Article

HEALTH EDUCATION & BEHAVIOR

Health Education & Behavior
1–9

DOI: 10.1177/1090198117752785
journals.sagepub.com/home/heb
SAGE

Promoting Resilience: Breaking the Intergenerational Cycle of Adverse Childhood Experiences

Briana A. Woods-Jaeger, PhD[1,2], Bridget Cho, MA[1,3], Chris C. Sexton, PhD, MSW[1], Lauren Slagel, MPH[1], and Kathy Goggin, PhD[1,4]

Abstract

Adverse childhood experiences (ACEs), including trauma exposure, parent mental health problems, and family dysfunction, put children at risk for disrupted brain development and increased risk for later health problems and mortality. These negative effects may be prevented by resilience promoting environments that include protective caregiving relationships. We sought to understand (1) parents' experiences of ACEs, (2) the perceived impact on parenting, (3) protective factors that buffer ACEs potential negative impact, and (4) supports and services that can reduce the number and severity of ACEs and promote resilience among children exposed to early adversity. We conducted in-depth qualitative interviews with 11 low-income, urban parents of young children who had experienced ACEs. Interviews were analyzed for emergent themes and shared with parents from the community to ensure relevance and proper interpretation. Themes from these interviews describe the potential intergenerational cycle of ACEs and key factors that can break that cycle, including parent aspirations to make children's lives better and parent nurturance and support. Parents' suggestions for intervention are also presented. Our findings illuminate protective factors and family strengths that are important to build upon when developing and implementing interventions to promote resilience among parents and children exposed to early adversity. This study benefits from highly ecologically valid data obtained from low–socioeconomic status, racial/ethnic minority parents through one-on-one in-depth interviews and interpreted with the aid of community stakeholders through a community-based participatory research approach.

Keywords

adverse childhood experiences, qualitative research, resilience, trauma

Recent scientific advances have highlighted the role that early childhood experiences play in human development (Fox, Levitt, & Nelson, 2010). Chronic exposure to adverse childhood experiences (ACEs), including abuse, neglect, and household dysfunction can damage long-term physical and mental health (Danese & McEwen, 2012; McEwen, 1998; Shonkoff, 2010). The effects of ACEs on neural circuitry are particularly salient during sensitive developmental periods and highlights the need for effective intervention during infancy and early childhood (Anda et al., 2006; Danese & McEwen, 2012; Fenoglio, Brunson, & Baram, 2006; Hildyard & Wolfe, 2002). Safe, supportive, nurturing environments have been shown to reduce the risk of negative health outcomes associated with ACEs. Thus, enhancing responsive caregiving early in life may promote resilience and support child development among ACE exposed children (Cicchetti, Rogosch, & Toth, 2006; Garner, 2013; Luthar & Brown, 2007; Shonkoff et al., 2012).

Parents with multiple ACEs are at risk for mental health and substance use problems, disrupted social networks, and limited educational attainment (Shonkoff et al., 2012). The weight of these problems combined with the stresses of economic disadvantage make it difficult for families to provide a supportive, nurturing environment for their children, which can lead to an intergenerational cycle of ACEs and chronic stress (Bridgett, Burt, Edwards, & Deater-Deckard, 2015). Nevertheless, many families demonstrate resilience in the face of ACEs (Masten & Monn, 2015). Understanding how the parent–child relationship

[1]Children's Mercy Hospital, Kansas City, MO, USA
[2]University of Missouri Kansas City School of Medicine, Kansas City, MO, USA
[3]University of Kansas, Lawrence, KS, USA
[4]University of Missouri Kansas City Schools of Medicine and Pharmacy, Kansas City, MO, USA

