



Care of Adolescent Parents and Their Children

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Teen pregnancy and parenting remain important public health issues in the United States and around the world. A significant proportion of teen parents reside with their families of origin, which may positively or negatively affect the family structure. Teen parents, defined as those 15 to 19 years of age, are at high risk for repeat births. Pediatricians can play an important role in the care of adolescent parents and their children. This clinical report updates a previous report on the care of adolescent parents and their children and addresses clinical management specific to this population, including updates on breastfeeding, prenatal management, and adjustments to parenthood. Challenges unique to teen parents and their children are reviewed, along with suggestions for the pediatrician on models for intervention and care.

INTRODUCTION

Adolescent parents and their children represent populations at increased risk for medical, psychological, developmental, and social problems. Pediatricians can play an integral role as the primary care provider for both adolescent parents and their children. This clinical report updates an American Academy of Pediatrics (AAP) clinical report published in 2012.¹ Although the most recent birth rate data from 2017 indicate historically low birth rates for 15- to 19-year-old adolescents and young women in the United States, the rate remains higher than in many other resource-abundant countries.²⁻⁵

BACKGROUND INFORMATION

Epidemiology

Birth rates among adolescents and young women 15 to 19 years of age have declined overall and for each race and ethnicity group in 2017, the year of the most recent available data.^{3,4} Overall teen birth rates were 18.8 per 1000 live births and have declined 51% since 2007 and 67% since 1991, with the greatest decline among 15- to 17-year-olds.⁵ American Indian or Alaskan native teenagers had the highest birth rates (32.9 per

abstract

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1000), followed by Hispanic (28.9 per 1000), Black (27.5 per 1000), and white teenagers (13.2 per 1000).⁴ Repeat birth rates in teen mothers have also declined from 20% in 2004 to 17% in 2016.⁶ This decline is likely attributable to the increase in sexual education and/or increased contraception use among this population over the past 20 years.⁷ Despite the perceptions that teen mothers have high preterm birth rates (10.3%), the highest rates of preterm births occur in women 40 years and older (14.6%). However, among teen births, mothers younger than 17 years are at increased risk of preterm delivery, of delivering low birth weight infants, and of neonatal mortality, compared with older teen mothers.^{8,9}

The Pediatrician's Role

Pediatricians can shape the health of adolescent parents and their children because they are optimally trained to provide comprehensive care for infants, children, and adolescents and they understand the importance of creating a medical home for all patients, including the adolescent parent. The adolescent parent may first present to the pediatrician or adolescent specialist to seek a pregnancy test and options counseling. The AAP policy statement on options counseling provides more detailed recommendations for best practices when discussing positive pregnancy test results with newly pregnant teenagers.¹⁰ Once the adolescent decides to continue with a pregnancy, the pediatrician can advise the pregnant adolescent to start prenatal care from an obstetrician, family physician, or other qualified health care provider.¹¹ It is also optimal for the pregnant adolescent to resume routine pediatric or adolescent care and initiate the care of her future child with the pediatrician with whom she has built a long-lasting relationship.

The pediatrician can play an important role in assessing the social supports of adolescent parents and linking them to proper resources, including transportation, medical insurance, housing, and accessible food.¹² It is also important for the pediatrician to understand the legal rights adolescent parents have regarding decisions for their children. Some states do not allow adolescent parents to make decisions for their children. Pediatricians can research online through the Guttmacher Institute to determine what their state's laws mandate (<https://www.guttmacher.org/state-policy/explore/minors-rights-parents>). Pediatricians may provide information concerning community-based options for social supports to adolescent parents, including school-based programs, community programs, and home visitation programs. There is an association between prenatal and early childhood home visitation programs and reductions in the number of subsequent pregnancies, use of governmental assistance, child abuse and neglect, and criminal behavior in adolescent mothers.^{13,14} Beginning prenatally, home visitation programs can reduce risk of serious antisocial behavior and substance use by children born to adolescents during the first 15 years of life.^{13,14} The Nurse-Family Partnership is an evidence-based program that pairs young first-time mothers with trained nurses beginning in early pregnancy and continuing through the child's second birthday. It is available in many communities (nursefamilypartnership.org) and is one of many community programs that can aid young mothers. Programs such as Head Start and Early Head Start are designed to address the needs of both low-income parents and children.¹⁵ Some health insurance companies offer coordination services during prenatal care, and the provider can encourage pregnant teenagers to access these

support services. Lastly, pediatricians are encouraged to begin early discussions regarding the teen parent's plan to continue and complete her education after giving birth as well as birth control options to prevent rapid repeat pregnancies.

