as helpful or unhelpful.

The Makeup of the Interview Protocol

Adverse Childhood Experiences Survey (ACES).

Adverse Experiences: The Adverse Childhood Experiences Survey (Felitti et al., 1998; ACEstudy.org, 2011) is a 10-item survey in the form of a paper questionnaire. This survey can be found at http://acestudy.org/survey. It was administered to collect each participant's level of adverse childhood experiences.

The tool is typically used as a quantitative measure. It records individual responses that are totaled into a final score. This score is entered online to obtain an ACE score of childhood adversities. The survey can either be given to an individual to complete on their own, or by a researcher or a professional. For this study, the researcher used the questions in an open-ended way to prompt conversation around adverse childhood experiences. These questions were asked in succinct, flowing, and cohesive manner, as part of a larger interview protocol. The interview protocol is listed in the appendices of this research project.

The ACE study was created to obtain and assess baseline information surrounding the "… retrospective and prospectively long-term impact of abuse and household dysfunction during childhood on the outcome during adult life" (Felitti et al., 1998). The ACE study has been used to measure household factors (as well as long-term, cumulative influences of exposure) across multiple categories of adverse childhood experiences including the following, as described by Felitti and others (1998):

1. Sexual abuse …
2. Physical abuse …
3. Psychological abuse …
4. Exposure to household dysfunction during childhood …
5. Exposure to substance abuse, mental illness, violent treatment by a caregiver, and criminal behavior in the household …

The traumatic stressors termed as ACE are common. The ACE score assesses the total amount of stress during childhood (CDC, 2013). The purpose of using existing questions from the ACE survey for this research study was to determine if participants have been exposed to any negative early-childhood experiences and, if so, to get a sense of those experiences. For example, questions sought to uncover whether participants experienced the following:

1. A caregiver in the household using swear words …
2. A caregiver in the household using verbal, physical, or sexual insulting gestures or language in a way that felt abusive, or threatening …

3. Whether a participant felt unloved, or uncared for, by the adults in the household …

4. Whether the participant experienced absence of basic needs …

5. Whether the participant experienced adult absences in the household, such as incarceration, separation, divorce, hospitalization, long-term travel, mental illness, or chemical health challenges (see appendices for full interview protocol questions) …

The ACE questions were developed directly from a survey conducted with 17,000 HMO members between 1995 and 1997 as a part of a physical examination. The survey asked questions about childhood experiences and current health status and behaviors. Of the 17,000 member surveys, respondent demographics were as follows:

1. 54% identified as female and 46% as male …

2. 74.8% identified at White, 11.2% as Hispanic, 7.2% as Asian, 4.5% as African American, and 2.3% as "Other" …

3. Ages ranged from 19 to 60-plus, with 60-plus making up 46.4% of members surveyed …

The Social Support Circle questionnaire.

Social Support: The Social Support Circle is a 10-to-15-minute interview that assesses and identifies current adult social-emotional supports for parents. This instrument directly

focuses on the quantity and quality of adult social support. Participants were first asked to describe their household structure, and to name those who have helped them in their lives.

The Social Support Interview (and scale) were designed by staff from the Minnesota Longitudinal Study of Risk and Adaptation (A. Sroufe, Egeland, Byron, Carlson, Elizabeth A., Collins, Andrew W., 2005). It has been reliably administered in prior research, and shown to have predictive validity with respect to parenting behavior and children's developmental outcomes (Carlson, 1995; Pianta, 1989; Yates, 2010). The social-support measure was created and administered in previous studies because "… these types of measurements are underrepresented in the literature" (Carlson, 1995). The instrument was initially used to specifically measure the quantity and quality of adult social support and to predict supportive parenting along with children's developmental adaptation. This instrument was used with pregnant mothers of whom 80% were Caucasian, 14% were African American, and 6 to 7% were Asian or Hispanic. These mothers ranged in age between 12 and 37 years, with 20.5 as the average age.

The rating scale developed with the Social Support Circle, titled Overall Quality of Emotional Support, focuses on the overall responsiveness of the parents' social-support network to the specific needs of the parent. This rating scale starts at "1" and ends at "7," as follows: (1) Almost nonexistent, (2) Very poor, (3) Poor, (4) Fair, (5) Good, (6) Very Good, and (7) Excellent. The breadth of this scale calls to mind a statement from Yates: "Social support encompasses the availability of meaningful and consistently nurturing relationships that communicate a sense of interpersonal security and commitment" (2010). Scoring the Overall Quality of Emotional Support involves tallying up the total

number of individuals in each relationship category, as well as looking at support provided from select relationships. The gathered information rates the parents' overall emotional and social support.

Scores were not calculated in this study. Instead, the instruments questions were used to ask participants to name:

1. Persons who provide support …
2. What type of support is provided …
3. How much support is provided …
4. How often the support is provided and accessed …

Examples of the questions that were asked from the social-support instrument are as follows (see appendices for full interview protocol questions):

1. Do you have social support?
2. Who is in your network of support?
3. What are things you are not getting help with that you expected or would like to get help with? Can you describe the help received from others?
4. What type of information or advice would you like more of?

Parent Development Interview, Revised (PDI).

Reflective Functioning: The Parent Development Interview, Revised (PDI) is a 32-question, semi-structured clinical interview, which takes approximately 60 to 90 minutes to administer. The PDI aims to assess a parent's representation of the parent-child relationship. It also assesses parental reflective functioning across all domains, including with the child, the self, and the parent's own care-receiving experience. Categories of the PDI are as follows:

1. View of the child …
2. View of the relationship …
3. Affective experiencing of parenting …
4. Parent's family history …
5. Dependence / Independence …
6. Separation / Loss …
7. Looking Behind, Looking Ahead …

Permission to use the PDI questions, in a qualitative way, was granted by its author, Arietta Slade, Ph.D. (See appendices for full interview protocol questions). The PDI was administered qualitatively in this study to uncover the following: (a) the mother's subjective viewpoint and her story about the dynamics of parenting a child, (b) her understanding about the relationship between her child and herself, and (c) her level of

understanding about the emotion and internal experiences of how she and her child experience one another. Examples of the categories and questions are as follows:

Category: View of the child.

Questions include: When you think of your child, what do you think of? (How do you see your child? How would you describe your child to another person? What do you know about your child?)

Category: View of the relationship.

Questions include: What kind of relationship do you and your child have? (Describe your relationship to a good friend. What kind of connection do you have with your child? What kind of connection would your child say she / he has with you? How do you think the relationship affects your child?)

Category: Affective experience of parenting.

Questions include: Who are you as a parent? (As a parent, what is challenging and what is easy? What feelings come up the most for you as a parent? Do you think your child notices your feelings and if so tell me more? Do you ever wish you had somebody to take care of you? When was the last time you felt that way?)

Category: Parent's family history.

When you think about your own childhood, what comes to mind? (What was your relationship like with your mother and father? Did you ever feel rejected or hurt as a child? Tell me about any good or bad memories that come to mind. How are you like or not like your mother or your father?)

Category: Separation loss.

Tell me about times you and your child were separated from one another? (Tell me about any special people that you wish were in your life and your child's life? Describe the times you felt you were losing a connection with your child and / or with yourself?)

Category: Looking behind / Looking ahead.

If you had a chance to choose parenting all over again, what would that look like for you and for your child? (Try to think about your child as an adult. What do you imagine your grown child will be like? What do you imagine you would be like as a grandparent?)

The PDI was initially developed to use with 150 parents with children ranging from infancy to adolescence. The initial group of parents were comprised of rural parents who were working-class or middle-class. This tool has been subsequently used with adopted parents and parents in treatment programs. The instrument was developed for use in a clinic or research environment to evaluate parental and child-affective experiences and mind-states. This tool is typically administered as a semi-structured clinical interview and

operationalized by obtaining scores measuring reflective functioning via an 11-point scale. Participants given a score below five are considered as having low reflective capacity. A person scoring higher than five is considered as having higher reflective capacity (Wright, 2011).

Higher scores demonstrate a higher capacity to reflect on one's own feelings and intentions, as well as the feelings and intentions of one's child. For the purposes of this study, responses were not scored. Instead, the interview was administered qualitatively with the goal of gaining an in-depth narrative understanding of a specific sample: young-adult African American mothers reflecting on their parenting relationships and experiences with their children.

Data-Collection Guidelines

Denzin suggests, "… the researcher follows guidelines that make it possible for other researchers to evaluate their work" (2001, p. 48). These guidelines are also effective for gathering the essence of the natural narrative as spoken by individual research participants. Denzin also states, "Interpretive evaluation studies are value-laden and take the side of the participant in any setting" (2001, p. 49). Thus, study guidelines should ensure the collection of all possible historical content of each participant. The historical context will allow each participant narrative to unfold naturally, telling a unique story. This also allows the researcher to have a personal historical relationship to the interpretive process (Denzin, 2001, p. 49).

The next process involves capturing power. Denzin (2001) describes power as interactive with history, and as the force and domination that actualize human relationships through manipulation and control under any type of dominant environmental factors. This involves individuals within an established community, neighborhood, and society as a whole, who either have power or no power. In this instance, power represents the majority and minority populations that allow us, under societal norms, to categorize individuals into groups according to income, race, status, gender, religion, and cultural expectations.

The next suggested guideline involves meaning and effects, which are described as the way in which individuals describes effects of being who they are, identifiably, in the world, and how they themselves are addressed via particular roles by others in the world. The "meaning and effects" guideline takes the point of view of the individual telling their story. It captures meaning in the involvement as it relates to the individual and how they are connected to all other entities in their world (Denzin, 2001).

Emotion comes next in Denzin's guidelines for interviewing research participants. Emotion is described by Denzin as "… looking at, capturing, and listening to the moods and feelings that individuals bring to a study" (2001, p. 50). Emotion also looks at the emotional dynamic between the researcher and the participant. Denzin writes that emotion is connected to history and power. Denzin believes that each individual has the power to tell their own story, and emotion helps the story to come alive. Emotion is also seen as an avenue to share with the power, the powerlessness, or the powerfulness of the individual with the researcher, according to the narrative that the individual chooses to share.

Collecting the knowledge of each participant is the next guideline in researching from an interpretive stance. Knowledge is described as the beliefs that are communicated to the researcher by each participant. The beliefs are about "… specific segments of reality in a person's life," and, "Those who have power and create power determine how knowledge is applied and how it will be defined" (Denzin, 2001, p. 51).

The final guideline mentioned by Denzin, is the power of interpretation. This indicates that, "Interpretive studies can reveal only the interpreted worlds of interacting individuals" (2001, p. 51). The researcher must have an understanding that interpretation may be left incomplete and unfinished. Meaning is interpreted only by what the individual participant shares with the researcher, within that particular research study (Denzin, 2001).

The guidelines detailed above framed the interviews for this research. Recorded data captured the affect, gesture, and interaction of each participant within the interview. This helped the interviewer as coding and analysis began, as a way to remember the participant's interview in its entirety, including participant expression, feeling, action, and interaction—as well as the level of rapport established with the researcher throughout the interview process.

Data Analysis

Participant interviews were reviewed and coded individually for themes. Following individual coding, interviews were collectively reviewed for related themes. Themes were organized using categories taken directly from the Parent Development Interview-

Revised (2003). During this process, the researcher kept in mind that, “The basic concepts and questions the investigator brings to a study are part of the research. Every inquiry is guided beforehand by what is sought” (Denzin, 2001, p. 74).

Denzin (2001) encourages the researcher to look at the symbolism within the keywords of the data collected from research subjects. By looking at the interactional text and organizing it into terms and codes, the researcher can direct attention to a system of larger meaning. According to Denzin (2001), “Uncovering the codes that organize a text and examine the opposition that structure its meaning draws attention to the multiple meanings of key words and utterances within interactional and narrative texts” (p. 77).

Coding identifies themes found within the data. This has been done line by line, by the researcher, initially through open coding and bracketing. Bracketing is a term Denzin (2001) uses to describe the researcher as “… taking the text of the story apart and interpreting key phrases. These phrases contribute to the essential, interpreted meaning of the story” (p.76).

Bracketing suggests going through each interview to assess for categories of information, to “… uncover the codes that organize a text and examine the oppositions that structure its meaning” (Denzin, 2001, p. 77). Through line-by-line bracketing, one key word or phrase is used to describe key themes that stand out. Themes were then crossed-referenced across all interviews to see if any relationships emerged.

Data from the PDI were crossed-referenced with the responses obtained from the ACE Survey and the Social Support Circle interview. Major categories were created using

categories pre-existing within each measurement used. Additional themes were also considered and recorded as they emerged from the data.

Major categories of the PDI are as follows:

1. View of the Child …
2. View of the Relationship …
3. Affective Experiences of Parenting …
4. Parent's Family History …
5. Dependence / Independence …
6. Separation / Loss …
7. Looking Behind, Looking Ahead …

Major categories of the ACE Survey are as follows:

1. Psychological abuse …
2. Physical abuse …
3. Contact sexual abuse …
4. Exposure to household dysfunction during childhood …
5. Exposure to substance abuse or mental illness …
6. Violent treatment of mother or stepmother …
7. Criminal behavior in the household …

Major categories of the Social Support Circle interview are as follows:

1. Supports defined by family, friends, professionals, significant other, parent, etc. …
2. Level of support and what type of support …
3. How often support is provided …
4. How much support is reported …
5. Quality of emotional support …

The data were examined for elements that occurred within each experience, individually and collectively. If we understand "bracketing" as deconstructing the data, then "constructing meaning" involves putting the data back together. Constructing is listing, ordering, and stating any relationships that exist for the purposes of making meaning of shared experiences (Denzin, 2001).

Deconstruction and construction in data analysis involves looking at the history and reflecting on the data collected, using comparisons to identify concepts and experiences that share meaning. These findings are then coupled with all biographical information presented to the researcher by participants who have, as Denzin states, "… experienced the types of experiences the researcher seeks to understand" (2001, p. 71). In the same text, Denzin says, "Life experiences give greater substance and depth to the problem the researcher wishes to study. Conceptualization of the phenomenon being studied is contained in the self stories and personal experience stories of the subjects" (p. 71).

In addition to coding themes based on the interview responses, the researcher noted memos of affect, gestures, comments, and interactions taking place within the video-recorded interview. This allowed the author to begin the interpretive research, described by Denzin as follows: “Interpretive research enters the hermeneutic circle by placing the researcher and the subject in the center of the research process” (Denzin, 2001, p. 74).

Once the audio transcripts were printed for each participant, the researched examined notes taken during video viewings. The researcher listened to interviews and recorded themes that emerged from each told story. These themes became the researcher’s findings and discussion, as shown in the next section of this document. The researcher checked for all themes and patterns that emerged within this population of participants, to see if any connections existed between adverse experiences, social support, and parental reflective functioning.

The data were analyzed by “… examining how the problematic, turning point experiences were organized, perceived, constructed, and given meaning to, by the interacting individuals” (Denzin, 2001, p. 71). Denzin (2001) suggests deconstructing the data by openly connecting the concepts of the phenomenon, and then interpreting and identifying any previous definitions. This should be done by examining the underlying theoretical model of the sought-out, implied human action. Finally, the researcher should use any prior studies of the phenomenon to present preconceptions and biases that surround existing understanding. “The researcher seeks to uncover how the problematic act or event in question give meaning to the persons studied” (Denzin, 2001, p. 71).

Ethical Considerations

Risks.

Through exploring the effects of adverse childhood experiences and social support on the reflective functioning capacity of the young-adult African American mother, it was written and noted by the researcher that the interview questions asked of each participant may have evoked an unintentional effect on the participant's mood, memory, thought process, or emotion during and following the interview. It was taken into consideration that feelings about past, unresolved issues may arise, as well as feelings about parent-child relationships. Therapeutic resources and a debriefing period were provided to each participant following each interview session. All of this was done to mitigate the influence of "ghosts."

> In every nursery there are ghosts. They are the visitors from the unremembered past of the parent; the uninvited guests. They appear to do their mischief according to a historical or topical agenda, depending upon the vulnerabilities of the parental past (Fraiberg, 1975).

Each participant was informed that if she felt emotionally triggered by questions during or following the interview, those emotions should be addressed. If not managed properly, the emotions could result in increased anxiety. The researcher considered that memories of adversity during childhood, or recognition of a lack of support, might create overwhelming feelings. To reduce any potential harm to research participants, the researcher used observation and monitoring throughout the interview to account for visible reactions to each question.

If the researcher observed, or was informed of, discomfort at any time during the interview, the researcher mentioned the observation to the participant, and asked if the participant needed a moment, or simply asked the participant to let the researcher know what she needed. The researcher paused at any suspected emotional reaction that seemed less then desirable for the participant. The researcher was prepared and consciously thinking about the possibility of having to offer different options to the participant to address any perceived or known discomfort.

In these instances, the first option was to pause or stop. The next option was to keep going at the discretion of the participant, and take pauses as needed. Another option was to go to a different section of questions and come back to the section that created the distress. The researcher was prepared to explore the option of stopping the interview altogether, either fully terminating it or finishing at a later date and time, per participant discretion. The researcher was prepared to offer an option of being referred to a fellow clinician for a one-time, free 60-minute therapeutic consultation, whether the interview continued or not. The participant was instructed that she was free to choose from the list of therapists who agreed to see any participant identifying herself as part of this research study. The participant was also given the option of engaging with any of the other therapeutic resources referred to her by the researcher, keeping in mind that these resources had their own policies and procedures not established by the researcher. No participant needed to stop during the interview due to emotional distress.