Corresponding Author:
Briana Woods-Jaeger, Children's Mercy Hospital, 2401 Gillham Road, Kansas City, MO 64108, USA.
Email: bwoodsjaeger@cmh.edu

contributes to resilience for children exposed to early adversity is critical to break the intergenerational cycle of early adversity and chronic stress. The present study used a community-based participatory research (CBPR) approach to actively engage low-income, urban parents affected by ACEs in qualitative research with the aims to better understand (1) parents' experiences of ACEs, the perceived impact of these experiences on parenting, and protective factors that buffer ACEs potential negative impact and (2) parent recommended supports and services to reduce the number and severity of ACEs and promote resilience among children exposed to early adversity. To our knowledge, no qualitative research to date has explored these aims with parents who have experienced a high number of ACEs. This study is novel in that it solicits parents' lived experiences in one-on-one, in-depth interviews to produce highly rich, detailed data and employed a CBPR approach that included partnering with community stakeholders in developing study aims, refining interview questions, and ensuring the ecological validity of our interpretation of results. This extends current ACEs and resilience research by identifying and describing community defined and vetted intervention targets and approaches.

Method

Design and Setting

We conducted in-depth, semistructured, one-on-one interviews with 11 low-income parents with histories of ACEs. Participants were parents of children between the ages of 6 weeks and 5 years attending an Early Head Start/Head Start Center. Parent participants were recruited from flyers in the on-site pediatric clinic at the center and during recruitment events where research staff shared information about the study. The local hospital's institutional review board approved all study procedures and materials. This study was developed as part of a larger CBPR study informed by a Community Action Board (CAB) composed of key stakeholders, including parents impacted by ACEs, education and social service providers, health care providers, and community leaders. Over the past three years the CAB has developed a research and action agenda related to preventing toxic stress resulting from ACEs and promoting resilience among children exposed to violence and early adversity. This formative study engaged parents and community stakeholders directly impacted by ACEs in developing research questions, reviewing and refining research methods, interpreting research results, and translating those results into action as well as future research questions. The CAB was crucial in informing study methods (e.g., edits to study recruitment tools for readability and to emphasize confidentiality, content areas of the interview, location of interview and important characteristics of interviewers), interpreting study results, and determining next steps for research and action building from this formative study.

Data Collection

Parents provided informed consent for themselves and assented to their child's participation. Parents answered demographic questions, completed the ACE questionnaire, and participated in semi-structured interviews (see the Supplemental Appendix, available with the article online, for the interview guide). Parent interviews lasted approximately one hour, and were conducted in private rooms at the pediatric clinic in the Early Head Start/Head Start Center. Compensation for completing the interview was $40. All interviews were conducted by the first, second, or third author, who were each trained in qualitative methodology. Interviewers asked all questions as written in the interview guide, and selected generic probes from a list as needed (e.g., "Tell me more about that."). Parents were recruited until saturation was reached with evidence of replication and redundancy in the data and no substantive new information being added (Bowen, 2008).

Qualitative Analysis

All interviews were audio-taped and transcribed verbatim. Interviews were analyzed using a thematic analysis, which informed the following data analytic steps (Braun & Clarke, 2006). First, analysis team members (first, second, and third authors) familiarized themselves with the interviews by reading transcripts and writing memos about conducting and reading interviews. Then, using an inductive approach, analysis team members reviewed the first two transcripts to develop a descriptive coding scheme based on what emerged (Miles & Huberman, 1994). The analysis team met to discuss these preliminary codes and refine, merge, and define to form the initial codebook. After developing the codebook, additional transcripts were coded using Atlas.ti Version 7 by the second author with the initial codebook being continuously revised as needed in consultation with the analysis team. Following the coding process, code reports were generated to identify patterns emerging across transcripts. Patterns were discussed among the analysis team to group each code into broader categories and identify prominent themes. Themes were named and defined in an iterative process informed by member checking. The analysis team engaged community parents to provide guidance on interpreting the themes by presenting results and soliciting feedback during Community Action Board (CAB) meetings; Parent Café meetings, a parent support group at the Early Head Start/Head Start Center; and Parent Committee meetings, a parent group facilitating feedback to the center. The parents engaged in member checking reflected the demographic characteristics of study participants. Parents provided critical insights about concepts that the analytic team could describe more fully based on the data analysis, such as emphasizing parents' strengths as well as challenges. Member checking has been described as the most crucial technique for establishing credibility in qualitative research (Lincoln & Guba, 1985) and guided the interpretation process.