Perceptions of Adolescent Parents

Pervasive negative stereotypes of both adolescent mothers and fathers persist, with society often viewing adolescent mothers as irresponsible, sexually promiscuous, and ambivalent about their future educational and career goals and adolescent fathers as absent from their children's lives and ambivalent toward their children.¹⁶ Although much of the literature is focused on the negative aspects, teen fathers' involvement in the lives of teen mothers and their children can have beneficial effects, such as improved self-esteem of the mothers, decreased maternal postpartum depression, and decreased infant distress in the newborn period, in addition to positive effects on fathers.^{17,18} In cases in which the pregnancy may be a result of coercion or rape, the pediatrician can identify supportive parents or partners during the prenatal and postpartum periods. In other cases, the teenager may have chosen to become a parent because they live in cultures in which it is normative behavior to have children between 16 and 18 years old. Despite the negative perceptions that may persist regarding adolescent parents, it is important to highlight positive aspects and solutions.

Adolescent parenthood can present itself in different ways, such as an adolescent mother with her female partner, an adolescent mother with the father of the infant, an adolescent mother with a male partner who is not the biological father, an adolescent mother with maternal or paternal grandparents, or the adolescent alone. It is important to acknowledge that not all people who will become pregnant identify as

female (such as transgender men) and not all people who contribute sperm that lead to pregnancy identify as men (such as transgender women). In addition, not all adolescent parents are heterosexual, and pregnancies can occur as the result of sexual contact that is consensual, coerced, related to sex work, or in the context of sexual assault. To date, however, the majority of the literature has been focused on adolescent parents who are cisgender and in heterosexual relationships. Although it is critical to continue to explore the varying landscape of adolescent parenthood, for simplicity throughout this report, the term “adolescent mother” is used to describe a young person who experienced a pregnancy and chose to parent a child, and the term “adolescent father” is used to describe a young person who has contributed to a pregnancy as a result of heterosexual sexual contact. Additionally, “partner” will be used to refer to a male or female partner of the adolescent mother. Because this clinical report aims to provide pediatricians with concrete management guidance for the care of the adolescent parent, it is important to dispute these negative stereotypes, concentrate on the positive influences that can aid in decreasing repeat teen pregnancy, and promote healthy behaviors, social supports, and longitudinal educational and career goals to improve adolescent parents’ lives.

MEDICAL MANAGEMENT OF THE ADOLESCENT PARENT AND CHILD

Prenatal Management

Once the pediatrician diagnoses a pregnancy, it is important to provide a timely referral to prenatal care, ideally occurring within the first trimester. There are obstetric providers who have expertise in adolescent pregnancy and in using a medical home model. Timely entry into prenatal care can help reduce

medical complications of teen pregnancy. As the mother approaches the end of the third trimester, the obstetric provider can stress the importance of the postpartum visit and give anticipatory guidance on health insurance options for the mother and infant. The teenager can then be referred back to her primary medical home after the pregnancy (whether this is back to her pediatrician or an adult or family provider). Some health care payers may provide patient navigators to assist the mother in care coordination.

Medical complications associated with adolescent pregnancy include poor maternal weight gain, anemia, and pregnancy-induced hypertension, and these complications are greatest for the youngest adolescents.¹⁹ Poverty, lower educational level, and inadequate family support can contribute to a lack of adequate prenatal care, which may account for most negative health outcomes for both the adolescent mother and her child, including anemia, preeclampsia, poor nutrition, preterm birth, and low birth weight.²⁰

The Prenatal Visit: Meet the Pediatrician

It is optimal for the pregnant teenager, the partner, and a trusted family member to schedule a prenatal visit with the pediatrician during the last trimester. The AAP *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Fourth Edition, outlines the goals of this visit to include assessing family resources, community resources, and parental well-being and discussing breastfeeding decisions.¹² The AAP prenatal visit policy statement advocates that pediatricians meet with mothers during their third trimester to establish and/or reestablish care.²¹ The adolescent mother may not have seen her pediatrician while she was receiving

prenatal care; thus, it is important for her to reconnect with her pediatrician and establish care for herself and her infant. This policy statement discusses the importance of this visit, especially for first-time parents, single parents, and/or women with high-risk pregnancies.²¹ Intent to breastfeed may drive breastfeeding initiation²² and allow for time to attend classes and seek support. The prenatal visit is also an opportunity to meet extended family members who may be assisting in the care of the child. The pediatrician can determine the need for resources, such as child care, transportation, financial support, housing, and food. Additional support systems, including the involvement of the partner and other family members who may be assisting (ie, maternal or paternal grandparents), are important in the care of both the adolescent parents and the child.^{12,21} Although this visit is ideal, we acknowledge that there may be potential barriers to scheduling these visits (ie, time constraints, insurance payment for the visit, etc). When possible, this visit can help transition the mother back to the pediatrician.

