

# Adverse Childhood Experiences, Poverty, and Parenting Stress

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Adverse childhood experiences (ACEs) are associated with physical and mental health problems in adulthood, as well as unresolved or discordant states of mind regarding attachments that have implications for problematic parenting. Currently, there are no studies on the association between ACEs and adults' subjective experiences of stress in the parenting role, where socioeconomic status (SES)—related poverty effects have been controlled for—the central question behind the current study. We examined exposure to ACEs among 118 mothers ( $n = 33$  low SES/impoverished and  $n = 85$  middle/high SES) and parenting distress. Participants completed an ACE questionnaire that assessed exposure to 10 adverse experiences from childhood (e.g., abuse, neglect, household dysfunction), and the Parenting Stress Index—Short Form. Parenting distress and ACEs were significantly higher in the low SES group; yet, even after controlling for SES, higher ACE scores added significant explained variance in parental distress in a linear regression model. Discussion focuses on the need to administer ACE screening in prenatal and pediatric settings to identify and to offer trauma- and attachment-informed treatment, so to reduce the intergenerational transmission of risk associated with problematic parenting.

*Keywords:* adverse childhood experiences (ACE), parenting stress, poverty, child maltreatment

More than 50 years of literature on attachment theory has shown that early childhood experiences, especially parent–child relationships, influence how adults parent their own children (Bowlby, 1951; Fraiberg, Adelson, & Shapiro, 1975; Grossmann, Grossmann, & Waters, 2005; Main, Kaplan, & Cassidy, 1985; Sroufe, 2005; H. Steele, Steele, & Fonagy, 1996). The transition to parenthood brings potential joys as well as significant challenges (Cowan & Cowan, 1988). Caring for an infant may be especially trying for parents who themselves had difficult childhoods, including abuse, neglect, and household dysfunction. Early attachment experiences, according to attachment theory, shape the development of internal working models or representations of the self and others, guiding

expectations about relationships. When one becomes a parent, he or she has in mind an internal working model of the “self-as-parent.” This representation is, following attachment theory, based on prior childhood experiences of one’s own parents, and corresponding assumptions about one’s own likely behaviour as a parent—including one’s expectations regarding if and how the newborn infant will respond—all play important parts in determining levels of stress experienced in the parenting role. This article sought to determine whether parenting distress increases with exposure to adverse childhood experiences (ACEs)—regardless of socioeconomic status (SES). Furthermore, by using a brief 10-item tool to assess ACEs, we sought to demonstrate that assessment of ACEs was feasible in research and clinic settings to identify parents in need of support.

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 behaviour and consequent child outcomes (Bailey, DeOliveira, Wolfe, Evans, & Hartwick, 2012; Crnic, Gaze, & Hoffman, 2005; Deater-Deckard, 1998; Pereira et al., 2012). The most widely used and previously validated measure of parenting stress is the Parenting Stress Index—Short Form (PSI-SF; Abidin, 1995), which is comprised of three scales that pertain to the parent, to the child and to the parent–child relationship: Parental Distress, Difficult Child, and Parent–Child Dysfunctional Interaction.

Abidin’s (1995) widely used measure of parenting stress has positioned the concept at the forefront of research on developmental psychopathology. Studies link parenting stress to higher likelihood of child maltreatment, as well as more punitive, less re-

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sponsive, and less stimulating parent–child interactions (Whiteside-Mansell et al., 2007). Furthermore, parenting stress in the earliest years predicts internalizing and externalizing behaviours in young children (Bagner et al., 2009). As such, understanding the causes of parenting stress is critical to achieving the goal of reducing child maltreatment and setting children on healthy developmental trajectories.

Previous research from the Adverse Childhood Experiences (ACE) Study has demonstrated that exposure to ACEs in the first 18 years of life is associated with adverse medical and mental health outcomes in adulthood. Some outcomes demonstrated to be associated with ACEs could potentially impinge on parenting. They include depression (Chapman et al., 2004), suicidality (Dube et al., 2001), risk of illicit drug use and HIV sexual risk behaviour (Dube et al., 2003; Meade, Kershaw, Hansen, & Sikkema, 2009), alcohol abuse (Dube, Anda, Felitti, Edwards, & Croft, 2002), heart disease, skeletal fractures, cancer, diabetes, and overall poorer health (Felitti et al., 1998). Findings from the seminal ACE Study showed strong and graded associations between the total number of ACE exposures and these physical and mental health problems across the life span. Additionally, high levels of ACEs are associated with pronounced difficulties in making sense of early childhood experiences that have implications for parenting.

Research on the impact of ACEs and attachment among adults may provide a better understanding of the mechanisms through which problematic parenting may occur. Using a 10-category Adverse Childhood Experiences Questionnaire, Murphy et al. (2014) found that mothers who reported four or more ACEs demonstrated significantly higher rates of unresolved loss or trauma or highly disparate states of mind (cannot classify) in response to the Adult Attachment Interview (AAI; Main, Goldwyn, & Hesse, 2003; Main, Hesse, & Goldwyn, 2008), the gold standard measure of attachment patterns in adults. Interviews classified as unresolved and/or cannot classify show failures in reality testing, dissociation, absorption, rapid shifts in one's emotional stance, and numbing or passivity, and predict the most troubling infant–parent relationships, in which fear and disorganization predominate (Lyons-Ruth & Jacobvitz, 2008; H. Steele et al., 1996; van IJzendoorn, 1995). In parents, these interview-based attachment classifications tend to be associated with higher rates of child maltreatment and more hostile intrusive behaviours (Lyons-Ruth & Jacobvitz, 2008). Thus, a parent's early childhood experiences may indirectly impact parenting; parents' attachment patterns tend to shape both their representations of their children and parenting behaviour, namely, sensitivity and responsiveness (Haft & Slade, 1989; Slade, 2005; van IJzendoorn, 1995). Evidence for the direct impact of ACEs on parenting behaviours includes data on infant spanking and corporal punishment. In a sample of over 100 Black mothers, those who had been exposed to physical and verbal abuse were more likely to report spanking their infants than those who did not have such experiences, and the group who spanked their infants also (not surprisingly) used of corporal punishment as a parenting strategy (Chung et al., 2009).