Table 1. Parental Demographic Characteristics (*N* = 11).

Characteristic	*n* or *M* (Range)
Age, years	31.5 (24-58)
Female	10
Race	
Black	7
White	1
Black and White	2
Native Hawaiian/Other Pacific Islander and White	1
Ethnicity	
Non-Hispanic/Latino	11
Highest education level	
Secondary/high school	4
Some college	7
Employment status	
Employed, full-time	2
Employed, part-time	4
Student	1
Unemployed	2
Retired	1
Disabled	2
Living situation	
Living alone	3
Living with a partner, family, or friends	7
Other	1
Number of people in household	4.4 (2-7)
Number of children in household under 18	3.2 (1-6)
Total income	
<$20,000	10
$20,001-$40,000	1

Table 2. Parental Adverse Childhood Experience (ACE) History (*N* = 11).

ACE History	*n* or *M* (Range)
Abuse	
Emotional abuse	6
Physical abuse	5
Sexual abuse	4
Household challenges	
Mother treated violently	4
Household substance abuse	7
Mental illness in household	4
Household member in prison	6
Parental separation or divorce	9
Neglect	
Emotional neglect	7
Physical neglect	2
ACE score	4.9 (2-9)
ACE ≥4	6

Results

Participant demographics are presented in Table 1. The mean parent ACE score was 4.9 (range 2-9) with the break down presented in Table 2. Three major themes emerged from our analysis illustrating the negative effects of ACEs on families that create an intergenerational cycle and protective factors related to parenting (i.e., aspiring to make children's lives better and providing nurturance and support). We present these themes and supporting quotations below along with their relation to parents' intervention recommendations (Table 3). Themes were represented across multiple participant interviews and were supported by a number of quotations; see Table 4.

Theme 1: Intergenerational Cycle of ACEs

Participants described impacts that ACEs can have on individuals and relationships. A parent explained how the psychological effects of ACEs can lead to health behaviors that affect oneself and one's children developing a cycle:

> Just, like, getting stressed out is going to cause you to get depressed, not want to get up out of bed, not want to take care of your kids. I mean, I went through those stages. . . . And then let's say, you know, you're not eating right, well, your kids aren't eating right. Because you aren't eating right. So, it affects everybody. (29-year-old White female, 2 children).

Participants spoke consistently about how their own burden of ACEs affects their children and their parenting behaviors and described the cyclical sequence in which ACEs transfer from one generation. Parents described how a parent's trauma history is passed down to their children through unresolved mental health problems.

> Because I think—I think those—experiences like those, they traumatize the child and then the child still has those issues when they have children. So, it affects their children. (32-year-old Black/White female, 6 children)

Parents gave several examples of how one's ACEs can limit parenting capacities or result in negative, unhealthy expectations for themselves and their children. One parent shared how it can damage a person's perceptions of what is acceptable or normal.

> You know, parents that just—the kids—they know they might have been sexually assaulted, so you know, that's all you know. So when a kid come to you . . . your mama didn't believe you, so you didn't believe your kids, and maybe you believe it but that's all you know, so you think it's okay. Or you know, domestic abuse. You think it's okay, you know? (29-year-old Black female, 4 children)

Parents also described how the experience of ACEs can cross generations due to similar social environments:

> A kid sitting in the window for her whole childhood, looking out the window because it's too dangerous to go outside . . . Yeah. I sat in the window like every single day. Now it's my kids sitting in the window because I'm afraid for them to go outside because it's so bad. (32-year-old Black/White female, 6 children)

Table 3. Recommendations and Supporting Quotes.