The Newborn Visit and Well-Baby Visits

The newborn and subsequent well-baby visits are opportunities for the pediatrician to evaluate the needs of the adolescent mother and other close caregivers.²¹ *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Fourth Edition, recommends pediatricians address family readiness, home life of the newborn infant, and routine infant care.¹² In addition to obtaining a full prenatal history and neonatal course, the pediatrician may obtain a full social history, including maternal wellness, adjustment to new parenthood, and family resources.¹² During these visits, the grandparents may be present to provide support. It is important for the pediatrician to

reinforce that the teen parent is primarily responsible for the care of the infant. The adolescent mother can give explicit permission for the pediatrician to speak with the grandparents about the infant's health care. The pediatrician may use the "meet the pediatrician visit," newborn visit, and the subsequent well-baby visits to discuss contraceptive plans and safe sleep practices, perform psychological and/or depression screening, and ask about educational plans of the mother. Dual appointments for the adolescent parent and child may assist in time constraints to address all these issues.

"Teen-tot" clinics, in which the teenage parent or parents and their children are seen by the same provider at the same appointment, have successfully cared for these families in a patient-centered approach.^{23,24} Brief parenting and/or life skills interventions coupled with these medical appointments improved maternal self-esteem and decreased repeat pregnancy during a 36-month trial study.²⁵

Contraception Management

Approximately 17% of births to adolescents are repeat births.^{5,26} There is a significant relationship between repeat adolescent births and decreased educational achievement, increased dependence on governmental support by the adolescent mother, increased infant mortality, and low birth weight.²⁷ In contrast to adult women experiencing a second pregnancy, adolescents with a repeat pregnancy tend to delay prenatal care.²⁸ A second adolescent birth may have negative effects on the teen mother and her offspring by compounding negative socioeconomic effects and the influence of a short interpregnancy interval. The American College of Obstetricians and Gynecologists recently published recommendations for interpregnancy care, including the following:

interpregnancy intervals shorter than 6 months should be avoided; family-planning counseling should be encouraged during prenatal care visits, with conversations about interest in future childbearing; women at high risk (including adolescents) should be screened for sexually transmitted infections; and the mother should be counseled on safe sex practices.²⁹

Research has revealed that provision of intrauterine devices (IUDs) and implants immediately postpartum is acceptable to teenagers and reduces rapid repeat pregnancies.³⁰ Long-acting reversible contraceptives (LARCs) can be placed immediately after delivery of the placenta (IUD) or before hospital discharge (implants).³⁰ Adolescent mothers who receive IUDs are more likely to continue this form of contraception, with low risk of expulsion.^{30,31} In addition, there is a reduction in repeat pregnancy rates among adolescent mothers who receive immediate postpartum (labor or delivery unit) contraceptive implants compared with those who do not.³² Any LARC implementation before 8 weeks' postpartum is associated with decreased repeat pregnancy rates within 2 years,³³ which demonstrates the importance of LARCs in the postpartum period in reducing short-interval repeat pregnancies. The AAP policy statements on contraception for adolescents and LARCs^{34,35} recommend that pediatricians have a working knowledge of the various types of contraception and be able to counsel adolescent patients on all available methods, including implants and IUDs, which are the most effective reversible methods. After the obstetric postpartum visit, the adolescent mother can choose to return to the pediatrician for primary care. If she is not on a form of birth control at that time, the pediatrician can provide contraceptive counseling to determine the mother's preferred form of contraception. She can then

be referred to an obstetrician or gynecologist or adolescent health care provider if the pediatrician is not comfortable with managing her contraception needs. Pediatricians, in conjunction with obstetric and gynecologic providers, can help improve LARC use by counseling adolescent mothers on the benefit of these contraceptive methods.

Breastfeeding by Adolescent Mothers

The AAP and Centers for Disease Control and Prevention recommend that mothers exclusively breastfeed their infants for the first 6 months of life, followed by continued breastfeeding, after introducing complementary foods, until the infant is 1 year old and beyond, as desired.^{36,37} Adolescent mothers who lack social support and who are at a lower socioeconomic status are less likely to breastfeed compared with older mothers.³⁸ Adolescent mothers who are at a higher socioeconomic status and attend prenatal classes have higher rates of exclusive breastfeeding at the time of hospital discharge.²² Preparation before birth and early breastfeeding support are crucial to successful breastfeeding among adolescent parents.²² Studies have shown early maternal behaviors, such as skin-to-skin contact, are associated with positive breastfeeding decisions and initiation before hospital discharge.³⁹ Breastfeeding education extends the duration of breastfeeding for adolescent mothers.^{40,41} Breastfeeding interventions, including school-based programs, home visits, and telephone support, demonstrate that combining education and lactation counseling yields improved breastfeeding initiation, duration, or exclusivity outcomes.^{42,43} Professional and peer support programs have shown promise in increasing both initiation and duration of breastfeeding but can be resource intensive.⁴⁴ Regular use of a breast pump has also been shown to help continue exclusive

breastfeeding.⁴⁵ Policies for pumping, including appropriate space and break times at school and work, should be encouraged.