Per the therapeutic-resource list given to each participant, the researcher explained that if the participant opted for one free session with a given therapist and then wanted to continue therapeutic services with that therapist, it would be at the participant's

discretion. Each participant was also given a list of free and low-cost community resources for psychotherapists who would be available for further processing of information that surfaced during the interview process. (See appendices for a list of free and sliding-scale-fee community resources specializing in mental-health services.) All participants took the list of resources and referrals following the completion of the interview. Participants were reminded both verbally and in writing that further psychotherapeutic sessions will be in accordance to the participant's health-insurance plan, or in accordance to the financial arrangements per each therapist or mental-health community agency.

Benefits.

The researcher acknowledged the possibility that participants would receive indirect benefits by participating in this study. The demographic questions, including the social-support questions, gave each participant an opportunity to tell her story, in her own voice and from her own point of view. This story could include events that happened to the participant while growing up, as well as current events. Additionally, the participants had the opportunity to talk about the future, and to reflect on feelings associated with being listened to by the researcher. These disclosures may be cathartic for participants. Each participant might also have recognized that she is informing researchers and professionals in the field to better understand what life is like for her and other young-adult mothers with similar experiences.

Identification of social supports provided another potential benefit. By having the participants name their social supports, and the different ways in which they can be useful, it raised awareness of exactly whom each mother could go to for support if needed.

Answering open-ended, thought-provoking questions allowed many participants to reflect on questions they had never been asked before. This showed each mother that she is of interest to others. This may have also created a parallel process: The participant experienced the researcher reflecting on the participant throughout the interview, just as the researcher wanted to assess reflective processes of each participant as she described her experiences within the parent-child relationship.

One potential benefit for social workers or other professionals is increased knowledge about the reflective capabilities of young-adult African American mothers and the mother-child relationship. With this knowledge, professionals working with this population can model and support reflective capacities and connections for young-adult clients who are mothers, and thereby support the mother-child relationship. Young-adult clients can also use their voices to inform professionals about personal experiences that different from existing notions of the young-adult African American mother.

Through the mother's told stories, coupled with the possibility of increased mother-child relational awareness, each participant was given the opportunity to learn about reflective capabilities. After completing all the interviews, the researcher recognized the interviews as interventions, creating reflection in the moment. Being introduced to the meaning of Reflective Functioning might have created a "knowing" that reflection is a

vital part of parenting. Throughout the interviewing process, the researcher hoped for and discovered an increased capacity to purposefully demonstrate reflection within the parent-child relationship.

Privacy / Confidentiality

Informed consent.

All participants received, read, and signed the informed-consent document, which stated the following:

1. Purpose of the research study …
2. Procedures, costs, and benefits to the participant and the researcher …
3. Risks and potential harm …
4. Privacy and confidentiality information …

The form also included instruction on how to withdraw from the study without consequences, at any time, with no questions asked. Each participant received the researcher's contact information via a copy of the signed consent form. The researcher used the consent form approved by the Institutional Review Board approval process. To assure privacy, the participant was asked to answer the research questions in the privacy of her home or in the privacy of the researcher's business office. The researcher explained the private nature of the interview questions, and that participant responses were viewed by the researcher as private and confidential. The participant was asked, for

privacy purposes, if she could set up a time to interview when others would not be at home. If this was not possible, the participant was asked if she could find a quiet, safe room within the home to talk for the entire duration of the interview process.

Each participant received an identification number, which was used in place of the participant's name on all interview documents collected during the study. All documentation was labeled with the participant's number and kept in an individual folder. A list of participant names was kept in a separate and locked file cabinet. The list of names was only used as needed by the researcher, to identify documents for accuracy and order. The researcher further assured confidentiality by dedicating a locked file-cabinet drawer to materials associated with the study. Only the researcher has access to the locked file cabinet, which is in a locked office.

Interviews were transcribed as soon each interview ended. Recordings were destroyed after the researcher confirmed that all transcriptions were accurate. When this study concludes, all data will be destroyed via paper-shredding (for written documents), and deletion (for all electronic documents). All remaining information pertaining to the study will be kept in a locked file for an amount of time specified by the Institute of Clinical Social Work Institutional review board. If for any reason, participants ask about results of the research study, the researcher will arrange for information to be given to the participant following completion of the study.

Issues of trustworthiness.

The researcher assumed each participant would answer questions honestly. Credibility was established through the trustworthiness of participant answers. Each participant discussed potentially challenging information about themselves, their children, and their families. All questions were fully answered, and elaborated on, as much as each participant felt comfortable. When the participant was not reflective or if the participant did not feel comfortable answering certain questions, she was not challenged to do so. Instead, the researcher attempted to ask the questions another way, or moved on to the next question and category.

In the data-collection process, participant answers have been used to ultimately determine and write the research findings. It was determined and assumed that each participant answered all questions to the best of her ability and to her own satisfaction. Through this qualitative, narrative approach, only the participant can determine the credibility of the story she told about herself for the purposes of this study.

Chapter IV

Results

Introduction

This section includes in-depth description of the narrative stories told by the study participants, who were young-adult African-American mothers with children between the ages of one to five.

The researcher had a specific interest in the following: (a) the participants' childhood experiences and whether they experienced adversities, (b) if participants had social support while parenting, and (c) how parents thought about their relationships with their child(ren). The interviews looked to capture the mothers' reflective thoughts through their own words. In general, most of the women interviewed did not describe their early experiences as "bad." Rather, most characterized their difficulties as normal life challenges.

All participants were interviewed using an interview tool that created especially for the purposes of this study. The interview tool included questions taken from the Adverse Childhood Experience Survey, the Parent Development Inventory, and the Social Support Interview Protocol.

Description of Study Participants

The participants in this study were 11 young women from urban and suburban Minnesota. They ranged in age from 21 to 25, and identified themselves in pre-screening process as African American mothers with children between the ages of one to five. To recruit participants, the researcher circulated study announcements. Although participants described receiving and seeing an announcement, each participant pointed out that she did not attempt to contact the researcher until a member of the community or another source vouched for the researcher. All participants described wanting to help, but also needing to know that it was safe to share with the researcher. This created a sense of connection immediately upon each interview.

All participants were raised by at least one of their biological parents, mostly a mother, during the first year of life. Of the 11 participants, three reported being raised by both a biological mother and father. One participant described being raised by her maternal grandmother after her primary caregiver was incarcerated. Another participant was raised by her mother. However, she reported that during either kindergarten or first grade, when she was taken away from her mother temporarily due to reports of physical abuse.

Of the 11 participants, one identified as being married. The rest identified as single and in domestic partnerships. All participants interviewed for this study indicated that their children have been with them for their entire first year of care, and at the time of this study. All children were enrolled in programming during the day, such as childcare, preschool, or therapeutic day treatment. Nine participants reported being employed. Six

of these nine were also enrolled in college. Only one reported not working or being in school. All but two participants described themselves as head of their household.

Table 1. Participant Demographics

Study Participants by Number	1	2	3	4	5	6	7	8	9	10	11
Single or Married	s	s	m	s	s	s	S	s	s	s	s
# Children	2	1	2	2	2	1	2	1	2	1	2
Child in Mother's Care	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Child In Early Education Program	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Employed	no	yes	yes	no	yes	yes	yes	yes	yes	yes	yes
Student	yes	yes	no	no	yes	yes	no	yes	no	yes	yes
Living on Own/No adults	yes	yes	yes	no	yes	no	yes	yes	yes	yes	yes
Both Parents in the Home [BP] or Mother Only [MO]	bp	mo	mo	mo	mo	mo	mo	bp	mo	bp	Mo
Participant Ever Removed From Parents As A Child	no	no	no	no	yes	no	yes	no	no	no	no
Child Ever Removed from Participant/Mother	no	no	no	no	no	no	no	no	no	no	no

Summary of Research Findings

This study was designed to look at three concepts related to young-adult African American mothers: (a) Adverse Childhood Experiences, (b) social supports, and (c) reflective-functioning capacities. Each of these concepts is divided into sub-themes to illuminate the lives of these participants directly from their narratives. This study also addresses how these social and psychological experiences have influenced the ways that

participants parent their children. The interview questions were designed to help participants explore these concepts and explain them in their own words. The following sections of this dissertation offer a glimpse into the worlds of these participants, highlighting (a) their early-childhood experiences, (b) their current sense of their social-support systems while raising children, and (c) their perceptions of their relationships with their children.

Adverse childhood experiences.

This section highlights what participants described as childhood abuse, neglect, and distress in their family systems. Six of the 11 participants talked explicitly about having difficult childhoods. Only one participant initially reported multiple difficulties during childhood. While two participants said they did not have difficult childhoods, once stories were shared, some difficult moments were revealed. In contrast, two other participants discussed having a good childhood, with difficulties that they saw as everyday challenges. Of those participants whose narratives revealed early-childhood adversities, three went into great detail, describing different moments. But again, they described these challenges as normal parts of childhood.

Sexual abuse was the only adverse concept that participants identified as "something bad happening," while otherwise reporting "not having a bad childhood." Two of the participants who described having a difficult childhood gave short, quick, dismissive responses when answering questions surrounding their early relationships and challenging experiences. The remaining participant who directly discussed having a very

difficult childhood went into greater detail with some questions, and less detail with others. Her responses were consistent with the questions. Of the two participants that described having a "good childhood," each of them talked about relationships and experiences of childhood in detail and at great length.

All participants in this study were forthcoming with information. They seemed comfortable and thoroughly engaged throughout the interviews. There were no times when it felt like participants were holding back information. The researcher felt privileged to have these experiences with all 11 participants. The emotional tone of the narratives, with one exception, was expressive, thoughtful, genuine, and appreciative—much like a common conversation. One participant described being choked up while answering the questions, but she waited until after the interview to mention the emotional shift.

Another participant spoke with a slight stammer as she talked about the most difficult moments of her childhood, which were instances of sexual abuse. This same participant described "not wanting to be like her own mother" after recalling the pained and difficult history of her childhood. This participant's interview was rich, lengthy, and descriptive. She spoke about things that the researcher registered as adversities, but which the participant spoke about as normal events. Only one participant did not show any emotion at all during the interview. Her affect and tone were flat, and she answered quickly with blunt responses. Her interview was the shortest in length. The researcher did not get the sense of any participant purposefully downplaying their life experiences. The researcher had the impression that participants did not consider their adversities as bad. Rather, participants seemed to truly see these adversities as the norm.

Abuse / neglect.

About half of the study participants shared stories of abusive and neglectful childhoods. They openly talked about instances of physical, sexual, verbal, and emotional abuse, as well as fears, disappointments, betrayal, and basic needs not being met. The participants who reported abusive and neglectful childhoods talked at length and in detail about the adversities that occurred in their lives. They described verbal, emotional, and physical adversities as if they were normal in the home. In addition to reports of physical and emotional abuse by their caregivers, 3 of the 11 participants disclosed incidents of sexual abuse with the following admissions:

1. "Yes, I was raped."
2. "I was sexually molested."
3. "I was touched and made to touch her. I was really young."

When these three participants described sexual abuse, they all expressed anger. Each of them also expressed that they were only talking about it now because of the question had been asked. Each participant described in detail, and in confidence, the incidents that happened. Each participant said she felt like she could trust the researcher with the information. The researcher felt more guarded about the information than the sharing participants seemed to be. One participant voiced how angry she was that her mother did not do anything about the sexual abuse suffered by the hands of a neighbor, once she told her mother what happened. Another participant reported feeling isolated and overwhelmed when a friend of her brother raped her and she could not tell anyone. Another participant discussed her experience of being sexually assaulted and became emotional. She directly expressed her feelings, which were also evident in her saddened

tone and stammer. She seemed nervous while telling her story, as if it were the first time talking about the abuse, and how she has been affected by it. She then expressed her disgust, anger, and judgment of the family member who performed the sexual acts. She said, “I know it’s wrong. I didn’t know what to do, I feel some kind of way now. I feel like it made me become sexual too soon in life.” The researcher felt both protective and sad while listening.

When asked about their relationships with their caregivers, the study participants described the following physical and emotional treatment:

- I got whoopings. I was fearful of my parents, yes.
- I got whooped with a hanger, a shoe, whatever was around. I felt hurt when mom would say mean things. I even made up a song about my feelings being hurt. I use to always tell her, “Nothing hurts like your mouth, Mom. What you say hurts me.” She would say, “Girl, shut up.”
- Sometimes they were hurtful. Mom was crazy towards me. She was mean. I never took offense to what they told me. It didn’t faze me.
- Mom could be very strongly discouraging, from my point of view. My grandmother was the softer one. My mom was the tougher one. So, I looked at it like a mom-dad situation. Dads are usually strict. So, I looked at my mom as more hardcore, cutthroat. It was kind of tough with her, but I never felt unsafe.
- She would come home from work, and we would get her problems. My mom did not spend any time with us. She didn’t feel like dealing with kids.

- Me and Mom never got along. We have different ways of thinking. She is more street-smart, I am more book-smart. She kept me occupied, like in sports, and activities. She showed up. I learned to never really ask my mom for help. When I was younger, I asked for help reading. She couldn't help me read. She thought I should just get it. I wished she would have worked on it with me much more when I was younger, so I could excel instead of thinking I should just get it. I got myself up for school. I made my own eggs in the morning. Mom had to work, so I was independent. I was an only child. I guess she was just trying to manage.

- My mom swore at me and called me "stupid" may times. I thought it was normal to be called "stupid" and "dumb." Mom was going through her own stuff. She would get verbally abusive sometimes. She used to whoop us, sometimes hit us with hangers and shoes, because she was going through her own little stuff, raising all of us kids by herself.

- My mom ranked my siblings and I in front of one another and in front of company. It was about who had the best body, or hair. I felt rejected when she did this and allowed her friends to do it too.

- My mom left me, and I guess you can say my dad did, too.

- Everybody cussed. I thought this was normal. You get cussed out, yelled at. What's the big deal? It was just a normal part of life. And, to be honest, when it did happen, I deserved it. I definitely did. I wasn't listening. I wasn't doing something that I was told to do, or I was acting in an inappropriate manner every

time I got cussed out. I didn't have any negative feelings about it. It was just an everyday part of life. It's what Momma does.

- "You are a child. Stay in a child's place," was what I was often told.

Neglect was also prominent for the participants in this study, as they described:

- I was neglected, lied to, disregarded by my birth father. I don't talk to him at all. I know who he is. I just figured he doesn't want to be in my life, so we just keep it at that. We tried for a while to build something because I have a sister. We would be in the same room … the conversation just didn't ever work between us.

- We never had enough to eat. I used to go hungry all the time. I was so hungry, I ate jelly, the only thing I found in the cabinet. I took a spoon and I ate the jelly (chuckling).

- We were homeless a lot. Mom never gave her kids away when things got hard. I have never thought about doing that, either. I don't want to do the same things Mom did. I want to be a better parent and be there for my two kids.

Distressed family systems.

Participants were asked to talk about problems in the household and among family members. Nine of the 11 participants described various kinds of household dysfunction that caused significant family distress. Household distress included:

1. Mental illness …

2. Substance abuse …

3. Domestic violence …

4. Incarceration / absenteeism from the home …

5. Lack of felt love or feelings of specialness …

Physical / mental illness and substance use had a profound effect on family life:

- My dad struggles with mental illness. He has been diagnosed with schizophrenia. It was rough until he told us about it. I know he had a very traumatic childhood and (it) affected his mental health. He would be noticeably different and noticeably cold. He is not medicated. It was difficult because there are points where he would just be, like, very closed off. (During this part of the narrative, the participant picked up her daughter, sat her in her lap, held her close, and continued with the narrative). When they told us about it, allowed us to ask questions, and do research, it made more sense.

- My mom had a mental break. It was kind of stressful at times. I think that is probably why we argue more now. That was when we went homeless and then she was in the hospital. So, it was pretty much like me taking care of my brothers.

- I felt alone a lot because my mom was always in the hospital. My dad was there with her. My older siblings started dating and not being around, either. I didn't have anybody to talk to.

- I felt overwhelmed, taking care of myself and Mom too, with her emotional problems. My mom also has high blood pressure and cancer. I went through depression and anxiety.

- My grandmother was addicted to crack cocaine. My mom has some alcoholism. Everybody in my family smokes marijuana. People in my family used (substances) to take care of their problems. I felt like it was a part of life, until I experienced other people in the world outside of my family. I thought everybody got drunk or smoked weed.

- I honestly think my dad suffered from mental illness but he will not admit it. He also had problems with drugs. He did not do them around me, but I just know when he was on them. Then grandma is an alcoholic. That didn't really affect me. I just grew up around it. I was used to it, but it never harmed the children in the family. My grandmother was addicted to crack cocaine for years. So was my grandfather. I hated when they got drunk and abusive. When my uncle got drunk, he got meaner. He'll whoop you faster and longer. Or sometimes my mom got drunk. She'd do name-calling and make you feel real low. That's the only thing I hate, when they're drinking, the side effects of what happens. But I thought it was normal. It still made me feel bad. (Participant was biting her lip during this story.)

- Both of my parents were addicted to drugs. Now they are both clean, which is good. When I was young, a baby, my mom and dad were together. My dad, I guess, got together with my mom's friend. My mom wasn't with him anymore. I was the only child. She then got into trouble with the law. She was incarcerated. I went to live with my grandma and I barely talked to my dad. I think my dad was on a whole bunch of drugs. I think he's an alcoholic, too. I found out he has cancer now. My mom's current husband helps her stay sober, and that makes me happy.

Some study participants witnessed violence in the home, and had caregivers who were incarcerated or absent, as described:

- I've seen my mother's boyfriends' and my grandmother's boyfriends' hit them. It made me scared and angry. Now I have just experienced an abusive relationship and I don't like it.