Aim 2 results: Intervention recommendations	Quotation	Implication for practice incorporating Aims 1 and 2 results	2Gen Thrive research and action priorities resulting from study findings
Raise awareness about ACEs in the community	"Um, probably the same thing as—just voicing about it and things like that. And letting other moms know that they're not alone and things like that. They don't have to be embarrassed or you know, of things that happened to them." (29-year-old White female, 2 children) "Just by being involved and just being, you know, talking more about it, because you don't hear a lot about it. People try to brush it underneath the rug and say, "Oh, I can handle this," when really it's eating them up inside because I know. I've dealt with it." (29-year-old White female, 2 children) "So I just felt like, you know, if they had more of, uh, a community like how we doing, and be—and—and people was able to talk about it, I think it would—it would change the world a lot." (33-year-old Black female, 5 children) "I mean everything—phone calls, you know, sending mail, you know, in the—in the mail, e-mailing them, you know, catching them in the school, you know, catch them in the church, catch them—you got to go somewhere where you can just go ahead and put it out there." (33-year-old Black female, 5 children)	Reduce stigma about the intergenerational cycle of ACEs and encourage parents to seek support for challenges associated with ACEs by increasing awareness and communication throughout the community.	• 2Gen Thrive ACEs and Toxic Stress Brochure • 2Gen Thrive community forums • 2Gen Thrive speaking engagements and trainings locally, regionally, and nationally
Build and nurture a supportive community	"Good parenting comes from the interaction with other parents. Um, a phone call to another—another parent. . . . I got people that call me, "What happened in the parenting committee . . . I'm committed to, you know, family, so let me draw other families, you know, let them know this family is being, you know, nurtured and on the spiritual level, um, to me. So that's what I strongly agree on, you know, to be able to, um, network." (58-year-old Black male, 3 children) "Our groups here, you can go to counseling, you can get on pills. But you can't really get over your situation unless you can share it with somebody. And it's not the same thing as talking to a therapist. Like, if you're in a group, you can be like, 'Oh, you experienced that? So did I.' You have somebody you can relate to." (32-year-old Black/White female, 6 children) "You know, because some parents like having a thing that, like, parent—other parents that have gone through this having like a little group thing that would, you know, so we could all get together and they might have advice that I've never heard of and I might have advice that they've never heard of. And it's like coming together as parents and learning different things to do would be really neat." (29-year-old White female, 2 children) "Um, a support group . . . where you come in, you tell them your problem, then they give you support." (25-year-old Black female, 4 children)	Develop support groups and create spaces where parents with ACEs histories can come together and share their challenges and factors that have promoted resilience.	• Parent Café intervention
Provide accessible parenting education and support (including mental health treatment for parents)	"Um, just getting out there and speaking about, like, things that—you know, other people have gone through. You know, uh, trying to come together to come up with different coping skills or parenting classes or things like that to help out. Especially like single moms." (29-year-old White female, 2 children) "Um, I would set up the things like they do at [name of Head Start center] but I think if you make parental education a mandatory part of the Head Start program it would literally give our kids a head start." (28-year-old Black female, 1 child)	Implement parenting and adult skill building programs in accessible settings along with opportunities for parents to receive individual therapy.	• DBT Skills for Parents intervention development and implementation research • Incredible Years well-baby intervention development and implementation research

(continued)

Table 3. (continued)