Breastfeeding cessation has been related to the lack of parental knowledge of breastfeeding and pain associated with breastfeeding, often a result of improper positioning and attachment to the breast.⁴⁵ The role of the adolescent mother's partner is important because partner involvement in the adolescent mother's life is associated with an increase in breastfeeding.⁴⁶ The pediatrician can inquire about challenges related to breastfeeding and provide supportive counseling to promote breastfeeding success.

Pediatricians can encourage adolescent mothers to breastfeed their infants to improve bonding as well as the cognitive development of their children.

Adjustment to Motherhood

The transition to motherhood for adolescents can be difficult, and common themes and barriers arise in adolescent mothers of all ethnicities.⁴⁷⁻⁵¹ One common theme is coparenting, in which the maternal grandmother or another parent figure helps in the parenting of the child. Studies have shown the most prevalent coparenting, specifically with maternal grandmothers, can have positive effects on adolescent parenting efficacy, social competence, and academic achievement of children.⁵¹ These results may be strongly influenced when the family of origin places high priority on positive family values.⁴⁷

In addition to the adolescent mothers learning successful parenting techniques, such as strong communication and minimal coparenting conflict, it is important for providers to identify the adolescents' readiness for parenthood. Some adolescent mothers do not anticipate the new

responsibilities, and this is reflected in their emotional readiness to parent.⁵⁰ There are screening tools to identify mothers at high risk for nonoptimal parenting and depressive symptoms, such as the Parenting Responsibility and Emotional Preparedness (PREP) screening tool.⁵⁰

Adolescent mothers may also experience low self-esteem during pregnancy and may benefit from social supports to improve parenting efficacy.⁵² The bodily changes of pregnancy may lead to poorer body image, which can lead to poor maternal attitudes and affect the ability to adjust to motherhood during pregnancy and after delivery.⁴⁸ Adolescent mothers can have difficulty accepting their pregnancy, leading them to avoid thinking about their motherhood role during pregnancy and to only intermittently incorporate thoughts of maternal identity during pregnancy.⁵⁰ Despite risk factors, teen mothers can demonstrate resilience and ability to manage their households without the risk of child maltreatment or other adverse effects on their children.⁵³ These findings underscore the importance of supportive families and pediatricians in helping adolescent mothers in their transition to parenthood and self-discovery of their identity as a parent.

Fatherhood

When discussing teen pregnancy, pediatricians may inadvertently overlook the role of the partner of the adolescent mother. Of all pregnancies to adolescent mothers, it is estimated that 18% to 35% of the pregnancies involve fathers younger than 20 years at the time of birth.⁵⁴ A long-standing gender bias related to male adolescents' perspectives on and attitudes toward pregnancy and pregnancy outcomes exists, as most of the research has been focused on female adolescents' perspectives of male adolescents' views. Little

research specifically explores the male adolescent's views directly.⁵⁵

Although much of the attention to adolescent parenting is focused on the mother, the adolescent father's or partner's involvement and commitment in the life of his child is important to the psychosocial development of the child.⁵⁶ The literature defines paternal involvement in terms of a father's engagement, accessibility to the child, and responsibility to the child, in other words, the amount of support from the father to his partner and child.⁵⁷

A number of factors play a role in the father-child dynamic, including the nature of the romantic relationship with the adolescent mother during the pregnancy and after birth, paternal ability to provide and support the family, the father's level of education and socioeconomic status, the father's relationship with his family of origin, and the father's ethnic background, cultural values, and beliefs.⁵⁸ Evidence supports that fathers who remain in a romantic relationship with adolescent mothers are more involved with their children.⁵⁸ The fatherhood relationship between the male adolescent and his child or children is related to the type of relationship he had with his own father. Adolescent fathers who had high conflict with their own fathers are more likely to have signs and symptoms of depression and less engagement with their children.⁵⁹ It is important to encourage positive relationships between adolescent fathers and their children. Social workers, parenting classes, and formal parenting education can be great resources for the adolescent father.⁶⁰ Future research is needed on teen fatherhood because most of the literature on adolescent pregnancy and parenting includes only mothers. Furthermore, adolescent pregnancy prevention programs often target young girls.⁶¹⁻⁶³ The positive

contributions of adolescent fathers have not been well studied. It is important to understand the social and demographic context of adolescent fathers to provide comprehensive support for both parents.