- I watched my mom deal with a lot of physical abuse by men. I've seen at least three of her boyfriends hit her. One of them busted her head with a gun, locked us in a room while she was bleeding, and she was pregnant with my sister.

- I remember times watching my mom and stepdad fight. He would get drunk and go gambling. I think he was in an AA group. That was the only way my mom would stay with him, the group, and if he would stop drinking. I remember them getting into an altercation and him asking my mom where she put a ring or something. He was getting aggressive. He was on top of her and my mom was like, "Call the police." He said, "You better not call them because nothing is wrong with her."

  I didn't know what to do. I just sat on the floor with my legs crisscrossed-applesauce (chuckling), just staring at them. Then I went to get the phone and I sat there thinking, "Should I call the police or not?" At that time, I was really confused because this has never happened to our family and I didn't know what the hell was going on. I was asleep. My mom called me out of my sleep to come and look at what was happening and for me to call the police. They were loud and yelling and wrestling and all types of stuff. We eventually moved out.

- Yes, my family experienced incarceration and abused alcohol.

- The guy I thought was my father was incarcerated. I don't know my real dad. My mom lied to me all of these years. I got kind of close to him. I talked to him through the prison phone. He was in prison most of my life. Then we had a DNA test when I was 18 (and I found out) he wasn't my dad. But I thought he was my father all this time. So, I was mad growing up thinking, "Dang, why is my father in prison?" But now that I know he's not my father, I don't know who my father is. I just feel angry. I just feel empty because I feel like I don't know the two people who made me. I don't know the second person who put me on Earth. I used to always get jealous when other people talked about their dads and what their dads did.

- I feel like not knowing my dad hindered me as a child. I was very, very, emotional about the situation. I've gotten over it, because I feel like there are things that are out of your hands that you just can't control. So, you can't punish yourself for not knowing the answers, when there just things you just don't know or don't need to know.

Participants described feeling no sense of love, support, or connection within their family. Also, there was often competition for what little love was available.

- It was like a mixture of feelings: who had the better hair, the better body, the better this or that. She would do this in front of her friends and allow them to instigate it. My mom told me a lot about sex and her sex life, like we were friends. That kind of made me feel rejected. I felt like we grew up together. I felt like I

was too young to know the stuff she shared. It kind of made me grow up fast. I don't want to sound like I'm complaining.

- Finding out my dad isn't really my dad, that hurt me. The man that raised me wasn't my real dad. I felt betrayed. I found out at 12. They should have told me. I felt anxiety and depression when I found out my dad was not my real dad.

- I did not feel valued or loved. Now as a parent and adult, I'm kind of understanding why I probably felt that way, and why my mom and dad acted the way they did. But now I definitely feel loved and (prioritize my) family first over everything.

- My mom kept my younger siblings, but left me with my grandmother. My mom went away because she got into trouble with the law and I was raised by my grandma. Around 10, my mom started to come back around. I chose to remain with my grandma, where I know I was supported, valued, and loved. Me and my mom finally have a good relationship. As a kid, I never liked going back around my mom. I felt resentment towards her. She had more kids and took care of them kids. Now she is real protective over my boys. I am still getting used to that.

- I was at school and they started teaching us (that) to have a family, you have to have mom and dad and a kid. And so, I went home and I told my mom, "Yeah, Mom. We don't have a family." And she's like, "Yes, we do. How come we don't have a family?" I said, "Because we don't have a dad here in our household." She like, "Just because your dad doesn't live here, doesn't make us not a family. We're still a family. I still have me and you."

I really couldn't grasp the concept because that's what America or what society makes a family: a mom, a dad, a kid. When I went to school and talked about it with my classmates, they were like, "Well, how does that work? You don't have a daddy." I said, "I do have a daddy. He just doesn't stay with me, but he's still there." I really didn't care. I can't recall me ever having some thoughts like, "Oh! My dad's not here." It really didn't bother me because like, I said, I'd always see my dad and we were always traveling to Chicago. So, it really wasn't a big issue with me.

- I was treated like a stepchild. Before my sister came, my stepdad, we were close. When she came, we slowly drifted apart and that's when I was treated like a stepchild. My family isn't supportive. My grandmother is. Both of my grandmothers are.

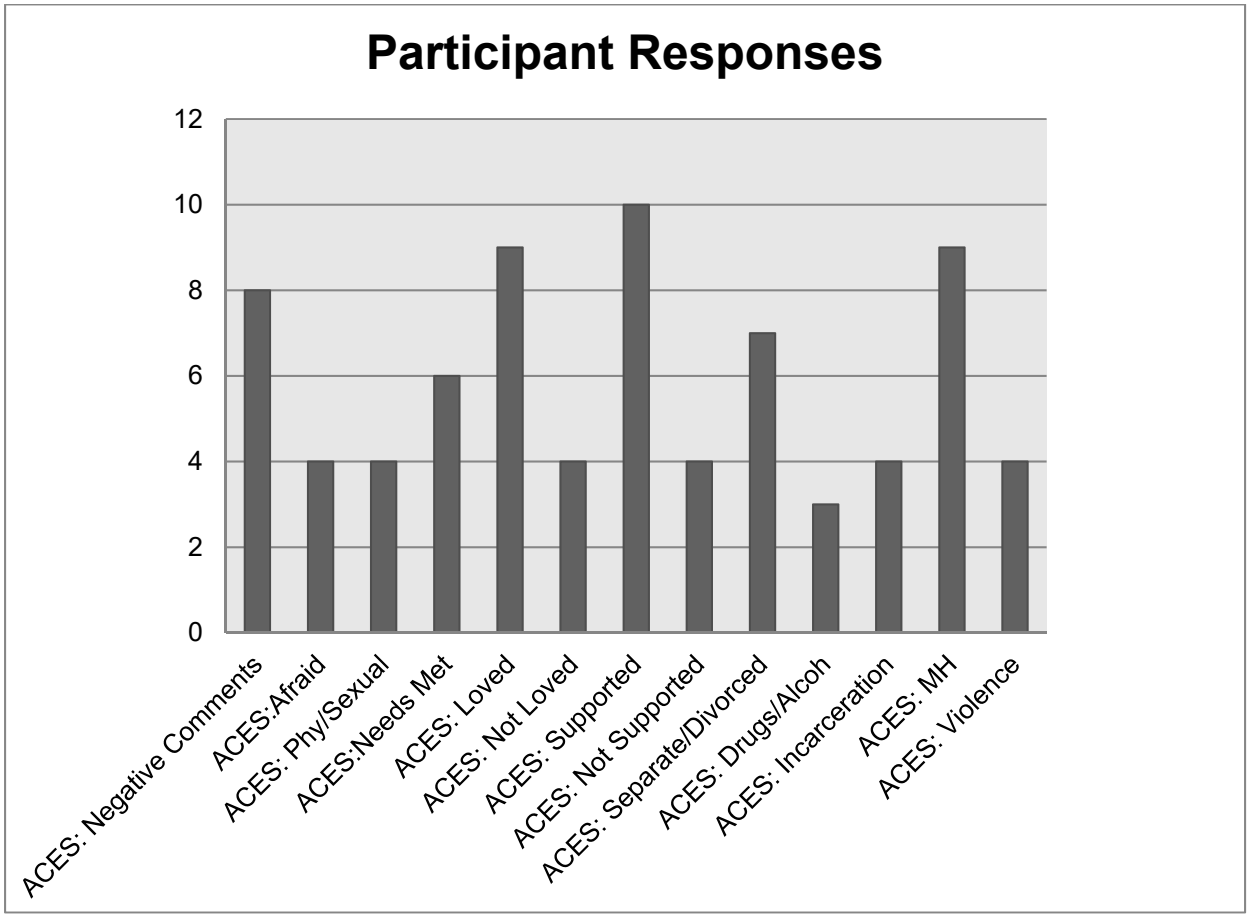
- Me and my mom and sisters were homeless a lot. My mom would ask some family members, "Can my kids at least sleep on the floor?" We had nowhere to go. They would tell her, "No." So, not too supportive. We used to have to sleep in my mom's boyfriend's car or, if his family would open the door for us, we would sleep on their cold basement floor. A lot of family kind of turned their back on us when we was homeless.

Summary.

The researcher asked participants to talk about the relationships they had with parents and other adults in the home and to discuss how they were treated during their childhoods. Participants used this time to describe memories that stood out to them. A

few participants initially stated that they could not remember their childhood. After a few minutes of thinking, all it took was one memory to spark the narrative. One memory seemed to trigger additional memories. Interestingly, every adversity shared was not characterized as a negative. The participants who reported adversities did not believe those adversities constituted negative experiences. Some of the participants said things like, “It is what it is. That is everyday life. It was normal to get cussed and yelled at.” One participant stated, “There is no need to dwell on what cannot be changed. We have to just keep moving in life.”

Table 2. Participant Responses to Adverse Childhood Experience (ACE)



In conclusion, the participants in this study had a range of adverse childhood experiences, including abuse / neglect, exposure to substance use, and violence. The most commonly reported childhood problems were:

1. Having parents with mental-health problems …
2. Coming from divorced families …
3. Exposure to negative comments …
4. Not having one's needs met …

Table 2 shows that many of the participants felt supported and loved, while they also discussed multiple adverse childhood experiences. Some of them still felt loved and supported despite the adversities. Perhaps this resulted from a psychological need to feel valued and worthy, which might explain why many felt their negative experiences were normal. To think of oneself as not loved or supported is devastating. To survive psychologically, the participants needed to hold on to some sense that they were loved, valued, and worthy. Many participants reported adverse childhood experiences as both normal and negative, or abnormal.

Social support.

This section highlights what participants described as current social support. Participants were able to name at least five people in their support network on whom they can call as needed. The types of social support and quality of supports were also discussed.

All 11 mothers talked about having access to a network of individuals they can call on for support. Each participant was forthcoming with this information and appeared happy to name the individuals. No one struggled coming up with names of at least five individuals who provide support. Only one of the 11 mothers reported not having the support of her family or close friends. Instead, she was able to name reliable professionals. This participant described "… not having family or friends that live in this state." Another participant named at least five people she could call on for support. However, she adamantly described not liking to ask for support. Therefore, she admits not utilizing her support network unless it is "… absolutely necessary or an emergency." With these participants, social support may be experienced differently based on its perceived usefulness. Social support is a notion that young adults in general tend to regard as either a positive or negative. One may feel that as they grow and mature, they also grow out of the need to "have to ask for help or support."

All participants went into detail describing whom they could call on for support, why they might call on them, and how those individuals provide support. The participants seemed comfortable and thoroughly engaged throughout the interview session. They answered all questions thoughtfully, confidently, and in a matter-of-fact way. The emotional tone during this portion of the interview was confident and positive, which led to recall that was more descriptive and quick, yet thoughtful.

Social-support systems.

Ten of the 11 participants discussed having family and / or close friends to utilize for support. Family members were the social supports talked about the most. The second

most-named social supports were close friends. Professionals were the least to be named. Social supports included:

1. Sisters …
2. Mothers …
3. Fathers …
4. Grandmothers …
5. Male and female friends …
6. Father of the child …
7. Aunts …
8. Best friends …
9. Caretakers / family friends …
10. Neighbors …
11. Uncles …
12. Stepfathers …
13. Boyfriends …
14. Godparents …
15. Grandfathers …
16. Student-parent advisor …

17. A Christian groups for young adults …

18. A public-health nurse …

When asked, "Who are the people in your support network," participants responded as follows:

- She is the student-parent program coordinator at my college. I will go to her with all of my immediate problems. She has helped me out greatly. She gives me awesome advice even though she is a white lady who ain't never been through … you know, she has one baby's father and is married. She has never been through anything I've been through, but she still gives me advice. She has helped me out financially within the program. She helped me to get money to pay someone to watch my kids for a semester so I could attend classes. She helps me with a lot of resources.

- She helps me with resources and great advice. She has helped shape my college major and helped me land an internship with her agency.

- My mom will help if I need a babysitter at times, but she does not live here. I can also vent to my mom over the phone if I call her. I will ask my aunt who does live here if I need a babysitter immediately. I try not to bug people for a sitter. I'll only do it if it's an emergency. My grandmother helps out financially when I ask, but I rarely ask.

- My mother, my sister, my dad—those are the people I go to if I actually go to (anyone) when I have problems, (also) one of my friends. My mom is a lot of

support. Whenever I need support, she provides it. She is the first person I go to. My second go-to is my sister. She helps out with my daughter and if I need advice, I sometimes go to her. I'll go to my mom first.

- My friend is always there to let me vent. I am there for her as well. I'm a protective mother. I don't like having my daughter around a bunch of different type of people. I'll go to those people I named in my network first. I usually don't like to ask my friends for help with my daughter or anything. I usually don't ever really need any help. Can I say I never ask for help? Cause I'm like a strong-willed person and I'm not asking this person or that person for help.

- My mom, my dad, my grandmother, my granddad when he was alive, my sister, and my godparents—they are also my cousins. My whole family is supportive. I really don't have too many friends. If I do, they are like friends I've had since I was a kid. So just family and close friends. Everyone around me, they're really supportive—oh and my boyfriend. He is supportive. I used to get counseling, but (the counselor) moved to a different company out of state. I didn't want anybody else. When I had her, she was my main go-to person. She was very, very supportive.

- I literally call on my best friend for everything. The only thing that I haven't leaned on her for, thank god, is financially. I have maybe once or twice, and she's always been there. But as far as my mental state, just the reality check, emotional check—she is my rock. (sadness in her voice) You know, before she left, instead of resigning a lease, they stayed here with me. It's so crazy because she is 10

years older than me, and our babies are seven months apart. She was here with her newborn. It was awesome, and then she had to leave. It was sad. Every day we talk on Facebook and video chat, so the kids can see each other and stuff.

- My stepdad and my boyfriend are my biggest supporters. My boyfriend is like 70% help. He always wants to weigh, outweigh the options. For my stepdad, he helps verbally and financially. If I get into a hard spot or if I can't pay something, he'll do it for me, without even telling my mom (chuckling). If she finds out, she will try to get on me, like, "You're not going to keep getting help from Dad because he tried to yell at me for trying to yell at you (chuckling)." I know my mom got her own problems. I've been trying to stop asking my mom for so much help now. She still got little kids too.

- My friend was living all the way in the South for school. She would randomly send me stuff for my son. My other friend I am able to vent to, emotionally, about stuff. Then if I do need something for (my son), she helps. If I need a sitter, she's able to help out with that too.

- I know that's a struggle for a lot of people, to ask for help, but I am not one of those people. I don't mind asking for help. I don't put my pride in front of that. If you need help, you need help. And if you are willing to help me not struggle, then why not accept it?

- There are people I would want to help more than what they are doing now. I don't hold people to certain positions, because some people may not want to talk about it or what they're going through.

- I have people that are very supportive. If I'm emotional I call (my friend) at any time and talk to her. I can call if I have problems and people will listen to me. I wish I had more help with raising my kids. I live by myself. Their dads are not around. Their dad doesn't help me do anything. I do it all by myself off the little money I get from the state. I don't have no help with them. My mom barely watches them for me. Their dad doesn't watch them at all.

- My grandmas, both of them. No matter what situation I am in, they are always supportive. My dad's mom, even if we're on bad terms, it doesn't matter. If I had just had an argument, I'll call her a few minutes later telling her what's going on, "I need something," and she's very supportive.

- My grandma is my baby daddy (laughing). She provides childcare. She buys clothes. When needed financially, helps us. She is overall supportive.

- My sisters and my brother are helpful. My mom and dad too, they are most important. Even when I have an attitude or I'm feeling emotional, they still understand me and will be there no matter what. I have group on Wednesdays. They are really helpful because they are like having another set of parents and sisterhood. They don't judge me. It helps me with being the best me. They have more love and support then anything. I also call on my church family too.

The participants in the study discussed having a wide range of support which includes family, friends, and professionals. Overall, some participants feel comfortable reaching out to their support network when needed. However, it was apparent that they try not to depend on them too much. The mothers described having a sense of confidence when

they can take care of things themselves, whenever possible, adding how much they also appreciate having support available to them as needed.

Type and quality of support.

Participants were asked to talk about the type of support received from the individuals named as their social-support network. The researcher also asked about the quality of the support received. The type of support participants reported receiving were:

1. Emotional support …
2. Financial support …
3. Help with childcare …
4. "Me time" …
5. Resources …
6. An outlet to vent …
7. Seeking advice …
8. Time to sleep …
9. Information sharing …

All 11 participants voiced appreciation for having others to call on in times of need. Participants enjoyed what people could do for them. They also understood when people were not able to provide support in the desired way. All participants shared that they

wished their children's fathers would help more. Additionally, all 11 mothers wished they had more financial resources and money to help with day-to-day living expenses and activities for their children. All mothers reported needing additional support in areas including the following:

1. Vacations …
2. Rest time away from children …
3. Advice on parenting …
4. Better housing …
5. Educational activities for the children …
6. More social opportunities with peers …

Each participant expressed appreciation and gratitude when talking about social supports. One participant summed it up as, "I know they don't have to do anything for me or my children."

Means and quality of support.

On these two topics, participants responded as follows:

- One of my sisters provides 100% support. Another sister provides 70% support. My mom, I would say 100% as well. My dad I would say 98%. He is a pastor. He

moves around a lot. He talks to me as much as possible, but sometimes, my mom steps in for the additional 2% he doesn't provide.

- My Wednesday group sends a text whenever I don't come to group. I missed last Wednesday because of my depressive mood. I know they are there. They tell me they are praying for me when I am not there.

- My mom supports me and my kids like three times per week. I try to get her to go to the park with me and the kids. Being around her makes me happy. She is my fighter. I know she enjoys being around the grandkids, too. My dad is my spiritual, empowering person. No matter what I am going through, he sees right through me, and my tears. He tells me I should be celebrating more instead of crying.