Aim 2 results: Intervention recommendations	Quotation	Implication for practice incorporating Aims 1 and 2 results	2Gen Thrive research and action priorities resulting from study findings
	"Um, not having, like, the proper help about, like, parenting and things like that. Because kids don't come with a handbook. And so, just like not having the proper tools to, you know, take care of your child the right way. Instead of just winging it, is what most parents do is just wing it. So not having tools or things like, enough parenting classes or things like that to help." (29-year-old White female, 2 children)		
	"I learned a lot. I think I—I'm more calmer than probably I—I would be if I didn't, you know, join those groups and go to those classes and, you know, that this is normal, nothing is wrong with my child. That she's going to, you know, she's going to throw temper tantrums. She's going to act out." (26-year-old Black female, 4 children)		
	"And not having the right tools to help me to become a better parent than my parents was is what's really hard. Or getting so stressed out and not having good coping skills to deal with children that, you know, my child gets angry, well it makes me angry, so then we both get angry at each other." (29-year-old White female, 2 children)		
	"I think a lot of people take it as, "Well, you're just trying to tell me what to do. You want my child to be this way." So I think a different approach, like, I want to teach you skills to help you. You know, these skills will benefit you. I don't want—you know, every skill may not work for you, and you'll tweak it in your own way, but you have to get the skill first." (26-year-old Black female, 4 children)		
	". . . We take an incentive to remind the moms to take care of themselves, …. We have the self care for bodies that we do downstairs with Miss XXXX. And while you're sitting there for the self care Friday, you think to yourself, "What am I doing for me? What I am doing, you know, for this?" So it's a very, very, very good thing because that one moment where you take the time to realize like, "I'm falling to pieces," um, that's when you really have to accept that if you fall to pieces, you won't be there for your kids." (28-year-old Black female, 1 child)		
	". . . There's like literally nothing that you could have gave—given me other than therapy. . . . Talking to somebody and someone else validating that I'm not—you know, questions that I'm asking myself are not—I'm not tripping." (25-year-old Black female, 4 children)		
	"Um, see a therapist. So, you know, talking about it. Um, for a long time I blamed, you know, myself on why my biological mother, you know, there were so many thoughts that ran through my head. . . . But, you know, talking to people and realizing, you know, I ain't crazy and something was wrong with her and you know, it's not your fault. But look what—look where you're at now, look what you've accomplished. And you know, yeah—everybody needs a therapist." (26-year-old Black female, 4 children)		

Note. ACE = adverse childhood experience; DBT = dialectical behavioral therapy.

Table 4. Thematic Findings Across Interviews.

Theme/Code	No. of quotes	001	002	003	004	005	006	007	008	009	010	011
Theme 1: Intergenerational cycle of ACEs	33	×	×	×	×	×	×	×	×	×		×
Theme 2: Aspiring to make children's lives better	30	×		×	×	×	×	×	×		×	
Theme 3: Nurturing and supporting children	33	×	×	×	×	×	×	×		×	×	×

Note. ACEs = adverse childhood experiences.

Another parent reflected on the intergenerational cycle and the importance of someone breaking the cycle:

> My mom . . . she got tooken away. Her kids got tooken away. You know? My son got tooken away from me. It's like a cycle. Like I said, my family's a big cycle. It's just horrible. Somebody has to break the cycle. (29-year-old Black female, 4 children)

Parents also discussed the power of learning from one's social environment as a way that an intergenerational cycle may continue:

> I mean, you—you emulate what you see. Um, you only know what you know. And your knowledge, um, as humans is primarily based upon watching each other. You know, we've got the little receptor in our brain—that teaches us to mirror things that we see out in the world. (28-year-old Black female, 1 child)

Overall, the pervasiveness of ACEs in one's childhood and one's social environment both as a child and an adult promote an intergenerational cycle that requires robust protective factors and supports to break.

Theme 2: Aspiring to Make Children's Lives Better

A common response to ACEs was the expressed aspiration for their children to have better lives than they themselves had. Participants consistently referred to their hopes, goals, and motivation to do what was necessary for their children to be safer, happier, and more successful than they were.

> You have parents who want to be parents and parents who just have to be parents. And I wanted to be a parent—but I don't want to just, you know, be a half parent. I want to be the person who dedicates everything so that my kids can have something better for their future not what's—what's easy. (32-year-old Black/White female, 6 children)

One parent described being driven by wanting to avoid mistakes that she felt her own parents made. Another parent explained how she and her partner use their own parents' parenting styles as a guide for what *not* to do with their own children. Overall, the aspiration for their children to have better opportunities and outcomes than they had was one of the most commonly repeated themes throughout the interviews. Parents repeatedly described an unwavering commitment they have to their children.