Adolescent fathers are more likely to live in poverty, which often repeats from one generation to the next. Sons of adolescent fathers are more likely to become adolescent fathers compared with sons of older fathers.⁶⁴ In addition, substance use, early adolescent dating, school delinquency, and high physical-risk environment are significant predictors of becoming an adolescent father.⁶⁴ Research has shown that risky sexual behaviors, low educational attainment, and lack of birth control self-efficacy are associated with future fatherhood in male adolescents.⁵⁷ Young adult men who father children with adolescent mothers are also more likely to be impoverished and have lack of contraceptive knowledge.⁶⁵ It is important for adolescent fathers to be aware of contraception methods and engage in conversations with their partners to help decrease repeat pregnancies and the potential for further economic stress. Pediatricians can encourage adolescent fathers to play a central role in their children's lives. If adolescent fathers feel like their parenting role is peripheral or insignificant, they will likely not seek future advice or education around fatherhood topics.⁶⁶ Therefore, it is important for pediatricians to promote equal parenting with adolescent parents and provide community resources to assist in their developing role as parents.

Children of adolescent mothers who continue to have close ties with the child's biological father have better outcomes in employment and education, are less depressed, and are at lower risk of becoming adolescent parents themselves.⁶⁷ Fathers' engagement positively affects the

psychosocial, cognitive, and behavioral outcomes of children, with evidence that cohabitation of the mother and father is associated with less externalizing behavioral problems in their children.⁶⁷ Adolescent or adult fathers who maintain active participation in the prenatal, neonatal, and immediate postpartum processes with adolescent mothers have a greater likelihood of ongoing involvement with their children.⁶⁸ Such interactions include playing with their children, giving them gifts, or feeding them but are less likely to involve diapering, bathing, and caring for the child alone. Conversely, adolescent fathers who exhibit depressive symptoms within the first year of the child's life are more likely to have depressive symptoms within the next 3 to 5 years and have lower paternal involvement.⁶⁹ Depressed fathers read to their children less frequently and are 4 times more likely to spank their children.⁷⁰ Parenting interventions can help teach such skills to adolescent fathers as well as to adolescent mothers. There are several successful adolescent parenting programs that are focused on fatherhood, but it is important for all adolescent parenting programs to engage the adolescent father in his journey of becoming a successful parent.⁷¹

Additional education should be focused on prevention of child abuse because risk factors for abuse include young parental age, low income, and mental health issues,⁷² all of which can be observed in adolescent pregnancies. Because the alleged perpetrator of child abuse is male in the majority of cases,^{73,74} this education should be aimed at including fathers.

Family Support and Management

Family factors associated with improved outcomes for the adolescent mother and her child include early child care provided by

the infant's family of origin, which allows the adolescent mother to focus on positive outlooks during her journey through motherhood.⁷⁵ Adolescent mothers who experience positive health outcomes are more likely to have a positive outlook, set educational goals, and have strong social supports. It is also important for the adolescent mother to develop autonomy from her mother figure to fully adjust to her own motherhood journey.⁷⁶

Management of Mental Health

Adolescent parents encounter multiple competing challenges, including transition to parenthood, complex living situations, and varying relationship dynamics between adolescent parents and the maternal and/or paternal grandparents.⁷⁷ A number of studies suggest that being a teen mother may be related to poorer mental health outcomes, such as mood disorders.⁷⁸ The Pregnancy Risk Assessment Monitoring System (PRAMS) reported approximately 12% of postpartum women of all ages self-reported depressive symptoms in 2012–2013.⁷⁹ Younger parental age (15–24 years) at the time of the birth of the child was associated with a higher risk of maternal depression.⁷⁹ In addition, 3% of fathers experienced postpartum depression within the first year.⁸⁰ Young fathers (15–24 years of age) with no previous history of mood disorders were more likely to experience depression compared with older fathers.⁸⁰ Parental stress during pregnancy and the postpartum period increases the risk of developing postpartum depression, and adolescent mothers with higher parenting stress and parent-child dysfunction scores have higher rates of depression.⁸¹

It is important for pediatricians to be aware of adolescent parents who have previous diagnoses of mental health disorders and refer them back to mental health care during the

postpartum period if they have been lost to follow-up. Research underscores the importance of detecting depression in parents, particularly younger parents, because parental depression is associated with adverse outcomes for children.⁷⁸⁻⁸¹ The AAP recommends integrating postpartum depression surveillance and screening at the prenatal pediatric visit and at the 1-, 2-, 4-, and 6-month well-baby visits.²¹ Both the American College of Obstetricians and Gynecologists and the AAP recommend using a validated tool, but the AAP prioritizes the Edinburgh Postnatal Depression Screen (EPDS) or a 2-question screen, such as the Patient Health Questionnaire 2 (PHQ-2) or EPDS-2. Recent studies have shown the EPDS and its subscales (EPDS-7 and EPDS-2), are accurate screening tools for adolescent mothers.^{21,82} Once an adolescent parent demonstrates symptoms of depression, the pediatrician can refer to or provide treatment. Prevention and treatment of postpartum depression are important in the management of adolescent parents; however, there are few studies that have shown consistent improvement in depressive symptoms.⁸³ Some studies have shown improvements in depressive symptoms with increased therapy use and use of a variety of care management models.⁸³ Further research in the area of prevention and treatment of perinatal depression in adolescent mothers is paramount for health care providers to better serve the mental health of this population.⁸⁴

Pediatricians can also screen adolescent fathers or partners for depressive symptoms. The 2018 AAP clinical report "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" recommends screening the adolescent father or male partner at the 6-month well-baby visit with the EPDS or having

the male partner fill out the screen at home and mail it back.⁸⁵ Pediatricians may find other useful mental health screening tools for primary care settings in the AAP's mental health screening and assessment tools for primary care grid (available at https://downloads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf).