- I receive powerful advice from my loved ones all the time. Some of it can be upsetting to hear but worth hearing. I feel encouraged afterwards.

- I would love for her daddy to be there for her in a supportive way. I feel loved and I want my daughter to feel loved. My boyfriend is around every day. He helps out and it's not his child. Sometimes he's the one that gets up and takes her to my grandma's house if I cannot.

- I could use more educational opportunities for my daughter. She is usually with my grandma or mom during the day. She will be starting school soon. I know she is not in a daycare center and they are helping me out, but I think it would be good if they could do more educational activities with my daughter.

- I like to receive information and resources. For instance, when I talk to my supervisor, he tells me about a whole bunch of programs I can qualify for to get my education for free. He says, “Why not use it if you qualify? Pretty soon those programs are going to change.” I think to myself, “I want to figure out these resources now, so I can get all these free resources and get all these things while I can.” I can save money that way, too. So, I need to learn more about these resources.

- I want someone to tell me to be strong and keep my head up so I don’t let things affect me.

- I like resources and community support. I just learned about a car-ownership program. My mom gives me information. I like to get resources on how to get loans, how to build my credit. I need somebody to watch my kids while I’m working and in school. Basically, when I need a place to study or something or a getaway place ...

- I get most of my information and advice from my best friend. She is 10 years older than me and she has a small child. She has raised two older children. So, a lot of my advice comes from her, like mommy stuff and like woman stuff.

- I like when my family tells me I can do it. (They say,)“Just keep going.” My family and friends are very opinionated. Sometime when I go to them, they tell me good things but sometimes it’s just the way it comes out, it offends me and makes me not want to talk to them. So, it’s two different kinds of advice that I get from them. Sometimes I learn from it and it is helpful, but the opinions sometimes

makes me not even want to go to them. My family is very outspoken and open-minded and I like that part. I want them to just say things in a respectful manner.

Desires for less support.

Support that participants said they could use less of fit under the following categories:

1. People telling us what to do …
2. Giving advice when advice was not asked for …
3. Resources others think we need …
4. People saying, "Stay strong" …
5. Overprotective parents …

- My mom can be supportive, but she picks and chooses when she wants to. I have a few aunts that can be. They also pick and choose when they want to help. So, it's always negative. It's like you have to go through a whole seminar and a whole bunch of stuff before they will even help you. Some other times, they are willing to help. I do what I need to do.
- I do not get help with day-care. I have day-care during the day but with my job, I am not making enough money. I still need to move. I can't make money and save money without getting another job. But I have no one to help keep my kids so I can get another job even for a month or two. If I had someone who could help

keep my kids so I can get another job, money would never be an issue. Money is not an issue now, but I can't save money. That's the issue.

- I feel like I could use more emotional support from my birth dad in every way. I feel like when I had my kids, he's been there for my son, and then went to jail. I feel like you owe my kids your time as a grandpa.

- I want help with school, relaxing, a break from my kids (chuckling). Me time, vacation, somebody to watch my kids for about three days. I'd just go on vacation somewhere to kind of just relieve myself. Sometimes I go to my mom's house, but I don't want to be at my mom's house all the time. I just want to come home and have somebody to cook something and it would be ready for my kids because that takes a lot of time. Like today, I am off, and so that is the only reason I was cooking something today. Otherwise it would be something out of the freezer, some processed food I can throw in the microwave and call it a day. But, I don't want to feed my children that, but because my time is limited, and I have no energy, I don't have the time.

- I'm tired of hearing everyone telling me that my kids come first. I know my kids come first. I know I have to make sacrifices, and I have. If it comes to something dealing with my health, I have to come first, before my kids. If I don't get my body together, I can't help my kids. I don't think a lot of people understand that. When you try to juggle school, work, kids, it's just too much and you need a break. When you cannot have a break then it will break you.

- I cut a lot of people off because they aren't able to support me. Like his dad, he doesn't help. Sometimes it takes two people to help (my son) settle down. He is kind of wild. I sometimes need help or he will get into every little thing. He needs multiple eyes on him at all times.

- I would love some parenting advice. I don't get that often. Things like how to get him to go to sleep, how to deal with his temper tantrums. He's a little stinker. He has temper fits. For a while I have had trouble with him not eating. He likes to throw food.

- I like the support my boyfriend provides. He provides support every day. I don't really see my mom and them every day. So, now that I'm in my own place, it's not that I try to keep to myself. I just really don't see them a lot. The women in my family are kind of wild. I need space sometimes, as I can't hear my own thoughts and I feel like everybody is trying to dictate my life. They are the type of women that they been through so much in life that their failures become lessons they want to give me before I have my own failures. I tell them I have to live my own life. I have to bump my head a couple times. That's just life. You got to let me do that, or else I'll never know.

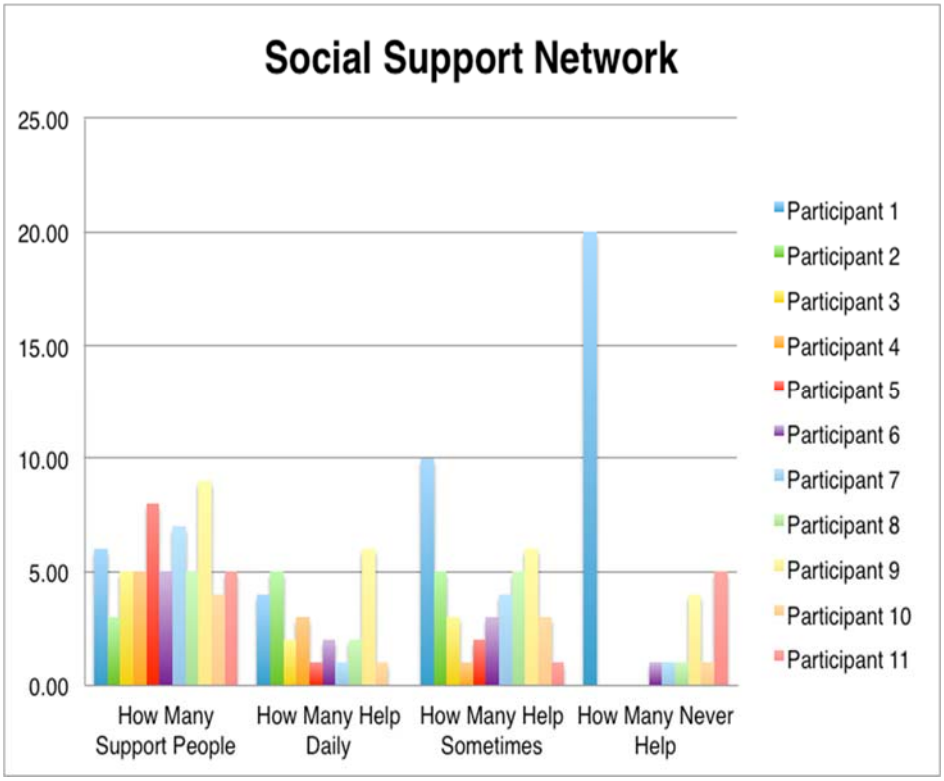
- I want my daughter's dad to ask about her and ask how her weekend went, just more consistency with the time he shares or spends with her. I don't want him to be content with where you're at. I don't need him to help me, just our daughter. My family does these things he is supposed to do more of.

Summary.

The researcher asked participants to talk about the relationships they have with individuals who provide support. Participants discussed each individual named in their social-support network. They described the type of support provided, while simultaneously talking about the perceived quality of the support. Participants seemed secure when asked to think about the people in their networks. All 11 mothers easily rattled off the top five individuals who came to mind. At least two participants named more than five social supports. No participants struggled to name at least five individuals. Only three participants stated that they had support every day in terms of caring for their children. When participants said an individual supported them 100% of the time, it means as needed, as requested.

All participants seemed confident and self-assured that their social supports have been available as needed. A few participants stated that the support was good, but that is has at times been unsolicited and emotionally negative. One mother expressed a common feeling when saying she was "… always grateful, and appreciative, of any help or support received." One participant was able to name her support network, and the type and quality of support provided. However, she repeatedly stated that she does not like to "… ask people for help, but I have support if and when I need it. So, yes, I know how to access my people if and when I need to." Participants in this study have shown that they have social support and that they know how to name it, and access it, as needed.

Table 3: Participant Responses to Social Support Questionnaire



In conclusion, the mothers in this study had support and knew how to access it. Participants stated that not all support is solicited. They determine whom they ask for help, and decide what type of support is needed or desired. They also talked about the support that they could do without. As young adults, participants want to both feel free of needing support and confident that they have continuous access to existing support. The young-adult mother needs to feel internally responsible for her mothering journey. Therefore, she may show defensiveness towards the ideal of needing and accessing supportive help. She also feels positive and developmentally supported by the existing external supports that she can call on as needed. Participants may outgrow the thought of "needed support'" as they began to feel more autonomous in their growth. Participants shared that all support has quality, is appreciated, and could be accessed as needed. They

actively felt loved, supported, and valued in the face of adversity, under the auspices of "less-than" socioeconomic status. These young-adult mothers continue to uphold and value their African American culture, connection to family, and community. African American culture heavily relies on family, extended family, and community to support efforts on all levels, when needed and as needed.

Reflective functioning: Parent development.

The concept of reflective functioning was used to explore, through interviews, participants' capacity to combine two things: (a) what is internally known, remembered, and understood about their own early experiences (and history of being cared for), and (b) the ability to simultaneously think about and talk about their children.

View of the child.

When the mothers of this study were asked about their children, they used positive and descriptive words. As observed on the video, during this particular question, mothers smiled more, elaborated more, seemed energized, sat with more erect posture, and spoke more quickly. Those with children present brought the child closer in proximity to their body, looked towards the child, showed facial expression of enjoyment and pleasure in talking about and describing the child. Only one mother had a flat tone and facial expression when talking about her children. However, this particular mother spoke and appeared this way throughout the entire interview, and she still had increased speech,

showed more observable thinking, and displayed more smiles while describing her children one at a time.

Overall, mothers had more positive words than negative when describing their children. No mother used more than one negative word when describing her child or children. (Some mothers had more than one child fitting the study criteria.) Mothers were able to be reflective on this topic with little to no prompting, and without additional guiding questions. During this part of the interview, participants seemed to enjoy themselves. Mothers described seeing "mini versions of themselves" in terms of their children's personalities. They were quick to recognize and name the connection they saw between themselves and their children. Participants also described seeing a pattern of what they see in their children as being similar to what their mothers have seen in them.

When asked, "Who is your child," participants offered the following descriptions:

- "D. is funny, handsome, smart. He is shy, but once he gets to know you, he will open up. He's a loving and caring person and he's funny. He's so full of life. He can make you smile. He is an amazing little boy. If he gets into trouble, he doesn't repeat what he's doing. He's really serious about making his mom proud. I don't want to put too much pressure on him. I can tell that I'm really important and he really want to make me happy. It's vice versa.

- I would say my son is bubbly. He's shy, but he opens up fast to people. He is also smart. He is full of energy. He is always jumping off of things. He has been doing that since being in my stomach. He kicked way more than my first son. They say you can't feel a baby kick until five months, but he started kicking at four. He never stopped. Sometimes I wanted to take my stomach off and just get a break

from him kicking. That's how he came out: kicking. He came out grabbing the nurse. It was so funny (chuckling). So, he has been energized since birth. I would just describe him, like, being my little energy ball. He will be quiet for a movie. Once the movie goes off, it's time for lightning.

- She speaks her mind, even when she is not supposed to (chuckling). She's a social butterfly. She loves to talk, likes to dance, likes to sing. She wants to know when she's going to be famous. When she was in day care, they let her go outside with her slippers on. I was like, "Why would y'all let her go out with her slippers? They were muddy. Her socks were wet." And they were like, "Well, she's very strong-willed." So, basically, you're telling me my daughter had a fit and you just didn't want to power struggle with her. She's always been strong-willed.

- Who is she? She's stubborn. She's very hard-headed, yet caring. She thinks that she's a jokester because of my mom. (Mom) tries to make it seem like her jokes be funny. She scared of animals, but she loves animals. The only thing she's not really scared of is cats and dogs. She likes people. She's very picky. She's very repetitive. She'd do the same things over and over and over and over again. I don't know if its just because she knows that it annoys you (chuckling), or if she just does it to satisfies her. She will watch the same movies. She will put on the same clothes. She will go and touch something and then turn around and go touch it again. You have to tell her to stop, and sometimes she'll keep touching it. I don't even think half the time she notices that she does it. She wants the same things every single day. But now that she got the kitten, she's a little more slipped on her routines and working out a new one.

- He's got a little personality, very energetic. He's my twin. He's born on my birthday. I can see my little personality in him sometimes. Ever since he was a baby, he's very vocal. On the first day, you'd hear little squeaks. He's persistent. If you teach him something new, like stacking blocks, he'll keep trying until he can do it. That's a funny thing. If I teach him something, I guess it's good that he keeps practicing it, but if it's something he's not supposed to have, he will figure out a way. So that's where it gets frustrating because he uses that persistence to do something else.

- J. is very funny. He's a silly guy. With L., the three-year-old, he's a funny guy, too. He asks random questions. J. is more conservative. He can sit in one place and just be calm and cool. L. is a busybody. He gotta move everywhere. You tell him to watch TV, he up and somewhere he ain't supposed to be, playing with the cats or something. Or asking me 1,001 questions. Sometimes I think he got a little bit of anger issues. He'll get mad at his brother. He'll just begin to cry. So, I be having to calm him down sometimes and tell him, "Okay, take a breather."

I've been through a lot of depressive stuff and my kids have seen some of it. They witnessed some of it. They're my number-one support. I do have depression. I'll be sad sometimes and not even saying that I'm sad, and they'll just be, "I love you, Mom." They just warm my heart. It's just unconditional love. I don't even know how to explain it because it'll never go away. They always going be there for me and I know that. Those are my babies, and nobody can take them from me, ever (chuckling). So that's how I would describe my babies.

View of the relationship.

When asked what kind of relationships they had with their children, all 11 mothers responded comfortably and quickly, saying they have an unbreakable bond with their child or children. Thinking of the connection, mothers responded with statements including:

1. "We are unstoppable together" …
2. "We have a friendship" (In some cases, "We are best friends") …
3. "We are all we got" …
4. "Real strong bond between us" …
5. "Pretty good relationship" …
6. "Good connection" …
7. "Twinship" …
8. "Super-connected" …
9. "It's just us" …

The themes that came up the most were, (a) best friend / friendship, (b) good / great / strong bond, and (c) good relationship. During video observations of this portion of the interviews, the researcher noticed the following behavior from the mothers:

1. Getting nearer to their children …
2. Smiling more …
3. Observing their children more …
4. Thinking intensely when describing memories …
5. Increasing hand movements and hand gestures …
6. Sitting up straight …
7. Making animated facial expressions …

“What kind of relationship do you and your child have?”

- I feel like I have a good relationship with both of them, but I feel like it can always be better. I don’t ever want them to feel like I love the other more. L. is the baby. He *is* like my baby still. You the older brother, but no matter what, I’m still always love both of you all equally. I do have to sit down and talk to them and remind the older one that there’s no difference between them.

  Sometimes I need to be more patient. I am a new mother to the two of them and I’ve only had them for five years. Sometimes I do get frustrated really quick and I just be ready to snap. That would throw them a lot. I got to understand that they are kids. Kids do crazy stuff. Because sometimes I just … lose it. I feel like I have a really good connection with my kids. I feel like it’s grown a lot better in the last two years. I think they’d say they have a good connection with me, too. I think they’ll say they love me. They know that I love them. That’s all I want them to know, that I love them. That’s it, that’s all.

- It’s kind of like a little best friend. I can tell her some things, but I don’t tell her everything. She knows when something is up with me. I’ve learned how to talk to her, so that she can get an understanding of where my emotions come from. We’re really good. If she responds to you, she’d say I was her best friend. I have a feeling. She tells me I’m her best friend (chuckling).

- I don’t know how to describe our relationship. I would say it’s unconventional. Lots of parents kind of tell their kids what to do and how to do it, very structured.

I count on her to control our relationship. If she doesn't like me today, she doesn't have to like me today. We talk about everything.

People say I spoil her. She's always attached to my hip or my boob (chuckling). I don't let her cry. I mean, I let her cry when she's just faking. I will let her scream her head off for an hour if that what she chooses to do. But if she's crying because something is actually wrong with her, I'm not going to let her cry. I will give her what she wants because she's a baby. I feel like you can't spoil a baby. (People) feel like I spoil her because I give her what she wants. If she asks for it in a proper manner, I'm going to give it to her. They say that I coddle her too much, I hold her too much. It's what they need. They need to be nurtured. They need to be held. They need to know that when they cry and something's actually wrong, it's not going to take you too long to respond. Those are all things that are good development for them.

Lots of the time when I'm feeling some type of way or if I'm tired, I can tell that she may not be tired, but she'll just lay down just because I am. It's weird to see how connected she is to me and my emotions and my energy and my thought-process. I feel like we're super-connected like that.

Affective experiences of parenting.

When asked, "Who are you as a parent," mothers responded across a spectrum, from "I don't know who I am as a parent" to "I think I am a good parent, or at least I wonder if I am a good parent." Specific responses included, "Being a parent makes me a go-getter,"

and, “I know how to love my child and care for them. That’s easy.” Mothers said it is easy to love their children, understand them, listen to them, and continue to learn what the child needs.