Theme 3: Nurturing and Supporting Children

Participants discussed a desire to break the intergenerational cycle of ACEs by supporting children's capacities to adapt well and thrive in the face of adversity and described the challenges their own ACEs history created related to this.

Communication, Connection, and Love. Parents talked about how they nurture their children by showing love, communicating openly, spending time together, and meeting children's needs. As one parent said, "Like I said, talking to your children. Listening to them. And spending time with them. Family time, you know?" (29-year-old Black female, 4 children). Other parents reflected on this open communication and expression of love in midst of adversity, "And so just showing them every day that it's going to be okay, we're going to be a family, telling them I love them every day and things like that." (29-year-old White female, 2 children). And one parent specifically discussed providing nurturance in relation to their child experiencing ACEs:

> Even though, like, you are trying to stop this from happening, but it happened anyway. So then that's where the overprotective comes from. Just like, now you never want your kid to do this, and you don't want your kid to do that, but you don't want your kid to just sit there and feel like they can't do nothing now just because this did happen to them. You got to tell them, just like, 'Okay, this happened, but we're never going to let this happen again. So we're going to work together and we're going to keep this—we're going to stay as a family. (24-year-old Black female, 2 children)

In addition to communication, closeness, and love, parents described the importance of preparing their children for the threat of ACEs.

Preparing for the Threat of ACEs. Parents described persistent dangers in the environment, requiring them to prepare for the

threat of ACEs. One parent explained the importance of vigilance to potential threats: "Just I guess just be aware of what you went through. Be aware of what you went through and keep your eyes open for certain signs. So that if you see it, you can prevent it" (32-year-old Black/White Female, 6 children). Parents noted that prevention is not always possible. Another parent described her efforts to be prepared so that she can deal with ACEs if they do occur:

> And so I'm doing all that and I'm taking care of myself so this way if it does happen to my child, I can learn what to do if it—because I can't prevent everything. . . . I can try to stop it, but just learning how to deal with it if my child comes and says this happens to me, then I'm going to know because I've dealt with it. (29-year-old White female, 2 children)

Preparing for the threat of ACEs includes teaching children how to cope with adversity which was described as a way to nurture and prepare their child for future challenges.

Difficulties Related to Providing Nurturance. Participants shared how their personal adversity and trauma history often acted as a barrier to what they saw as effective parenting. For instance, one parent described permissiveness due to past parenting shortcomings:

> Like, for me, parenting out of guilt, the things that I put my children through, I feel like they don't deserve to be put in time out because I feel like they've been punished enough. And so I'm like I—I was to the point where I'd be like just do whatever you want because I felt like I put them through so much they deserved to do whatever they want. That's parenting out of guilt. (29-year-old White female, 2 children)

Parents also described hypervigilance of potential threats to their children due to their personal ACE histories, which can prevent parents from nurturing their child and providing opportunities for optimal development. One parent explained that overprotectiveness stems from distrustfulness learned through parents' own past experiences which can isolate children with the intent to protect them:

> I know just like when things happen to parents it's like maybe they just don't never want their kids to do nothing. Don't never want their kids to go nowhere. Just like always have their kids in their eyesight because they'll never know, like, this happened to me when I was a kid, and you'll never know . . . Like, it's really hard to just trust anybody. (24-year-old Black female, 2 children)

Parents described the importance of nurturing their children and preparing their children for potential threats. However, parents described a potential danger of the goal of preparing children for threat leading to overprotectiveness and isolation.

Recommendations for Intervention to Break the Intergenerational Cycle of ACEs

Parents offered recommendations to break the intergenerational cycle of ACEs. These recommendations included (1) raise awareness about ACEs in the community, (2) build and nurture a supportive community, and (3) provide accessible parenting education and support, including mental health treatment services for parents (see Table 3). Combining these recommendations with the results from Aim 1 of this study has numerous implications for practice and has laid the foundation for our 2Gen Thrive intervention development and implementation research priorities described in Table 3.