In addition to depression, stress exposures for both the adolescent mother and her partner may affect behavioral and health risks, such as substance use, and have implications for both the pregnant adolescent and her fetus. As with all adolescents, screening for substance use, brief intervention, and referral to treatment (SBIRT) will be even more critical for pregnant adolescents.^{86,87} During the health visits, pediatricians can ascertain information about the history of substance use (including electronic cigarettes and similar devices) in the adolescent parent and any increased risk of child abuse.^{10,12,88} The AAP has additional guidance regarding alcohol, tobacco, and marijuana use during pregnancy.⁸⁹⁻⁹¹ Pregnancy provides opportunities to assist both the mother and partner in reducing stress exposures and to support the pair to change or establish healthier behaviors.⁹²

Intimate Partner Violence

The prevalence of intimate partner violence (IPV) specifically among teen mothers is 7%, compared with 2% in mothers older than 30 years.⁹³ Formal screening for IPV of adolescent parents during pregnancy and in the postpartum period is important. Violence during pregnancy is recognized as a serious public health concern, particularly for those of younger age (12-24 years). In the United States, approximately 27% of female and 11% of male individuals have experienced IPV during their lifetimes.⁹⁴ The National Intimate Partner and Sexual Violence Survey

defines 5 types of IPV, including sexual violence, stalking, physical violence, psychological aggression, and control of reproductive and sexual health. IPV, which can include verbal abuse, assault by a partner or family member, being in a fight or being hurt, or witnessing violence, may increase during pregnancy, with 3% to 19% of pregnant women identified as victims of IPV.⁹⁵ Another form of IPV can be "contraceptive sabotage," in which a partner refuses to allow the female partner to use contraception for pregnancy prevention.⁹⁶ An adolescent mother's own exposure to violence as a child complicates and sometimes normalizes her view of IPV.⁹² Specifically, there is a direct relationship between IPV and the adolescent mothers' childhood violence experiences.⁹⁷ Teen mothers may be reluctant to disclose IPV to their providers and may be more likely to stay with the abusive partner or father of the child so that the father can remain in the life of the child.⁹⁷ Children who witness IPV are more likely to experience child abuse or child mistreatment, especially children born to mothers younger than 21 years.^{98,99} Pediatricians can use multiple screening tools to assess for IPV. Use of universal screening methods is suggested, preferably the use of self-administered surveys versus verbally administered assessment tools.⁹⁴ Examples of self-administered IPV surveys include the Woman Abuse Screening (WAST) Tool¹⁰⁰ and the Hurt, Insulted, Threatened, and Screamed (HITS) Tool.¹⁰¹

Social Determinants of Health

Newer research suggests that social determinants of health strongly influence teen pregnancy. The Centers for Disease Control and Prevention defines social determinants of health as "conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes."¹⁰²

Poverty, a key social determinant of health, greatly affects teen mothers, fathers, and their children.¹⁰³ Within the first year of a child's life, 63% of teen mothers will receive public assistance benefits, and 52% of mothers who receive welfare will have had their first child in their teen years.¹⁰⁴ Poverty also influences rapid repeat pregnancies. Thus, it is ideal for prevention efforts to be expanded from the individual level to the community level, including the social, political, and economic environments in which teenagers live, work, and play. These efforts involve forging partnerships between health care programs and nontraditional groups, such as male mentorship programs and transportation services.¹⁰⁵ A broader focus on the communities where teenagers and their children live, rather than just a focus on individuals, may also assist in decreasing other social disadvantages for teenagers.⁶¹

For many teen parents and their children, poverty plays a key role in the difficult circumstances in which the children are raised. Therefore, focusing on a 2-generational approach to reducing poverty may improve outcomes for low-income families.¹⁰³ This strategy is aimed at helping both low-income children and their parents simultaneously through interventions such as job training for parents while their children attend high-quality child care programs¹⁰³ or addressing risk factors that increase the likelihood of daughters of teen mothers becoming pregnant,⁶² which may decrease the continuation of this cycle. Other programs may be found at <https://www.childwelfare.gov/topics/preventing/promoting/parenting/pregnant-teens/>.