At least half of the mothers interviewed described having some type of fear or anxiety around not raising their children right and being responsible for how their children turn out in the world. The mothers described this as stressful. Mothers stated that an additional challenge was not having enough to financially provide for their children’s every desire. These same mothers stated that they feel sufficient in providing for their children’s basic needs, e.g., housing, food, clothing, and essentials. Mothers also stated that knowing their children is the easy part, along with listening for their needs.

These mothers felt their children could read their emotional cues and understand when the mothers were feeling stress. The mothers saw this as a good thing and thought it strengthens the bond and connection between them.

The most common theme in this category was mothers stating they have a desire and fantasy of someone taking care of them. They described this as a time they could rest, pause, and take care of themselves. With one exception, all participants stated a desire to be cared for by another. The one mother who stated otherwise said, “I did not want anyone to take care of me. It was not a reality that would come true, so why wish for it?” The other mothers said their most recent desire or fantasy had occurred within the past 24 to 48 hours, and that they had these thoughts on a regular basis.

The overarching theme here is: Parenting is challenging given the multitasking involved with being a mom, working, and attending school—along with all of the other tasks that come along with parenting, with little to no support from fathers.

The contrast of feelings that come up the most for these mothers can be described as "happiness versus fear." Mothers asserted knowing how to love their children despite life challenges. When looking at the video of each mother discussing this topic, the researcher noticed mixed gestures. Some mothers looked frustrated when answering this question. Others looked puzzled and had to think and pause more. Some looked confident and in control in that moment. While mothers were answering this question, their children tended to fidget or whine, needing the mother's attention. The researcher became competition for the mother's attention, and the children were demonstrating to the researcher that they came first. Each mother who had a child present attended to the child. For the researcher, it felt good to observe.

The children who were present became frustrated during this part of the interview. Mothers became more focused, attending to both the researcher and the child. This speaks to participant statements about multitasking. They recognized a need to prioritize the needs of the child over their own, or those of the interviewer. The mother even became more intense or relaxed in her posture after attending to all needs in that moment. Eye contact became more engaged with the researcher after attending to the child's needs. Mothers became more excited and animated. The researcher observed increased hand gestures and a sense of pride, per each participant's facial expression. This was observed on video, when participants talked about themselves as parents. It was almost like observing each mother taking a test. She showed pride in acting as a mother, having just talked about her child in the previous question. There was a good feeling during this part of the interview, with each mother.

Verbatim responses to the question, "Who are you as a parent" included the following:

- Even when I'm alone, I'm not alone, not in my thought process. Then, having patience when you don't have any, you still have to find some. You don't get an "off" switch. There's no pause. There's no stop and come back to it.

  But she's at an age where everything else is pretty easy. She's lovable. She's fun. She's learning new things every day. But she's to an age where I am having a hard time finding a lot of the patience that I need, sometimes. It's a lot of checking yourself, like, "OK, she's a baby. Yes, she's getting on your nerves. Yes, she's doing stuff she's not supposed to be doing," but you still need to find the patience for that. So, I think that's the most challenging thing, right now.

  Everything about her makes me happy even when she's getting on my nerves. I never realized how vulnerable I was until I had a baby. I never want to live without my baby. I worry so much about all the little small, intricate things that could happen to her. Is someone going to do something to her? Or am I going wake up and she's not breathing? Is she going to choke and I don't know what to do? It's just so much to worry about. So other than happiness, fear is the only other emotion that sticks out the most.

- I try to be a good one, but I just make so many mistakes that I'd be, "Dang! Am I even a good parent?" I mean, they eat fruits and vegetables every day when they go to school, but sometimes on weekends, I get lazy and let them eat cereal all day and I feel like a bad mom. But I be tired, and they like it. (chuckling) As a parent, sometimes, I feel like overall I'm okay. But sometimes I be feeling like I just make so many mistakes that I need some parenting tips or some help or something.

It's challenging to provide for them. I want to get their hair cut every two weeks, but sometimes I can't afford it. Sometimes they need new shoes and sometimes I can't afford it, and I have to wait until I get some money. Then when I do get some money, I got to go to Payless or Goodwill. And the shoes there sometimes won't be good. So, I'll just say providing them necessities is hard. And I be feeling like a bad parent because sometimes I lose my patience and I got to walk away. It's really hard to have patience.

And also I feel like it's hard because I'm responsible for raising a whole human being, (to not) mess them up. Sometimes that thought is stressful, that I have to make sure I do everything right so I don't mess them up. But what's easy is just loving them. Loving them comes natural. Nurturing them comes natural, taking care of their basic needs. Making sure they're good comes natural and that's the easy part. But just providing certain things, it's hard. And just knowing that I got to do everything right to raise some good men in this society, good black men.

The most is happiness. I'm happy I got my kids. They give me joy. I feel grateful to have them, I really do. I feel like they help me. I probably wouldn't even have stuck with school if it wasn't for my kids. They really pushed me. I need to make sure that they have a place to live and they have some food to eat. I just feel all these great feelings when it comes to my kids, even though they get on my nerves. In the middle of the day, I always say, "I can't wait to see them. I can't wait to talk to them. I can't wait to kiss and hug them." Then I start to get angry at their fathers. Whenever I have a problem with my kids, I just think of their fathers and I get so angry. I've been trying not to because I want to love everybody, but I've been getting angry.

Sometimes I be feeling like I hate them almost, like, “You just left me to do this by myself.”

- I think I’m a pretty good parent. I always try to be calmer with him and do what’s best for him. A lot of situations that I was in, I’ll make sure he will never be in. Nobody can tell me what I can’t do to my kids. I have more of the say of what goes on in parenting. The challenging part is sometimes I really don’t know what to do. I have to rethink my priorities because it’s not me that comes first, it’s him. I always have to make sure he’s taken care of before I focus on myself. I think taking care of him is the easy part for me. I’ve always liked babies and kids. That’s what I go to school for, too. I love it. It’s fascinating. I think he can tell when I’m sad or something because he’ll try to come over and sit on my lap, or try to cheer me up. Sometimes I think if I have a lack of energy, he starts to feel it and get frustrated himself.

Parent’s family history.

When asked about each mother’s childhood experience, eight of the 11 mothers said they did not have a biological father present during their own childhoods. Some did not know their “real dads,” or stated that they knew who their real dads were in the community but had limited or no contact with him. Some mothers described having the experience of thinking the father figure, or man in the home (usually their mother’s boyfriends) was their dad until told otherwise. Each mother who shared this experience expressed how disappointed, hurt, and betrayed she felt once she found out the truth.

Three mothers reported growing up with their biological fathers present in the home. All three described having a connected relationship with their fathers. One described her father being in the home, but frequently absent due to caring for her physically ill mother, who was in and out of hospitals. Another mother stated that her father was in the home and she had a close connection with him. She described herself as a "daddy's girl." She shared that her father has a mental illness which occasionally him and made it challenging to connect with him. This mother smiled while talking about her connection with her father. The last mother who stated that her father was in the home described having a good relationship with him, and said she was a "momma's and daddy's girl."

All participants had a mother physically present, but most described the relationship as challenging. Several noted a close and safe connection with grandparents whom they could turn to when needed. One mother described her grandmother as her primary caregiver, along with her mother, explaining that her mother was both "present and not present," due to being incarcerated during the participant's latency years.

During this stage of interviews, participants described various childhood adversities, including:

1. Homelessness …
2. Having a primary caregiver out of the home due to frequent hospitalizations …
3. Parent incarceration …
4. Parents not together …
5. Primary caregiver working all the time …

6. Preparing one's own food …
7. Primary caregiver not available when home from work …

Most participants could see, recognize, and name similarities between themselves as parents and their own childhood caregivers. If the similarities were deemed by the participant as negative, they stated how they do not want to be like their mother in caring for their own children. If the similarities were recognized as positive, participants were happy to say, "I do (this) like my mom did." They seemed happy to identify good things as they remembered them. Some mothers found the similarities very easy to recognize and identify.

The researcher asked participants to talk about the relationships they had with parents and other adults in the home, and to then discuss how they were treated overall during their childhood. Participants used this time to think of what stood out to them from when they were children. A few participants initially stated that they could not remember their childhoods. As mentioned previously, after a few minutes, they tended to think of one memory, which led to many others. Interestingly, no adversity from childhood was described as negative. Some of the participants made statements like, "It is what it is," "That is everyday life," and, "It was normal to get cussed and yelled at." One participant said, "There is no need to dwell on what cannot be changed. We have to just keep moving in life."

"When you think of your own childhood, what comes to mind?"

- I'll say love and pain. Love, because I felt like my grandmother loved me. My auntie, my mom—I feel like they genuinely did love me and want the best for me. But also pain, because I grew up seeing a lot of violence. I grew up seeing a lot of fights, a lot of men beating my mom and my grandmother. That caused me pain to see that, especially when I was really little and couldn't do anything, but just sit there and cry and watch.

- When I was little, it was good. I felt like she loved me and cared about me and she tried her best to provide. We kind of grew up together. She had me when she was 16. She was like a friend. She would tell me certain things, adult stuff, and I felt like I was kind of too young to know. (It) kind of made me grow up a little fast, just knowing all this. I even saw some stuff, too. That's the only thing.

- I think I was a momma's girl. My mom said, "I breastfed you until you were …" and I'm like, "Oh, my gosh!" But I think I was a daddy's girl, too. But I was pretty close to my mom as a kid. I used to sleep in her bed, too. I was breastfed, just like my daughter. (chuckling) I was always under my mom. Just nurturing, loving. She's the same way with my daughter. I can see why (my daughter) clings to her. It's just something about a mother. She is just the nurturing piece. My dad was there, but it was different.

- My mother. My father was out at the hospital with my mother. We couldn't go just because I was so young. They didn't want me to break down, but it made me depressed. They didn't know until about 16 or 17, where I had to get treated for it.

> I tried to commit suicide. Just because my mother would slip into a coma, or her kidneys after dialysis wouldn't work. It started happening when I was four but I didn't understand until I was about seven. My mommy said she wouldn't be here for my tenth birthday. They told me that she wouldn't be here for my golden birthday. Then my golden birthday, she came home from the hospital. I always thought they weren't always honest because of that. It was confusing and I didn't know who to turn to. Everybody always just cried. I was like, "What's everyone crying for?" It was difficult. My dad would always call and say, "I love you and I'm going to be home." But I knew she loved me and she would come home like she promised me. My dad always came home to cook, so I was always looking for that. It's an unbreakable bond, just like I have with my children.

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Separation / loss.

Asked if they ever felt a lost connection with their children, all mothers answered in the affirmative, noting at least one relevant occasion. Participants attributed the following causes to lost connections:

1. Stress …
2. Feeling down …
3. Frustration …
4. Loneliness …
5. Emotionally instability …
6. Depression …
7. Anxiety …

8. Lack of rest …
9. Handling too many tasks at once with no foreseeable break …
10. Having a second child …

Mothers expressed the ability to re-engage with their children following a loss of connection. None of the mothers had experienced a long separation from their children. Many parents agreed that the longest separation involved their children spending a night away from home due to the mother working or traveling "close to home."

In answer to the prompt, "Tell me about times you and your child were separated from one another," mothers responded as follows:

- When I had to go to the hospital for five days because of my diabetes. Their dad didn't want to bring them up there to me, even though he was at the house with them. FaceTiming was not OK. I needed to hug them. I needed to put my smooches on them. Knowing that I could not make dinner for them or provide for them because I was in the hospital with diabetes, it was really hurtful. Seeing (my children) cry and say, "I want you" was really devastating. They felt hurt. And then when they'd seen me: "Mommy, what's wrong? You're not smiling. You're not here. Where are you?"

  "I'm at the hospital."

  "Well, can I come see you?"—and having their dad say, "No."

- When I was at school. My mom was like, "No, you need to focus on school. I'll come and get her and bring her back to you." I didn't have my baby who I just had for almost a year, who's always been there. I come home and be with her all the

time. Or she's there waiting up for me, which I used to hate. Every time I tried to do my homework and I would want her to go to bed, she would not go to bed. She would literally sit there and wait for me to finish my homework and to lay down with her in order for her to go to bed.

It just didn't work out for me and it was a real hard adjustment going from community college back to a four-year school, which is fast-paced. It was really a huge difference for me. That was about the biggest separation that I've had from her, especially after she had to stay with my mom when I had my son. I don't know if she thought that I was abandoning her or what she thought. It's hard to explain to a one-year-old: "I can't afford both of you guys, or I can't study and have both of you guys." It was really hard. She wouldn't express that she was sad, but you can tell that her demeanor was, "I miss my mom. I want to be with my mom." I didn't think that she would think that way because she was so young. I definitely thought, "Hey, she's not asking about that." Then, surprise—she did.

- When I was sent to jail. I think all together a total of five months. When I first went to jail, that part, was only five days. It was bad. I was breastfeeding him at the time. All my milk completely went away. That hurt my feelings so bad. When I went in to do the (five) months, I dropped them off at day care and then they didn't see me for a few months. I didn't tell them, "You probably won't see me." I maybe kind of felt like they were thinking, "She's left us." Now (my older son is) really kind of protective, like, "No, you're not leaving. You can stay with us at school." He knows now that I went to jail. I missed them so much.

- I guess my (10-day) trip. That was the longest I've been away from him. (Besides that) I've never been away from him longer than a day. It kind of made me sad. I was trying to FaceTime, and he didn't want to see me. He was having too much fun. Then I came back and he had learned new sounds and stuff. I was just kind of surprised. I didn't think he would grow up so much in a week. (chuckling) I think he missed me. Because when I came back, he was kind of shy at first. Then he just was on top of me for like three days straight. He didn't want to leave my side.

Looking behind / looking ahead.

When asked, "If you had a chance to choose parenting all over again, what would that look like for you and for your child," participants had a variety of responses, including:

1. Wait …
2. Have the same child(ren), but wait until a better relationship such as marriage …
3. Finish college …
4. Work on a better financial situation …
5. Have more knowledge about the child's father …

Most participants said they wished their children's fathers were more available and contributed more on all levels (e.g., finances, spending time with the child, asking about the child's day and well-being—and otherwise showing more interest). The majority of these responses came from participants who also stated that they wished their own fathers had been more available for them.

The researcher asked participants to think about their children as adults and what that might look like. All mothers answered easily. Some used occupational titles to describe the children:

1. Police …
2. Service professional …
3. Basketball or football player …
4. College-educated …
5. Good citizens …

Some used skills to describe their children's potential futures, based on each child's current traits. These characterizations included the following descriptors:

1. Kind …
2. Sweet …
3. Nice …
4. Having a temper …
5. Successful …
6. Like me …
7. Smart …

Parents also expressed a desire for their children to "attend college" and become "good citizens."

When asked if they could see themselves as grandparents, participants were amused. There was a lot of big-eyed facial expressions and chuckling. However, some mothers displayed serious facial expression, straightened up in posture, and considered the

prospect of their children having children. Indeed, with some participants, the question did not seem to sit well. Answers included the following:

1. “I don’t want to think about that. I don’t want my child having children young or early.”
2. “I cannot see that at this time.”
3. “I want them to wait. My children are too young. That means having a girlfriend or boyfriend.”
4. “I don’t want my kids to have no babies.”
5. “I want them to be financially stable before having children.”
6. One participant simply responded with a prolonged cry of “No,” with the “o” drawn out …

After the initial shock of the question, mothers reflected and answered in greater detail. At this point in the interview, responses included:

1. “I would be an okay grandmother. I would be there. I would help out with the children.”
2. “I would do what my mom does for my children even though she wasn’t there for me.”
3. “I would be there as needed but not entirely. I want to live my life when I get older. That is not a freedom I have now”
4. “I would be supportive and nurturing, I would spoil them.”

This question produced a range of emotions. Overall, it seemed that participants enjoyed answering it more than any other question. The researcher observed fear,

laughter, shock, resistance, resignation, and pride. For the researcher, these reactions were a fitting way to begin winding down the interview.

Below are responses to the question, “If you had a chance to choose parenting all over again, what would that look like for you and your child,” as well as, “Can you see yourself as a grandmother?”

- The beginning of my pregnancy, I would do a little bit differently. Otherwise, I think I’m doing pretty well raising him. I don’t really have to discipline much yet. I don’t know what I could have done different. I think he’s going to have a lot of personality. I feel like he’s going to be really sociable. I feel like he’s just going to be that person that knows everybody (chuckling). I think I’ll be a good grandma because I always want to take the babies and do trips. That’s always interesting, me as a grandparent. He’s only one. I’d be very happy to have little grandchildren. I would want to be really involved.

- I would wait until I was more established in life. I would want to go to college and experience the campus life and all of that. (I would) experience everything that I couldn’t experience because I *did* have a baby when I was still a baby. But I wouldn’t change my kids. I wouldn’t change nothing about them. I wouldn’t change the fact of that they’re here. I’m happy they’re here. I feel like it’s a blessing. I feel like they better me.