Discussion

Our qualitative findings among low-income, predominantly Black parents with significant early life trauma and adversity histories deepen understanding of multigenerational trauma by shedding light on the lived, intergenerational experience of ACEs. Data presented here not only describe the burden of ACEs that manifests in an intergenerational cycle but also highlight the parenting practices and familial strengths that can be mobilized to break the cycle. Resilience promoting factors that emerged from these in-depth interviews include: open-communication, expressions of love, and close family relationships.

Prior qualitative research conducted among mothers with significant trauma histories has highlighted some of the ways in which ACEs affect parenting. In one qualitative study mothers who experienced childhood sexual abuse described parenting as a process of continually "reopening wounds" of painful childhood experiences (Wright, Fopma-Loy, & Oberle, 2012) and commonly expressed doubts about their parenting efficacy. Another study among low-income mothers with trauma histories highlighted parenting challenges, including the use of harsh discipline and coping with parenting stress by taking prolonged periods of time away from their children (Kistin et al., 2014). While our study also illustrates the considerable toll of ACEs on parenting, findings presented here also highlight family strengths including parents' aspirations to make their children's lives better in the context of exposure to chronic stressors and economic deprivation and parents existing responsive caregiving practices. These qualitative findings show the multidimensional, dynamic processes of the intergenerational cycle of ACEs and highlight the need for trauma-informed, accessible parenting interventions that build on parents' inherent wisdom and strengths.

Strengths and Limitations of the Study

Strengths of this study include the use of qualitative techniques that support internal validity, (i.e., semistructured interview guide, audio-recording and verbatim transcription, standardized data coding in Atlas.ti Version 7) and iterative thematic extraction based on research team discussions and member checking with community members (Lincoln & Guba, 1985; Miles & Huberman, 1994). Furthermore, by using a CBPR approach, this study benefited from the influence and active participation of community members in all stages of the research process (Israel, Schulz, Parker, & Becker, 1998). Our partnership with parents has helped us

identify research and action priorities to prevent toxic stress among low-income, minority children in a way that builds on community strengths (Table 3).

Limitations to this study include constraints on its generalizability. It is possible that these findings are somewhat specific to the context of the Early Head Start/Head Start from which participants were recruited. Second, our recruitment includes one man and ten women, precluding generalization of differences between mothers and fathers. Additional qualitative research in other community settings will help to determine the extent to which the resilience promoting factors identified here are present in other communities disproportionately affected by ACEs and how these factors relate to gender.

Implications for Practice

Our findings illuminate protective factors and family strengths that are important to build upon when developing and implementing interventions to promote resilience among children of parents with histories of early adversity and the importance of focusing on breaking the intergenerational cycle of ACEs. Traditional parenting interventions designed to promote parent–child attachment and teach positive discipline approaches tend to be less effective among mothers with histories of trauma (Ammerman et al., 2012; Silverstein et al., 2011) and point to the importance of engaging parents as partners in developing and implementing parenting interventions. Our study found parents want support and are open to parenting interventions particularly those that build on their existing parenting strengths while directly targeting their greatest concerns (intergenerational cycle of ACEs.). It is recommended that health educators and public health professionals partner with parents in the design, development, and implementation of evidence-based parenting interventions to provide culturally responsive, trauma-informed interventions in early childhood.

Future directions include partnering with parents and other caregivers of children at risk for toxic stress to develop, implement, and evaluate parenting interventions that explicitly address parents' ACE histories, including promoting parent mental health, and are accessible to families experiencing numerous chronic stressors. Furthermore, research identifying familial and cultural strengths and examining how to adapt existing evidence-based interventions to incorporate these strengths is critical, particularly in responding to public health issues that are often stigmatized and approached from a deficit framework. Finally, future research examining implementation factors that improve access, reach and sustainability of two-generational, multilevel interventions is needed.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Internal institutional funds.