Other social determinants of health for adolescent mothers include high rates of residential mobility, decreased levels of financial support, and limited resources for child care support during the prenatal and

postnatal periods.⁶³ Teen pregnancy is a high-risk period for homelessness as a result of parents kicking out the pregnant teenager or partner conflict or violence.¹⁰⁶ Pediatricians can inquire about housing status or safe shelter and refer the pregnant teenager to social and/or community supports if needed. Teenagers may self-report the need for financial support and job training in the early postpartum period but may have a relatively low use of community resources to meet their needs.⁶³ Further research is needed to determine potential barriers to adolescent parents receiving community resources.

Addressing Toxic Stressors

Adverse childhood experiences may increase lifelong risks for psychological and medical diseases, such as obesity, heart disease, diabetes, and suicidality.¹⁰⁷ To prevent the effects of childhood adversity, models that aim to address both adolescent parents and their children (ie, a 2-generational approach) can be used.¹⁰⁸ This approach includes increasing resources available to adolescent parents and their children, supporting workforce development, and raising awareness of adverse childhood experiences.¹⁰⁹ Directing resources toward schools and early childhood programs may help mitigate risk.¹⁰⁹ Identifying exposure to childhood adversity, focusing on parenting practices, and encouraging return to school may reduce the effects of adversity and promote healthy development.¹⁰⁹ Two types of programs have been shown to improve school completion: multiservice packages with academic and vocational support, case management, and child care provision and attendance-monitoring programs with financial support.¹¹⁰

Assessment of the effects of social disadvantage, such as housing insecurity, neighborhood violence,

and racial discrimination, is important. Capitalizing on teen mothers' strengths and their families' strengths may facilitate intergenerational repair of the effects of childhood adversity on both the mother and the child.¹¹¹

Median block income, low infant birth weight, maternal smoking, maternal childhood history of neglect, IPV perpetrated by either the mother or her partner, and maternal use of mental health services are associated with infant neglect.¹¹² Identifying high-risk families and intervening during the earliest months of life may prevent neglect and the subsequent effects on the child.¹¹² This intervention includes provision of counseling on effective, nonphysical discipline to decrease potential physical and emotional harm to the child.

Cognitive Development of Children Born to Teen Parents

Maternal support can directly affect the cognitive development of children. Children born to adolescent mothers who have low levels of emotional responsiveness and show no maternal support during playtime with their infants are at higher risk of having poorer cognitive and receptive language abilities compared with children born to adult mothers.¹⁵ Conversely, higher levels of maternal support during infantile play may lead to greater gains in both cognitive and language abilities from infancy to age 3 years.¹⁵ Greater resources within the family setting and lower levels of family conflict may enhance developmental gains over time.

Although children of adolescent mothers may have lower school readiness, there are modifiable factors related to higher school readiness, including maternal gains in education, maternal age of at least 18 years, lower rates of postpartum depressive symptoms, and receiving nonparental child care in infancy.¹¹³ The following policy changes may

improve school readiness: Children should attend on-site child care centers with qualified staff while their mothers attend school, and targeted pregnancy prevention services should be provided for school-aged adolescents who have not yet attained a high school diploma.¹¹³

Despite studies showing concern for lowered IQ and long-term intellectual development of children of teen parents,¹¹⁴ there are interventions that may improve cognitive development; specifically, interventions that were shorter in duration, conducted in smaller groups, or placed strong emphasis on the quality of parent-child interactions led to greater gains in cognitive achievement among the children.¹¹⁵

Social Development of Infants

Adverse social developmental outcomes of infants born to adolescent parents are associated with high levels of maternal depression and preterm birth.^{116,117} Increased social support, including social work involvement, home visiting nursing programs, and early intervention programs, positively influences the development of infants of adolescent mothers.¹¹⁷ Head Start and Early Head Start programs support early learning, including social and emotional health realms, physical health, and family well-being for low-income families.¹¹⁸ Comprehensive follow-up and coordinated care services for extremely preterm infants and their adolescent mothers are important.¹¹⁷ Other clinical interventions, such as those focused on coparenting relationships and conflict resolution skills between adolescent mothers and their partners, may improve the social-emotional development of children of teen mothers.¹¹⁹

Teen parents may not be prepared to handle a young child's social-emotional development, and studies

suggest that teaching parents how to play with their children can improve children's vocabulary skills and emotional regulation.¹²⁰ Sit Down and Play¹²¹ and Reach Out and Read¹²² are interventions that pediatricians can integrate into their practices. Sit Down and Play teaches low-income families to make toys for their children and interact with their children in a positive fashion. Promotion of this program may involve partnerships with community resources, such as Parents as Teachers, to facilitate positive parenting behaviors through take-home play activities. The AAP clinical report on the importance of play¹²³ also provides advice for encouraging play for children at high risk. Reach Out and Read promotes child development through strengthened parent-child relationships, advises families on the importance of early literacy and modeling reading together, and provides a new book to children 6 months through 5 years of age during well-child visits.¹²² Additional early literacy resources can be found at <https://www.aap.org/en-us/literacy/Pages/Early-Literacy-Resources.aspx>. Another method to encourage social-emotional development is teaching the 3 T's (tune in, take turns, and talk more) during well-child visits.¹²⁴