  Sometimes I sit back and I think, “Dang! What if I just waited?” It would just be me. I wouldn’t have no worries. I would know how to be 23 with no kids, doing whatever I felt like. But then, that all shuts down because I think, “Well,

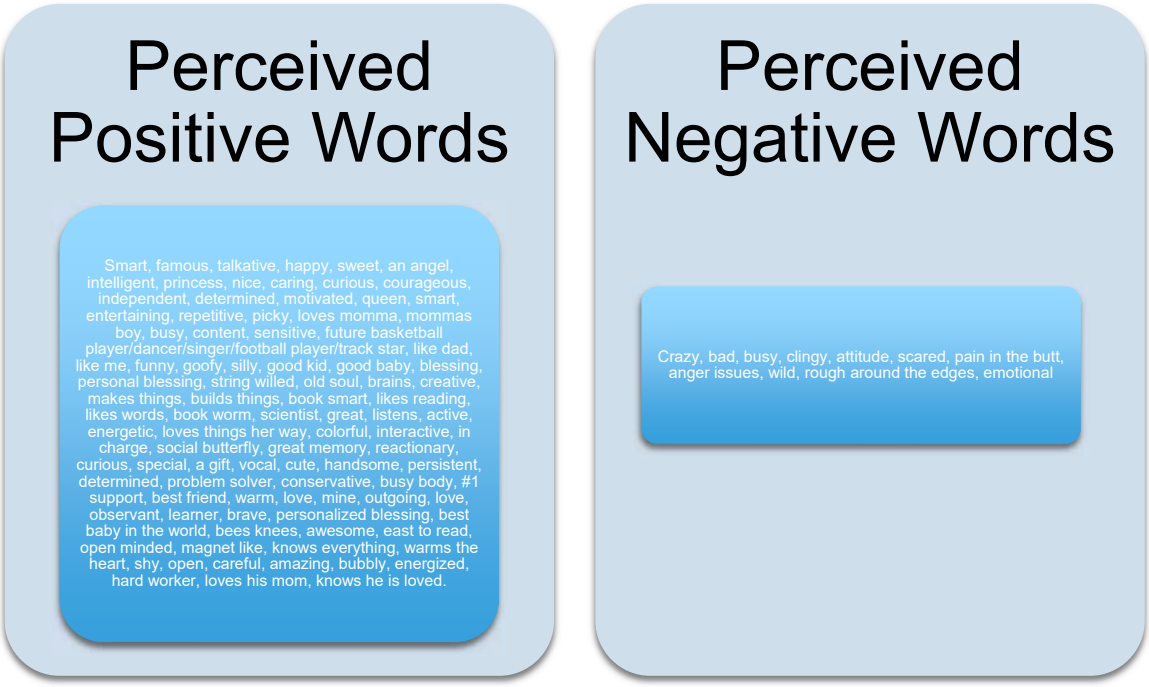
what if I didn't have them?" I would still be in the predicament I was in, probably going through way more depression than what I am now because I am only stronger because of them. So, it outweighs it. I feel like I wouldn't be nothing without them. I feel like I wouldn't even be here if I didn't have them boys. They're my blessings.

- I don't like thinking about when they get older. I don't want to think about that. I can't imagine it. I just want them to stay little. I'm going to be sad, but I'll be happy because I want them to be successful. I want them to be great. I want them to shoot for the stars. I know they both have a creative mind. I got a lot of goals of what I want them to do in the future. I want them to stay busy into stuff, so they don't have time to be out here with all of this reckless stuff that's going on. My boys have got to stay busy—sports and music, whatever they want to do, just as long as it's good and I don't have to worry about them. .

I don't want my kids to have babies. I tell them, "You can't have no girlfriends." I understand what my mom meant now when she was like, "Don't make me an early grandma." I know how boys can get with these girls and all this. I've been through it, so I know. I'm not scared. I think I'll be a great grandma. It's just I don't want my babies to have babies. I just want them to be safe about it (and) not too early. I want to have the talk with them and everything and let them know right and wrong with all of that. My grandbabies are going to love me. I'll probably end up being just like my mom, overprotective of the grandbabies. Thank God that's so far away (in the future). I don't got to worry

about it now. I'm going to try to instill in them, "Wait 'til marriage." I wish I could have did that, find the right man.

Table 4. View of the Child: Positive and Negative Words as perceived by the Researcher



Final question: "What was it like for you to be interviewed?"

After the interview, the researcher asked participants a follow-up question: "What was it like for you to interviewed?" In the researcher's opinion, this question provided some of the most powerful moments in the entire interview. The researcher assumed participants would become emotional, especially while being asked adverse childhood experiences. However, it was this final question that produced the most emotional responses and the most powerful answers. The mothers offered a variety of responses, but they all agreed on one point, which we can summarize here as: "People don't typically

ask me these types of questions, where they are genuinely interested in who I am as a parent, who my child is, and what that looks like for us".

Table 5. "What was it like for you to be interviewed?"

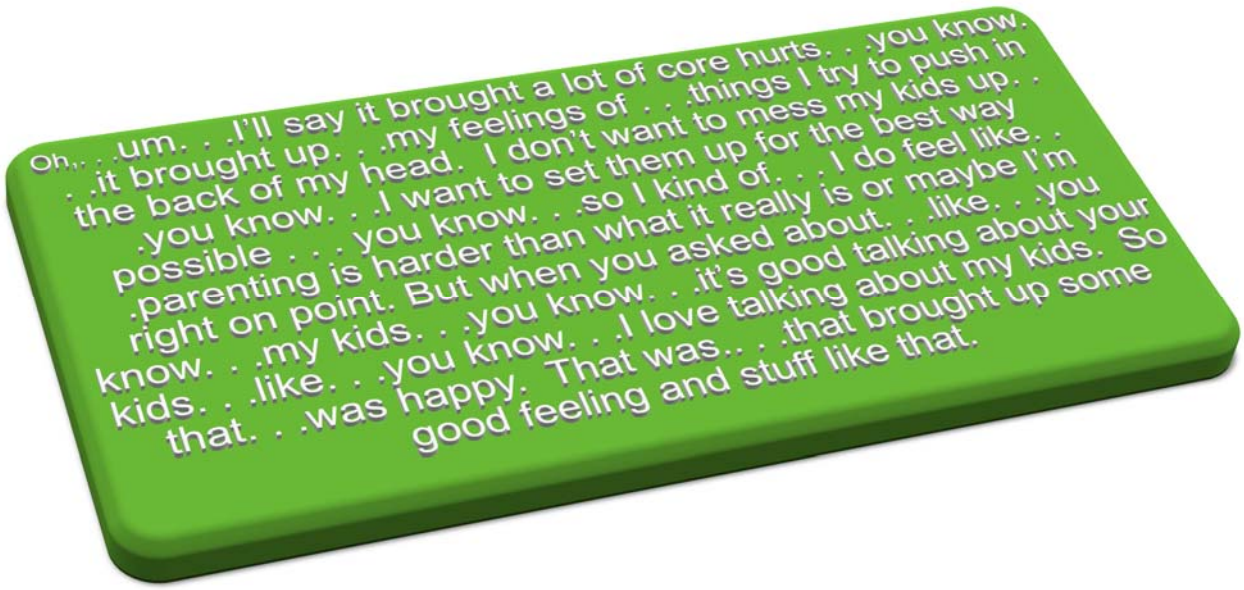


Table 5a. "What was it like for you to be interviewed?"

Summary of Overall Results

Throughout the course of an in-person interview, participants described their parenting experiences. They did so by sharing thoughts about their children and themselves as parents. Participants initially began to describe their children in a formal way, and were

then prompted to talk about their child as if they were speaking to a "good friend." This allowed participants to become more comfortable with their responses to the researcher.

Participants showed joy, confidence, and parental competence when describing their children. The 11 mothers were able to take what they have experienced as children, what they currently experience as a parent, and ultimately discuss what it is like for their child to be in a relationship with them. All participants were comfortable moving through each question because the previous question promoted a deeper level of confidence and comfort—as observed by the researcher. Each mother appeared to have an "all-knowing" boldness when talking about the child, themselves as parents, and the dyadic relationship. They were able to connect how they were parented with how they parent their own children. Participants discussed childhood experiences that were good and bad, and they furthered the discussion by describing what is appropriate to transfer to their own children and what experiences are not. Mothers talked about transmitting good things to their children, while simultaneously protecting against negative experiences, thereby changing patterns that could affect their children's well-being. Participants acknowledged that parenting is simultaneously challenging and rewarding.

Participants built a capacity of holding two things in mind simultaneously: their ambivalent childhood experiences, and their children. Meanwhile, they were able to imagine what the parenting dyadic experience might look like in the future. When assessing past events and imagining future possibilities, the mothers expressed that it was challenging to think about separation and loss of connection with their children. However, they were all able to consider the past and future.

The 11 mothers used more positive words than negative words to describe parenting in general and their children in particular. They were also able to hold their emotions together until the end of the interviews, when they accessed and described emotions that perhaps had been stirring throughout the encounter. Participants appeared comfortable telling their stories to the researcher. They seemed to feel supported during the interview process, just as they do within the support networks they discussed.

Chapter V

Discussion

Relationship Between Adverse Childhood Experiences, Social Support, and Reflective Functioning

As previously discussed, this study used a constructivist viewpoint, which embraces multiple realities of participants, previous literature, and the experience of the researcher (Creswell, 2007). The researcher intended to interpret and understand the meanings of participant statements, as described by Creswell (2007). This study also sought to interpret and construct multiple realities as experienced by the young African American participants, while detecting potential interaction between parental reflective functioning, adverse childhood experiences, and social supports. Finally, given the existence of such interaction, the study would examine how functioning, experiences, and support intersected and influenced each other.

Using the constructivist, interpretive approach, the researcher had opportunities to listen to, acknowledge, and understand the realities of the parent-child experienced story, as told by each mother during the interview. To collect and interpret each participant story, the researcher engaged in the following:

1. Listening …
2. Observation …
3. Feeling …
4. Interaction …
5. Understanding …
6. Reflection…

The researcher's overall assumption, based on previous studies and available literature, was this: Young-adult African American mothers face a greater challenge reflecting within the parent-child relationship when they (a) have experienced adversities during childhood, (b) have little to no supportive relationships, and / or (c) they lack the ability to use available social support. Based on their narratives, these 11 mothers appeared resilient and determined to not allow early adversities to affect their connectivity, and thus their reflective capacity, with their children.

For the purposes of this study, resiliency is defined as the ability to hold oneself together in the face of adversity, opposition, and oppression. As a whole, participant narratives demonstrated an ability to be reflective of children's emotions and experiences, as well as the parent-child relationship. Participants maintained this ability while describing experiences that felt simultaneously normal and distressing. The 11 mothers gave no real indication that histories of adverse childhood experiences negatively impacted their ability to maintain connectivity and attunement with their children. Further, these mothers all have access to social support and use it as needed.

It was assumed that if a mother is exposed to early adverse experiences, this may have a negative effect on her developing self and can be brought into the relationship with her child. The mother might not able to reflect on her child's needs if she misreads cues because of her own history of unresolved adversities. In turn, this could lead to challenges within the parent-child relationship, leaving the child more vulnerable to adverse experiences, thereby setting an ongoing pattern of multi-generational difficulties. This did not seem to be the case with the 11 mothers in this study, who showed flexibility and multi-dimensional assertiveness through their reflective capacities, in connection to their overall experiences of being cared for and giving care to their children.

A mother's ability to separate her child's mind from her own is optimal for the parent-child relationship. During participant interviews, the mothers talked about their children as separate beings from themselves. "Evidence suggests that being able to make sense of both one's own, as well as one's child's mental state can serve as a protective buffer in relation to child development" (Katznelson, 2014, p. 115). These mothers were able to separate their own minds from the minds of their children, which calls to mind this passage from Katznelson:

> There is strong evidence to support the theoretical notion that parents' mentalizing capacity plays an important role in the ability to provide care and comfort to a child, which points towards reflective functioning as a central mechanism in the intergenerational transmission of attachment. (2014, p. 115)

While most participants discussed histories of abuse, neglect, trauma, exposure to violence, substance use, etc., they seemingly have become "good enough" mothers,

consciously working to keep these adversities out of their relationships with their children. Their narratives contain hints of connection, support, and feeling valued and important—all at different points in their lives, and by important others (e.g., certain relatives, such as grandparents). The literature does support the idea that positive caregiving experiences and attachments promote healthy parent-child relationships. Perhaps these participants experienced relationships that were good enough to diffuse their adversities. These relationships may have helped participants develop a sufficiently cohesive sense of self, efficacy, and worth, allowing them to connect with their children in healthy ways (Winnicott, 2002). In other words, these participant-mothers may have good internal working models of reflective relationships, and were able to integrate those models into their roles as mothers.

The researcher also assumed that a social-support system could impact mother-child relationships. Each mother described having at least five individuals in their lives as direct support. Support systems consisted of family, close friends, and in at least two cases, professionals. Participant narratives also evidenced mothers' knowledge and ability to access available support. A few participants shared a dislike for requesting help. These participants said they knew how to access support, but might choose not to. All 11 mothers reported substantial, strong support networks, and most participants use their networks to some degree. Indeed, these mothers may have been less affected by adverse childhood experiences because they had such support. This is in line with the literature that suggests that support systems can help a parent's connectivity to her child.

Is there a relationship between quality social supports, feeling able to use those supports, and a mother's ability to be emotionally attuned to her child? Unfortunately, it

is not possible to answer this question in greater depth here, because there is no comparison group. All of the mothers had support systems, and not a single participant narrative evidenced a lack of reflective capacity.

Let us assume that a mother knows that she can show psychological availability to her child via her capacity to hold the child's mind and her mind in reflection, with or without support, and despite a history of adversities and life experiences. This mother will be more aware of her child's need for engagement and connection. To further explore this dynamic from a clinical perspective, a mother must be asked (a) what she wants, (b) where she sees herself within the parenting experience, and (c) where she wants to ultimately be. These questions must be asked, acknowledged, and listened to in order to fully understand what is needed and valued for continual promotion of healthy care.

The findings of this study raise several questions for the researcher:

1. Is there is something about the African American experience and cultural history that creates a mind-state in which adversities are a normative and tolerable occurrence?

2. Do these study findings speak to the African American interpretation (in this case, the African American mother's interpretation) of adversities and historical trauma—including violence and cruelty—as normal? If so, what accounts for this interpretation?

3. Why do some people accept and / or normalize adversity in early life, while others reject, deny, or minimize adverse experiences?

Participants felt that their adverse experiences are both normal and necessary, but not normal enough to pass on to their own children. One must hold and protect what is in culture, while surviving it as well. These mothers seemed to be unconsciously holding onto their trauma. They appeared to use intellectualization, a psychological defense mechanism that allows them to acknowledge and speak about adverse experiences, but that cuts off any emotional connection to the experiences, in order to avoid pain. Intellectualization is protective. It allows them to hold the trauma and child separately and make themselves emotionally available to the child.

It may also be that these mothers have developed the capacity to integrate and mediate traumatic memories and experiences. Perhaps this is, in part, a result of a cultural adaptation for survival. Holding is the key here. In the face of adversity, the mothers hold what is intolerable as tolerable. This holding accounts for the resiliency evidenced in the mothers' stories.

The Experience of the Interview Process for the Participant and for the Researcher

This study does not necessarily support available research that suggests individuals who were abused or neglected in childhood likely lack social supports (or have such supports but do not use them) and may lack the ability to be reflective in terms of their children and the parent-child relationship. However, the study does suggest that being asked to tell personal stories, and telling them, has the potential to elicit reflection that may not be conscious or obvious, but which exists nonetheless.

The researcher is an African American woman and a clinician who has worked with young-adult African American mothers and their children. The researcher is also a mother of two young-adult children and was once a young-adult mother herself. Through her training, work, and personal experience, the researcher knows the importance of a parent's ability to be reflective and help children manage emotions. During her career and time as a mother, the researcher has reached an understanding and appreciation for being aware of one's own history and how it may affect the parent-child relationship, along with a host of other internal and external realities, all with competing agendas. As a young parent, the researcher was not aware of this, but she came to recognize it over time. The researcher can use her knowledge in both her work with young-adult mothers and in her relationship with her own children and future generations.

By studying this issue in detail, the researcher hoped to bring to life the narratives of young-adult mothers and their stories about themselves and their reflection with their children. In this way, the researcher was able to construct an understanding of their experiences to help others, with the ultimate goal of improving and accessing parent-child relationships. The researcher can relate to the impact of lived experience on the parenting process. The researcher is aware, personally and clinically, of how these experiences can be passed from one generation to another—especially if the experiences go unnamed, unexplored, and unspoken. In the future, the researcher hopes that even deeper meaning will be derived from these rich stories of parenting and distress (with that distress perceived as normal within the context of African American culture).

Overall, the research process has been rewarding, exciting, emotional, and motivating for the researcher. The Parent Development Interview questions showed the researcher

how a participant could build a narrative based on prior questions. This process led each participant to formulate thoughts that evoked further questions and thoughts, in a cumulative way. It was amazing to see how these questions prompted each participant to start with bits and pieces of narrative, which grew into a holistic story capturing the mother as a parent, her child's identity, and the mother-child identity as a two-person unit. As one mother stated, "I am not telling my story or their story. It's our story."

The PDI was not normed on this population. I did not ask the participants these questions in their original closed-ended, quantitative form. However, participant narratives suggested that the responses given to the closed-ended questions may have differed from their qualitative narratives. Most of these mothers talked about adverse childhood experiences but did not necessarily define them as such, which suggests that a closed-ended question might not have detected trauma. This demonstrates the value of thinking culturally when examining experiences and developing tools.

By witnessing thick descriptive stories, the researcher fully heard the voices of 11 mothers. These women expressed appreciation for hearing questions that they had never been asked before, and for the researcher listening to their responses. For instance, the mother described as having flat affect (who was unemployed) showed a great deal more resiliency than expected. She showed up for the interview, participated, got through the interview, and upon finishing showed greater emotionality than at the beginning. Prior to the interview and once underway, this mother voiced a desire for better outcomes for her two children, but seemed unable to feel her experience. During the interview, she explored her experience by describing it, thereby releasing her thoughts and feelings. She left the interview with a very different and fulfilling talked-about and felt experience.