Supplemental Material

The Supplemental Appendix is available with the article online at http://journals.sagepub.com/home/heb.

References

Ammerman, R. T., Shenk, C. E., Teeters, A. R., Noll, J. G., Putnam, F. W., & Van Ginkel, J. B. (2012). Impact of depression and childhood trauma in mothers receiving home visitation. *Journal of Child and Family Studies*, *21*, 612-625.

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., . . .Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience*, *256*, 174-186.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77-101. doi:10.1191/1478088706qp063oa

Bowen, G. A. (2008). Naturalistic inquiry and the saturation concept: a research note. *Qualitative Research*, *8*, 137-152.

Bridgett, D. J., Burt, N. M., Edwards, E. S., & Deater-Deckard, K. (2015). Intergenerational transmission of self-regulation: A multidisciplinary review and integrative conceptual framework. *Psychological Bulletin*, *141*, 602-654.

Cicchetti, D., Rogosch, F. A., & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology*, *18*, 623-649.

Danese, A., & McEwen, B. S. (2012). Adverse childhood experiences, allostasis, allostatic load, and age-related disease. *Physiology & Behavior*, *106*, 29-39.

Fenoglio, K. A., Brunson, K. L., & Baram, T. Z. (2006). Hippocampal neuroplasticity induced by early-life stress: functional and molecular aspects. *Frontiers in Neuroendocrinology*, *27*, 180-192.

Fox, S. E., Levitt, P., & Nelson, C. A., III. (2010). How the timing and quality of early experiences influence the development of brain architecture. *Child Development*, *81*, 28-40.

Garner, A. S. (2013). Home visiting and the biology of toxic stress: Opportunities to address early childhood adversity. *Pediatrics*, *132*(Suppl. 2), S65-S73.

Hildyard, K. L., & Wolfe, D. A. (2002). Child neglect: Developmental issues and outcomes. *Child Abuse & Neglect*, *26*, 679-695.

Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: assessing partnership approaches to improve public health. *Annual Review of Public Health*, *19*, 173-202.

Kistin, C. J., Radesky, J., Diaz-Linhart, Y., Tompson, M. C., O'Connor, E., & Silverstein, M. (2014). A qualitative study of parenting stress, coping, and discipline approaches among low-income traumatized mothers. *Journal of Developmental and Behavioral Pediatrics*, *35*, 189-196.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Luthar, S. S., & Brown, P. J. (2007). Maximizing resilience through diverse levels of inquiry: Prevailing paradigms, possibilities, and priorities for the future. *Development and Psychopathology*, *19*, 931-955.

Masten, A. S., & Monn, A. R. (2015). Child and family resilience: A call for integrated science, practice, and professional training. *Family Relations*, *64*, 5-21.

McEwen, B. S. (1998). Stress, adaptation, and disease: Allostasis and allostatic load. *Annals of the New York Academy of Sciences*, *840*, 33-44.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. Thousand Oaks, CA: Sage.

Shonkoff, J. P. (2010). Building a new biodevelopmental framework to guide the future of early childhood policy. *Child Development*, *81*, 357-367.

Shonkoff, J. P., Garner, A. S., Siegel, B. S., Dobbins, M. I., Earls, M. F., McGuinn, L., . . . Wegner, L. M. Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, *129*, e232-e246.

Silverstein, M., Feinberg, E., Cabral, H., Linhart, Y. D., Sandler, J., Hegel, M., . . .Beardslee, W. (2011). Potential impact of trauma on the ability to prevent depression among low-income mothers. *Depression and Anxiety*, *28*, 478-484.

Wright, M. O. D., Fopma-Loy, J., & Oberle, K. (2012). In their own words: The experience of mothering as a survivor of childhood sexual abuse. *Development and Psychopathology*, *24*, 537-552.