Role of the Medical Community

The medical community consists of pediatricians who can have positive effects on teen parents and their children, particularly during the prenatal period. Obstetric providers care for the pregnant adolescent, and other support providers include doulas, who are lay prenatal, childbirth, and postnatal paraprofessionals. Doulas can provide emotional, physical, and social support and information during pregnancy, childbirth, and the postpartum period.¹²⁵

The pediatrician can play an important role in mitigating some

effects of teen pregnancy by encouraging early entry into prenatal care. If the adolescent mother chooses to return to her pediatrician for primary care after the postpartum obstetrical visit, the pediatrician's role can include social and financial supports, educational support, and contraception management in addition to routine adolescent care. The pediatrician may provide anticipatory guidance to strengthen a family's social supports, encouragement for a parent's adoption of positive parenting techniques, and facilitation of a child's emerging social, emotional, and language skills.¹²⁶ Resilience refers to the ability to overcome adversity built through positive experiences and learned coping skills. Primary prevention includes promoting the 7 C's of resilience: competence (knowing that you can handle a situation effectively), confidence (believing in your own abilities), connectedness (developing close ties to family and community), character (developing a solid set of morals and values to determine right from wrong and demonstrating a caring attitude toward others), contribution (realizing that the world is a better place because you are in it), coping (coping effectively with stress), and control (realizing that you can control the outcomes of your decisions).¹²⁷ The pediatrician can also link the family with supports to help promote optimism as well as encourage early learning via programs and provide information on community resources to promote emotional coaching and other positive parenting strategies.^{128,129}

CONCLUSIONS

Teen parents and their children face multiple barriers to optimal development, including negative stereotypes, lack of resources, depression, poverty, lack of support, and lowered educational achievement. Pediatric health care

providers can positively influence the long-term health and lifelong trajectories for teen parents, including young fathers and mothers, and their children by creating a supportive and educational environment.

GUIDANCE FOR THE PEDIATRICIAN

1. Create a patient-centered medical home for adolescent parents and their children. Teen-tot clinics, in which both the adolescent parent or parents and their child complete appointments at the same visit, model this approach.
2. Involve partners and families in the newborn period and infancy, actively supporting their involvement in their children's care.
3. Provide a multidisciplinary and comprehensive approach to caring for parenting adolescents by using community resources, such as doulas, social services, and nurse home visitation programs.
4. Promote breastfeeding initiation and continuation among adolescent mothers by providing lactation resources and encouraging partners and maternal grandmothers to be supportive around breastfeeding.
5. Provide contraceptive counseling during the pre- and postnatal periods in partnership with obstetricians and in subsequent health supervision visits. Offer access to the full range of contraceptive services, including LARCs. Provide adolescent fathers with contraceptive counseling.
6. Use a validated screening tool for assessing postpartum depression in all adolescent parents and refer to mental health resources when indicated.
7. Screen for IPV and provide community resources to address

positive responses from pregnant and parenting adolescents.

8. Emphasize the importance of completing high school and pursuing higher education or vocational training. Advocate for on-site child care in schools or training programs that can facilitate this goal.
9. Recognize all forms of parenting, including coparenting, and support the role of the adolescent father or partner.
10. Advocate for longitudinal, comprehensive solutions that are focused on primary prevention strategies to continue to decrease teen pregnancy rates. Push for funding of programs that support adolescent parents to reduce repeat pregnancies and optimize the health of both parent and child (ie, health care, food assistance, housing, and home visitation programs).
11. Promote low-cost activities with high yield in improving the social and cognitive development of young children, such as play and reading.
12. Recognize that social determinants of health, such as poverty and childhood adversity, contribute to health outcomes for adolescent parents and their children. Provide referrals to community resources to address these needs.
13. Become aware of programs in your community that support pregnant adolescents and adolescent parents.
14. Screen for substance use according to the screening, brief intervention, and referral to treatment (SBIRT) framework and refer to appropriate community resources.
15. Advocate for a 2-generational approach to improving outcomes for the dyad in areas such as poverty, education, and social-emotional development.

16. Coverage of, access to, and coordination of services among medical providers needs to be a priority for payers to assist pregnant and parenting adolescents.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
EPDS: Edinburgh Postnatal Depression Screen
IPV: intimate partner violence
IUD: intrauterine device
LARC: long-acting reversible contraceptive

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