Not only did the 11 mothers effectively survive their own traumatic childhoods, but they trusted the researcher enough to answer questions about potentially undesirable memories. The researcher quickly recognized the importance of capturing the stories of a population often deprived of opportunities to speak about caregiving and care-receiving experiences. It was amazing to hear, feel, and guide the interview process, as each mother brought her own flavor, resilience, fears, and reflections. Initially, the researcher thought that questions about adversity would evoke negative emotions and memories early in the interviews. However, participants did not show or report emotional distress until the end of the interviews, and only after being asked, "How is it to be asked these types of questions?" Perhaps the questions helped participants access and release previously unfelt emotions.

When the researcher asked uncomfortable questions, participants began to unconsciously scratch an area on their bodies. The researcher assumed that this was physiological response activated when participants were asked questions that were new, potentially unfamiliar, and perhaps harmful prior to their ability to further digest. This may have been another demonstration of resiliency, as participants answered questions while attending to present children and competing tasks.

The researcher did not plan this, but the interview tools were arranged in a particular order. This order was likely a result of the researcher's intuitive and professional clinical experiences, and contained the following sequence: demographics, ACE, and then social-support questions. Each tool allowed participants to process and digest information, and then answer questions about their experiences. Participants could thus keep going and trusting the process, even if emotionally triggered, waiting until the end of the interview

to release held and felt emotions and thoughts. Although tools were not used to measure how reflective each mother was in her parenting experience, the researcher could hear and observe each mother reflecting via thoughtful, engaging, and loving storytelling.

What professionals see as "dredging up the bad stuff" did not pertain to this study. The researcher expected initial interview questions to trigger negative emotions. Instead, the mothers characterized their adversities as status quo. They saw and spoke about adversities as something not to dwell on, but to move past. This was amazing to hear, and changed the researcher's perspective as a researcher, student, clinician, and professional working with this population of parents. What we recognize as "problematic" might not hold true for this population. Our "normative" may not be their "normative," and vice versa. Joining together, professionals and mothers alike can ask questions that are deemed important to each individual interviewed. This might allow us to uncover the whole, thick story with greater accuracy, which in turn can help us understand each person's current position and trajectory, simply through dialogue.

The clinician should listen to all sides, avoiding countertransference and personal assumptions. This is especially true when working with underrepresented and under-engaged groups. Denzin (2001) encourages interpreting and joining all sides into a joint experience. This makes one's experience accessible to the reader, who can experience and access the voice and lived experiences of participants, coupled with the interpretation of the researcher.

Each mother in this study was significantly different, yet their messages were similar and can be summarized as follows:

> This is what we want. This is what we do not want. This is what we think is good for us and our children. This is the norm and we don't like it, yet we tolerate it, because this is the way things are.

For the researcher, the most powerful message that came from hearing the mothers' stories is this: Joining participant accounts to create a cohesive narrative of understanding and effort is essential. If a mother knows she can show psychological availability to her child by being aware of her capacity to hold the child's mind and her own mind in reflection— with or without adversity—she can be more aware of her own needs and her child's need for engagement and connectivity in the relational dyad.

Questions must be asked, acknowledged, and listened to if we are to fully understand and encourage the telling of participant stories. In this study, through the dyadic interaction between the researcher and mother, patterns of meaning were developed through told stories (Creswell, 2007). These patterns were then constructed into an overall meaning of each mother's situation.

Hopefully the interviews were an interventive measure. Mothers might find their future parenting experiences enhanced by the study questions and subsequent reflection. For clinicians, instead of fixating on challenges, let us look at how we can build and grow the reflective thinking of African American mothers to restore hope and healing in the parenting process.

The researcher hopes this study will challenge assumptions held by researchers, clinicians, and people in wider society. We cannot properly label experiences within a marginalized population as "adverse" without first engaging with members of the affected population. What society and research deem as "data" on a marginalized

population is often only inference, not gathered via direct contact with population members. In this study, the literature search proved that young-adult African American mothers are not studied enough directly.

This study cannot predict the parenting experience, but it presents preliminary findings on the capacity of parents to think about parenting. Participants demonstrated the competence to grow and increase capacity. Their resiliency does not guarantee that life will be easier, but it can help withstand difficulties.

This research activated unexpected feelings and memories for the researcher. The researcher shares the common story of these young women. By empathizing with the mothers, the researcher understood and interpreted participant experiences that were previously held captive by fear and a lack of permission to share. The researcher too felt captive and resistant to give the full truth, even while compiling results and discussing this dissertation. This resulted from a protectiveness of the mothers' stories, and a desire to avoid any exploitation of their experiences. The researcher felt the need to keep the cultural experiences separate from the rest of the data—to join the participants in protecting cultural challenges and norms that can be difficult to share and hold onto. However, the culture and data are all intertwined.

This study continues to increase the researcher's capacity to be reflective. While interpreting the mother's stories, the researcher underwent a parallel process. She used her social-support network to process the shared stories. This overall experience has been powerful, full, real, and experiential.

The way this study was designed allowed for the concept of reflective functioning to emerge organically in different ways. I asked participants to tell me about their

experiences and their children—to be contemplative (i.e., reflective). In essence, these mothers, in answering the study questions through their narratives, were actually demonstrating their ability to reflect on their children. This lends additional validity to the study's design.

African American people have relied on social supports throughout history. Extended blood-family and non-blood-family relationships comprise the support networks in African American communities. Support is a norm, part of the cultural fabric. It is welcomed and placed on reserve as one grows more independent and can support others.

Support bolsters reflective functioning, which the mothers used to survive adversity and propel themselves forward with purpose. Instead of pathologizing adversities, we can use reflective thinking and dialogues to build mental capacities that restore, heal, help, and instill hope. Ultimately, we can break down both distressed family systems and systems that distress families.

Limitations and Delimitations

This exploratory study examined the effects of adverse childhood experiences on reflective functioning of young-adult African American mothers. It did not consist of a random sample. It sought to include a minimum of 10 young-adult African American mothers who parented toddlers and preschool-age children in the Midwest. The study ultimately captured 11 stories from women who fit the study criteria. These women took an interest in and chose to be part of the study. Perhaps there is something in this self-selection process (e.g., an innate ability for reflection and / or "good enough" caregiving experiences) that influenced the results and evidenced advanced levels of resiliency,

which is contrary to what was expected based on the literature. The study does not reflect the larger population. Therefore, other cultures, races, genders, ages, and experiences are not reflected. The results are not transferable, or generalizable to all young-adult African American mothers who meet the same or similar criteria as described in the study demographics.

Other potential limitations or biases may have come from the researcher's identification as a parent of two young-adult children. Also, the researcher began parenting as a young adult. She recognized the potential challenge of keeping her own biases in check throughout the study process, due to her identification with this race, gender, and parenting situation. Unforeseen memories, thoughts, emotions, and expressions surfaced throughout the process of collecting and analyzing data.

According to Denzin, a researcher is historically and locally situated within the very processes that are being studied. A gendered, historical self is brought to the process. This self, as a set of shifting identities, has its own history with situated practices that define and shape public issues and private troubles related to the study (2001, p. 3). With regard to this study, the researcher inserted her voice in reaction to the following: (a) data collection, (b) overall study experience, and (c) observations to each participant's experience in the interview. The researcher used self-awareness, self-care practices, and her "internal supervisor" (Casement, 1985) to detect potential biases during the study.

The conceptual framework used for this study was reflective functioning. This was used to describe a concept and pattern of acting in a reflective capacity within a relational context of a mother and child. There are numerous conceptual approaches that may have

also been a good fit for this population, topic of interest, and exploration. The researcher was aware that findings would not be generalized to all young-adult mothers or programs due to the use of available sampling.

Suggestions for Future Research

The interview questions provided information and insight to participants, and also provoked emotion. Participants expressed that no one asks them questions that show interest in their lives and the lives of their children. This population deserves more direct, observed research, as opposed to assumptive, or inferred data. Direct contact with specified participants is vital to our work. We make assumptions based on what we think we know and see, rather than directly asking the participants what is helpful and useful, for both them and us.

We also need more African American researchers, in order to decode, interpret, and understand the spoken and unspoken language specific to African Americans. This assures, at least at surface level, a baseline understanding involving culture and race within the research and interpretive process. As an example, the transcriptionist of this study does not identify as African American, and had challenges hearing, understanding, and transcribing words common within African American culture. However, the words were not challenging to understand for the researcher, who does identify as African American. The words could be referred to mostly as African American slang, or cultural words, comfortably used by each participant—and typically used with other African Americans in dialogue, as part of a natural understanding. From a constructivist

viewpoint, researchers understand how their own backgrounds shape their interpretations. They position themselves in the research to acknowledge how their interpretations flow from their own personal, cultural, and historical experiences.

Developmental research, coupled with culturally dynamic concepts, should be further examined. This will give the research community an increased understanding to better distinguish from participant thoughts of "good enough" in caregiving and care-receiving experiences. Researchers or other professionals may offer what they consider a good suggestion, but their own definition of "good enough" might differ from the definition shared by research participants. For example, in this study, what the researcher considered adversity, participants saw as proofs of strength and survival—and as the norm. Participants did not agree with the concept of "adversity" equaling "bad" or "abnormal" in relation to family and community. Participants felt that adverse situations were not stressful—with "stressful" defined by assumptions of this study and the literature. Therefore, parenting expectations imposed on young-adult African American mothers by the larger society may not match the thoughts and experiences of these young women, as told through their own described narratives.

These young women reported several adverse childhood experiences, but they also reported feeling supported and loved by family, friends, and professionals. Perhaps they hold onto this feeling to balance harm done to their psyches. The "held" thought of feeling loved, nurtured, supported, and valued serves as a protective factor. It helps the individual hold things together, safely, in the face of difficult past experiences and associated memories.

Clinical Implications for Social Workers

Many clients, regardless of racial or cultural background, may assume that their experiences are "normal" and relatively unimportant. But once they begin talking about their childhood experiences, they may uncover long-suppressed feelings and thoughts. Often these unconsciously suppressed thoughts and feelings are about traumatic childhood experiences. The experiences of being heard, acknowledged and validated can help a person rethink and rework their narrative. Together with the help of a trained clinical social worker or other professional, the individual can begin to confront previously unexamined patterns of parenting, and to make conscious changes that break destructive patterns.

Clinical social workers often hesitate to ask clients to "open up old wounds," fearing that clients will regress or be re-traumatized. However, this study shows that individuals can be immensely helped and relieved by discussing difficult past experiences. However, it takes training and consultation for clinicians to be able to do this effectively and therapeutically. The more that clinical social workers can be involved in research and training related to traumatized populations, the more we can help those populations improve individually and as a collective.

This study may provide insight into the parent-child relationships among young African American mothers for the following people:

1. Clinicians …
2. Social workers …

3. Psychologists …
4. Counselors …
5. Educators …
6. Infant mental-health specialists …
7. Developmental specialists …

This research may help elucidate whether, and in what ways, adverse early experiences affect mothers' abilities to be emotionally attuned to their children, and whether social supports have any impact. Our goal should be multigenerational healing. Early intervention includes family systems communicating stories and agency systems listening and asking questions. Clinicians need to recognize that evidenced-based interpretations will only be affective if clinicians maintain genuine conversations with the individuals. All too often, “relationship-based work” does not include an actual relationship. It is not enough just to say, “We have the numbers” or, “We have seen our clients.” We must truly hear client voices.

Professionals working with young African American mothers may have an opportunity to model reflection for their clients. This could help young-adult mothers prevent unhealthy patterns that are present in histories of neglect and abuse. Clinicians must look at their own biases as well, while recognizing that clients have their own biases, and a right to experience those biases. In this instance, bias relates to African American culture and its history of feeling unheard and unengaged. These 11 women expressed desire to not pass “this stuff” on to their children. It is important that we, as

clinicians, do not pass “our stuff” onto our clients. Again, genuine conversation helps facilitate the rapport-building process, which in turn promotes reflective connectivity.

The historical maltreatment of African Americans may not be understood by all clinicians. One may interpret the resistance and conflict of these young-adult mothers as opposing agendas of what the mothers say they want and what they display within the parenting experience. Clinicians who do not approach African American populations with curiosity and openness risk being out of tune with African American clients.

Additionally, enhanced knowledge of parent-child relationships and reflective functioning may assist with prevention, intervention, and harm-reduction programming efforts. Understanding if and how adverse experiences affect the parent-child relationship can guide programming with young African American mothers to ensure they are supported to meet their children’s emotional needs. Problems develop when a reactive system interacts with a distressed family system that was already misunderstood from the start. It would be interesting to see if the results from this study would align with results of interviewing involuntary clients who are encouraged to share their stories and who are actively joined in the experience by clinicians.

This would also be a good approach for parents of toddlers, as more developmental strain happens during this stage. Parents could learn to be reflective about the experience of parenting a toddler, while also considering what it may have been like for them as toddlers with and without distressing experiences.

The researcher did not consciously plan to place the research instruments in a sequential order that strengthened the interviewing process, but did so out of intuition.

Therefore, clinical researchers are encouraged to use their intuitive clinical knowledge when conducting research. The three models and concepts work together to both interact and intersect with one another to carry out the questions of the study. The reflective discussion becomes the intervention. It creates expansiveness, flexibility, and release. It encourages and invites connections with people. When we do not allow people to talk, we do not recognize that they have a voice that wants and needs to be heard just as these young adult mothers showed us through their narratives.

Difficulties surround the integration and resolution of African American experiences. Researcher-clinicians can help address these difficulties by fully welcoming African American clients into the therapeutic and professional relationship. The African American experience is painful to discuss for both the client and the African American clinician. However, this study suggests that such discussion can have profound and positive results.

Final Thoughts

This study suggests that adverse childhood experiences, social supports, and reflective functioning are not necessarily connected in the ways one might expect. Adverse childhood experiences may not always have a negative effect on a young mother's reflective-functioning capacity, and if it does, perhaps social-support systems help mitigate the negative impact. The 11 mothers in this study seemed resilient and were determined to not allow adversities to decrease connectivity with their children.

As a clinician conducting and facilitating this study, the researcher has been committed to reflecting on her own experiences. These experiences, coupled with her own thoughts about (a) adverse childhood experiences, (b) support, and (c) reflective capacity helped the women she connected with during the interviews. Since concluding the interviews, it has come to the researcher's attention that normative adverse experiences may be a characteristic of this population of parents.

The level of connectedness experienced during interviews created a boldness and richness that far exceeded counting numbers and acquiring a score. It felt important to listen to stories, feel the energy in the room, hear the undertone of unspoken words, and unpack and interpret shared stories—all in hopes of contextualizing and understanding true meaning from a cultural context.

The researcher intentionally chose a qualitative-based interview approach to fully capture stories in all their thickness. Examining ACE qualitatively has felt meaningful and powerful. The ACE tool asks closed-ended questions to obtain a quick and decisive ACE score. To some degree, this can be helpful. In this interview process, the researcher asked the same questions qualitatively instead of quantitatively. The result was a richer, more thickly described narrative. When asked closed-ended questions to warm up for the interview, most of these mothers answered each question with a simple "no." For example, they did not see themselves fitting within categories for adversity. When asked to describe adverse experiences in a descriptive way, these mothers told stories filled with insight and meaning.

The researcher also experienced “something happening” when asking ACE and support questions. This allowed reflective functioning to facilitate affective experiences throughout the rest of the interview. The researcher, a member of African American culture, had a brief moment of protecting the affective experiences felt and shared during the interview. She knew what she needed to share to complete the study. However, she felt protective of the mothers’ stories and experiences. The researcher feels a rawness regarding protecting the stories of these mothers. This is partially due to the researcher’s experience working with at-risk members of underserved and underrepresented populations. Throughout her career, the researcher has worked with:

1. County agencies …
2. Head Start …
3. Transitional housing programs …
4. School districts …
5. Special-education programs …
6. Government-assisted employment services …
7. Early intervention …
8. State departments …
9. Higher-education institutions …
10. Mental health clinics / institutions …

11. Court systems …

12. Probation systems …

13. City-based lead programs …

14. Emergency departments …

Professionals in all these organizations who service marginalized populations should consider using the sequence of questions in this study, as well as the rapport-building techniques described herein. The researcher suggests that such organizations train workers in reflective functioning and relating. Reflective functioning can be used to talk with people and help them build capacity, to both feel and think about experiences in ways that are tolerable and resolvable. Clinically, we assist people to become more reflective by demonstrating our own reflective capability. In using reflective functioning as the intervention, people can feel more resolute and more capable of formulating their own experiences.

Appendix A

Prescreening Questions / Interview Questions

Prescreening Questions

Participant#: _____ Date: _____

First Name Only: _____ Age: _____ Year of Birth: _____

Race/Ethnicity: (Please check the race/ethnicity you primarily identify with)
_____American Indian or Alaskan Native
_____Black or African American
_____Somali, Ethiopian
_____African
_____Hispanic, Latino, Spanish Origin
_____Middle Eastern
_____White or European
_____Asian
_____Native Hawaiian or Other Pacific Islander
_____Some Other Race, Ethnicity, Or Origin

Language (List primary language spoken in the household): _____

Gender: (Please check the gender you identify with)
_____Female
_____Male
_____Transgender
_____Other (please describe)_____

Relationship Status: (Please check the status you identify with)
_____Married
_____Partnership or Cohabitation
_____Single, Not Married
_____Divorced
_____Widowed
_____Other

Are you a parent: (Please check one, answer the additional questions listed)
_____NO
_____YES If yes, number of Children: total_____ between 1-5_____ Ages _____

Have the 1- 5 year old(s) been under your care for the past 12 months:
_____YES
_____NO

Has your child(ren) ever been removed from your care for any reason:
_____YES if yes, reason_____
_____NO

Does your child/children attend school or programming:
_____YES if yes, where_____
_____NO if no, who is your child with when you are away for any reason: _____

Met the prescreening qualifications to move forward: _____ Yes _____ No
Reason:_____

Date/Time of Interview: _____
Phone: _____ Email:_____

Address: _____

Demographic Questions

Source of Income: (Please check your current employment/academic status)
_____Employed, Full Time
_____Employed, Part Time
_____No Employment, Retired, Unable to work
_____Student, Full Time
_____Student, Part Time
_____Other sources of income:_____

Who lives with you: _____

Where do you live (area, city, state): _____

Where were you born (city, state): _____

Who were you raised by: _____

Have you ever been removed from your parents care as a child or teen:
_____NO
_____YES if yes, reason:
_____
where did you go_____
how old where you_____

Interview Protocol

ACE Questions (Questions adapted from ACE survey http://acestudy.org/survey. Felitti et al., 1998; ACEstudy.org 2011)

Tell me about your relationships with your parents and other adults in the house. How did they treat you?

- Did they ever make disparaging comments, swear at or insult you?
- Did they act in ways that made you feel afraid you'd be hurt by them?
- Did they ever hurt you physically or sexually?
- Did you ever feel that you didn't have enough to eat or clean clothes or that there was no one there to protect you or care for you when you were hurt?

How did you feel about yourself in relation to your family?

- Did you feel loved and important or not valued, nurtured, or special?
- How supportive was your family of you and other family members?
- We're your parents together or divorced/separated and how did that make you feel?
- Did your parents have problems with drugs or alcohol? If so, how did that make you feel and what was life like?
- Was anyone in your family ever incarcerated? If so, how did that make you feel and what was life like?
- Did anyone in your family struggling with mental health or emotional problems? If so, how did that make you feel and what was life like?
- Was there any violence in your home? If so, tell me about it and how it made you feel.

Social Support Questions (Questions adapted from Second Generation 12-Month Social Support Circle. A. Sroufe, Egeland, Byron, Carlson, Elizabeth A., Collins, Andrew W., 2005)

Tell me about your support system. Who would you consider to be a support to you and your child and it what ways are they supportive?

Your Support Network

Person/Relationship	How Much	Activities	How Often
1.			
2.			
3.			
4.			
5.			

Support can include:

Boyfriend/Husband/Partner: _____

Family: _____

Friends: _____

Professionals: _____

Total:
Approximate number helping on a daily basis_____ Total number of support____
Approximate number helping sometimes_____
Approximate number never helping____

What things are you not getting help for that you expected or would like to get help with?
_____
_____

Thinking about the help you receive, how would you describe the help?
_____
From whom could you use more or less? _____
What kinds of help could you use more or less? _____
_____

Thinking about the information and advice you've received, how would you describe the information and advice? _____
From whom could you used more or less? _____
What kinds of information would you like more or less of? _____

Reflective Functioning/Parent-Child Relationship Questions (Adopted from the Parent Development Interview – Revised 2012 Slade, 2012)

View of the Child
When you think of your child what do you think of? (How do you see your child? How would you describe your child to another person? What do you know about your child?)

View of the Relationship
What kind of relationship do you and your child have? (Describe your relationship to a good friend. What kind of connection do you have with your child? What kind of connection would your child say she/he has with you? How do you think the relationship affects your child?)

Affective Experience of Parenting
Who are you as a parent? (As a parent, what is challenging and what is easy? What feelings come up the most for you as a parent? Do you think your child notices your feelings and if so tell me more? Do you ever wish you had somebody to take care of you? When was the last time you felt that way?)

Parent's Family History
When you think about your own childhood, what comes to mind? (What was your relationship like with your mother and father? Did you ever feel rejected or hurt as a child? Tell me about any good or bad memories that come to mind? How are you alike or not like your mother or your father?)

Separation Loss

Tell me about times you and your child were separated from one another? (Tell me about any special people that you wish were in your life and your child's life? Describe the times you felt you were losing a connection with your child and/or with yourself?)

Looking Behind/Looking Ahead

If you had a chance to choose parenting all over again, what would that look like for you and for your child? (Try to think about your child as a grown up, what do you imagine? What do you imagine you would be like as a grandparent?)

Appendix B

Psychotherapy Services

Psychotherapy Services Following Interview:

Here are resources for psychotherapists in the area that have agreed to be available, by appointment only, for further processing of information shared throughout the interview process if needed.

- One, 45-60 minute session, will be provided to you, at no cost to you. Any session thereafter, will be in accordance to your health insurance plan and it's guidelines, or per a financial arrangement made with, and through each individual therapist, and it's agency, for any appointments made beyond the initial consultative 45-60 minute session.

Here are the 3 psychotherapists that have agreed to meet with you at anytime during or following the interview.

Kaye Mason
Psychotherapist
625 Snelling Ave N
Saint Paul, MN 55104
United States
(651) 304-6026

Dr. Willie Winston
Willie Winston & Associates
393 Dunlap Ave N, Ste 825
Saint Paul, MN 55104
(651) 587-6423

Dr. Willie B. Garrett, Ed.D.
WB Garrett Consulting LLC
1711 West Co Rd B 340N
Roseville, Minnesota 55113
(651) 964-4389

Mental Health/Counseling Sliding Scale Fee or Free Counseling Services*

- *Sliding scale or free services are not guaranteed. Each agency has a right to it's own policies, and are not subject to, or obligated, to provide free, or discounted services. All of the listed agencies accept insurance.
- All listed county crisis services will have additional fee based or free counseling resources available to it's county residents.

NAMI (National Alliance on Mental Illness Minnesota)
NAMI Minnesota
800 Transfer Road, #31
Saint Paul, MN 55114
phone: 651-645-2948
toll free: 1-888-NAMI-Helps
(1-888-626-4435)
fax: 651-645-7379
email: namihelps@namimn.org
http://www.namihelps.org
http://www.namihelps.org/Community-Resources-Sept-2011.pdf
Offers resources for all mental health needs and psycho educational information

180 Degrees
236 Clifton Avenue South
Minneapolis, MN 55403
612-813-5000
info@180Degrees.org

SuFamilia Multicultural Counseling
1301 East 7th Street
Saint Paul, MN 55106
Dave.Mathews@180degrees.org
(651) 332-5500

African American Family Center for Healing
2208A East Lake Street
Minneapolis, MN 55407
(651)332-5511

The African American Family Wellness Institute (AAWI) offers culturally specific mental health and family services primarily in the Twin Cities metropolitan area. Unique expertise in serving African American people who live in and/or have grown up in poverty, many of whom have experienced a disproportionately high incidence of trauma and violence. Ask about sliding scale fee.

Thad Wilderson & Associates
475 University Avenue
Saint Paul, MN 55103
(651) 225-8997
Providing therapeutic services to communities of color for over 25 years, predominately African Americans. Counseling services, psychological assessments, and other programming to fit the needs of individuals, families and communities.
Ask about sliding scale fee.

Comunidades Latinas Unidas En Servicio (CLUES)
Minneapolis:
720 East Lake St.
Minneapolis, MN 55407
612-746-3500
St. Paul:
797 E. 7th St.
St. Paul, MN 55106
651-379-4200
www.clues.org
Outpatient community mental health services, including diagnostic assessment, therapy for individuals and families, and support groups for women. They have a sliding fee scale for the uninsured.

Community-University Health Care Center
2001 Bloomington Avenue S. Minneapolis, MN 55404 612-638-0670 for an appointment
www.cuhcc.umn.edu
Individuals, couples, family, and group therapy. Culturally competent diagnostic assessment and medication management. If you have been denied Medical Assistance within the last 6 months, bring the letter of denial in order to apply for the sliding fee scale.

Minnesota Mental Health Clinics
3450 O'Leary Lane
Eagan, MN 55123
651-454-0114
www.mnmentalhealthclinics.com
Mental health services include group therapy, family counseling, psychiatric services for children, adolescents, adults, and biofeedback stress reduction. There are 6 clinic locations. They accept Minnesota Medical Assistance.

Fairview Health Services
2450 Riverside Avenue
Minneapolis, MN 55454
612-672-7272
www.fairview.org
Diagnostic assessment, psychotherapy, case management. Provides therapy for – depression and anxiety, marriage and family problems, and other issues. Multiple sites throughout the metropolitan and surrounding areas; call for more information on the site nearest you. There are a number of programs to assist patients with payment.

Hamm Clinic
408 St. Peter Street Suite 429
St. Paul, MN 55102
651-224-0614
www.hammclinic.org
Non-profit provider offers individual, group, and couples therapy, specialized counseling, mental health evaluation, medication prescription and management. Aims to provide services to the underserved; has a sliding fee based on income and number of dependents.

Indian Health Board
1315 East 24th St.
Minneapolis, MN 55404
Contact: Pam or Reva
612-721-9868
www.indianhealthboard.com
Serves residents of Minneapolis, primarily Native Americans. Outpatient mental health facility provides counseling for individuals, couples, and families, includes anger management, ADHD assessment and testing, walk-in counseling. Also provides education and consultation with community agencies and other professionals. A sliding fee scale is offered to private pay patients based on their income level.

Kente Circle
310 E. 38th St. Suite 209
Minneapolis, MN 55409
612-243-1600
www.kentecircle.com
Clients include individuals, couples, families, and children from various social, economic and spiritual backgrounds. They will accept a number of insurances; when needed, services are provided on a sliding scale fee, which is based on income.

Watercourse Counseling Center
3548 Bryant Avenue S.
Minneapolis, MN 55408
612-822-8227
www.watercoursecounseling.org
Provides individual, family, couples, and group counseling in English, Spanish, and Somali. There are clinics in South and North Minneapolis. They offer a sliding fee option.

Northpoint Health and Wellness Center Behavioral Services
1313 Penn Avenue N.
Minneapolis, MN 55411
612-543-2500
www.northpointhealth.org
Mental health diagnosis and assessment for emotional and behavioral issues; provides counseling for individuals, couples, and families, including mental health aftercare and medication monitoring. If you are a low-income patient, you may be eligible for a reduced fee program.

Catholic Charities
1276 University Ave.
St. Paul, MN 55104
www.cctwincities.org
651-647-3100 main number
651-647-3186 direct line to intake
Therapy and support groups, including couples communication and men's therapy group. Cost is based on a sliding fee scale.

Walk-In Counseling Center (WICC)
2421 Chicago Ave. S.
Minneapolis, MN 55404
612-870-0565
M, W, F: 1-3PM and M-TH: 6:30-8:30PM www.walkin.org
Short-term, face-to-face counseling, and referrals. Services are free.

Neighborhood Involvement Program
Counseling Center
2431 Hennepin Avenue South
Minneapolis, MN 55405
612-374-4601
www.neighborhoodinvolve.org

Services include individual psychotherapy, couples therapy and support groups. Fees are on a sliding scale.

Crisis Response Teams/Urgent Care

Metro Area Mental Health Crisis Response
Anoka: 763-755-3801, Carver/Scott: 952-442-7601
Dakota: 952-891-7171, Washington: 651-777-5222
Ramsey: adults - 651-266-7900, children - 651-266-7878
Hennepin: adults - 612-596-1223, children - 612-348-2233

Urgent Care for Adult Mental Health (Ramsey, Dakota & Washington counties)
402 University Ave. E., St. Paul - Walk-ins Welcome - 651-266-7900, also is a 24/7 Mobile Crisis Team and Crisis Phone Line
Monday - Friday 8:00 a.m. to 9:00 p.m.
Saturday - Sunday 11:00 a.m. to 3:00 p.m.

Appendix C

Recruitment Letter

Seeking Young Adult African American Mothers

Be part of an important research study about Young Adult African American Mothers

- Are you a female African American?
- Are you between 20 and 25 years of age?
- Are you parenting a child between 1 and 5 years of age?

If you answered YES to these questions, you may be eligible to participate in a research study on the Young Adult African American Mothers' experience of parenting and being parented.

The purpose of this research study is to shed light on how young African American mothers, with or without support, who may or may not have had difficult childhoods, understand, connect with, and relate to their own children and help them manage their feelings and behaviors.

The interview will be approximately 2 hours, either in your home or the researcher's office. You choose. You will be asked about your childhood, your support system, and your experience of parenting a child 1-5 years of age. Participants will receive an incentive, $15.00 dollar gift card to Target, for her participation in the study.

The benefits of your participation are: to give you an opportunity to begin the telling of your story, in your voice, as it pertains to what has happened in your life growing up. Your participation may also be helping researchers and professionals in the field better understand what life is like for young adult mothers who share your experiences.

The risks are minimal. However because we will be talking about memories and experiences, it may produce emotions. Your participation will be completely confidential. You will be provide with a list of free/low cost therapeutic services.

This research is being conducted by Sheila Sweeney, PhD Candidate, LICSW, under the direction of Dr. Denise Duval Tsioles, PhD, at the Institute of Clinical Social Work. If you have any questions, need further information or if you would like to volunteer, you can contact Sheila Sweeney at (651) 797-4094 or peacesnpuzsouls@gmail.com.

Appendix D

Consent Form/Transcriptionist Confidentiality Agreement

Institute for Clinical Social Work

Research Information and Consent for Participation in Social Behavioral Research

EXAMINING THE EFFECTS OF ADVERSE CHILDHOOD EXPERIENCES ON REFLECTIVE FUNCTIONING OF YOUNG ADULT AFRICAN AMERICAN MOTHERS

I,_____, acting for myself, agree to take part in the research entitled: Examining The Effects of Adverse Childhood Experiences on Reflective Functioning of young Adult African American Mothers

This work will be carried out by Sheila Sweeney, LICSW, under the supervision of Dr. Denise Tsioles.

This work is conducted under the auspices of the Institute for Clinical Social Work; At Robert Morris Center, 401 South State Street; Suite 822, Chicago, IL 60605; (312) 935-4232.

Purpose

This study aims to shed light on how young African American mothers, with or without support, who have had difficult childhoods, understand, connect with, and relate to their own children and help them manage their feelings and behaviors. The purpose of this narrative study is to explore the reflective capacity of young adult African American mothers who experienced abuse, neglect, inadequate relationships, and/or household dysfunction during early childhood.

Procedures used in the study and duration

The research study will include an initial phone interview to make sure you fit the criteria and are willing to join the study. You will then be interviewed One (1) time for approximately Two (2) hours at your home or the researcher's office. You may choose the location. You will receive a $15 Target Gift Card upon completion of the interview.

Benefits

Participating this study can give you an opportunity to begin the telling of your story, in your voice, as it pertains to what has happened in your life growing up. Your participant may also be helping researchers and professionals in the field better understand what life is like for young adult mothers who share your experiences.

Risks

The risks are minimal. However because we will be talking about memories and experiences, it may bring up emotions. Your participation will be completely confidential. I will provide you with a list of free/low cost therapeutic services in case anything comes up during or after the interview is over.

Costs

You will receive a small gift, $15 Target Gift Card, following the interview to compensate you for your participation.

Privacy and Confidentiality

Your privacy and confidentiality will be safeguarded by using a number to identify you, the identification number will be used in place of your name on all interview documents collected during the research study. All correspondence will be labeled with your number and kept in an individual folder. Using a locked file cabinet drawer dedicated only to the proposed research study will further assure confidentiality. The researcher will be the only one who has access to the locked file cabinet in a locked office. In order to assure privacy, you are being asked to answer the research questions in the privacy of your home or the researcher's office. Your responses will be viewed by the researcher as private and confidential information.

Interviews will be transcribed as soon as it is possible following each interview. Recordings will be destroyed after the researcher has confirmed that all transcriptions are accurate. At the conclusion of the proposed research study, all data will be destroyed using shredding for all written documents and erasing or deleting of all electronic correspondence related to research participant's identifying information. All remaining information and useful information pertaining to the proposed study will be kept in a locked file for the specified amount of time documented by the Institute of Clinical Social Work Institutional Review Board.

Subject Assurances

By signing this consent form, I agree to take part in this study. I have not given up any of my rights or released this institution from responsibility for carelessness.

I may cancel my consent and refuse to continue in this study at any time without penalty or loss of benefits. My relationship with the staff of the Institute for Clinical Social Work will not be affected in any way, now or in the future, if I refuse to take part, or if I begin the study and then withdraw.

If I have any questions about the research methods, I can contact Sheila Sweeney, LICSW at (651) 797-4094 or Dr. Denise Tsioles at (773) 880-1485.

If I have any questions about my rights as a research subject, I may contact Dr. John Ridings, Chair of Institutional Review Board; ICSW; At Robert Morris Center, 401 South State Street; Suite 822, Chicago, IL 60605; (312) 935-4232.

Signatures

I have read this consent form and I agree to take part in this study as it is explained in this consent form.

_____ _____

Signature of Participant Date

I certify that I have explained the research to_____and believe that she does understand and that she has agreed to participate freely. I agree to answer any additional questions when they arise during the research or afterward.

_____ _____

Signature of Researcher Date

Revised 1 Feb 2014

Transcriptionist Confidentiality Agreement

I, _____ transcriptionist, agree to maintain full confidentiality in regards to any and all audio files and documentations received from Sheila Sweeney, LICSW, PhD Candidate at the Institute for Clinical Social Work, related to a research study titled Examining the Effects of Adverse Childhood Experiences on Reflective Functioning of young Adult African American Mothers.

Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual who may be inadvertently revealed during the transcription of voice-recorded interviews, or in any associated documents.

2. To not make copies of any audio files or computerized titles of the transcribed interview texts, unless specifically requested to do so by the researcher, Sheila Sweeney.

3. To store all study-related audio files and materials in a safe, secure location as long as they are in my possession.

4. To return all audio files and study-related materials to Sheila Sweeney in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any back-up devices.

I am aware that I can be held legally responsible for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audio files and / or files to which I will have access.

Transcriber’s name (printed) _____

Transcriber's signature _____

Date:_____

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