Other research has explored the relation between parents' own experience of maltreatment and their subsequent parenting styles. Pereira et al. (2012) using the Childhood Trauma Questionnaire (CTQ), which assesses whether adults *feel* they suffered childhood abuse and neglect, found that mothers who reported greater childhood maltreatment were observed to be less sensitive with their

infants, and that this relation was mediated by the parents' level of parenting stress. Using the CTQ, Ammerman et al., (2013) found that childhood trauma had a significant positive association with parenting stress; this relation was mediated by maternal depression and social support through independent pathways. However, Bailey et al. (2012) found that, although childhood maltreatment was associated with parents' lack of confidence as reported on the PSI, there was no association between maltreatment, measured with a form assessing history of maltreatment and trauma based on the work of Toth and Cicchetti (1996), and parenting stress in general.

Thus, there appears to be a need for a validated, brief, easy-to-administer screening tool that measures the number of ACEs experienced by an individual prior to 18 years of age, but that does not inquire into whether and how the respondent *feels* about his or her experiences (an interview can probe most effectively into these questions of meaning). A questionnaire aiming to discover the extent to which an adult has been exposed to adversity should ask specifically about types of abuse and household dysfunction. The ACE Questionnaire (Murphy et al., 2014) is just such a measure.

Given the association between ACEs, attachment, and increased rates of homelessness in adulthood (Herman, Susser, Struening, & Link, 1997), it is also important to consider the impact of both ACEs and poverty on parenting stress alongside each other in order to isolate the possibly distinct influences of ACEs and poverty. Previous research on the impact of poverty on parenting stress has shown that low income is linked specifically to parental distress (Reitman, Currier, & Stickle, 2002; Whiteside-Mansell et al., 2007), but has not drawn connections between SES and other environmental factors, such as childhood maltreatment or trauma exposure. To address this gap, the present study evaluated both ACEs and SES to determine whether ACEs in combination with poverty may independently or additively increase parenting stress. The present study therefore considered the possible additive effect of ACEs, poverty, and clinical levels of parenting stress. This study used the 10-item ACE Questionnaire to explore the following two questions:

1. Do clinical levels of parenting distress, as expected, differ between a low SES, urban clinical sample compared with an urban, middle-class community sample?
2. Does exposure to ACEs lead to significantly increased levels of parenting distress even after controlling for poverty?

## Method

### Participants

Study participants ( $N = 118$ ) were recruited from two samples: a clinical sample of mothers ( $n = 33$ ) from our Group Attachment Based Intervention (Murphy et al., 2014; M. Steele, Murphy, & Steele, 2010) for the prevention of child maltreatment, and a community sample of mothers ( $n = 85$ ) recruited to participate in parent–child attachment research. All respondents provided both AAI and ACE Questionnaire responses. Demographic data for the two samples studied appears in Table 1.

The clinical sample was recruited from GABI participants in the Center for Babies, Toddlers and Families, in the Department of

Table 1  
*Frequencies (and Percentages) for Social Demographic Characteristics (N = 118)*

Characteristics	Community sample (n = 85)	Clinical sample (n = 33)
Age (years)		
19–34	26 (31)	18 (55)
35–49	41 (48)	13 (39)
50+	0 (0)	1 (3)
Did not report	18 (21)	1 (3)
Ethnicity		
White	42 (49)	4 (12)
Black/African American	5 (6)	9 (27)
Hispanic/Latina	10 (12)	17 (55)
Asian/Pacific Islander	4 (5)	0 (0)
Did not report	24 (28)	2 (6)
Income level		
Under \$30,000	0 (0)	33 (100)
\$30,000 or more	72 (85)	0 (0)
Did not report	13 (15)	0 (0)
Marital status		
Single	3 (4)	20 (61)
Married	43 (51)	5 (15)
Cohabiting	1 (1)	5 (15)
Divorced/separated	2 (2)	0 (0)
Did not report	39 (46)	3 (9)
Employment status		
Not employed	18 (21)	26 (79)
Employed	39 (46)	1 (3)
Student	4 (5)	2 (6)
Did not report	24 (28)	4 (12)
Reporting > 4 ACEs	21 (25)	26 (79)
Reporting clinical levels of parenting stress	12 (14)	23 (70)

Note. ACE = adverse childhood experience.

Pediatrics at Albert Einstein College of Medicine, Bronx, New York. Families are referred to GABI from pediatric screenings (Briggs, Racine, & Chinitz, 2007) and/or child welfare agencies when there is a concern regarding the “parent’s ability to meet their child’s emotional needs” (Murphy et al., 2014; M. Steele et al., 2010, p. 3). Referrals are typically made when concerns about the parent–child relationship are linked to the parent’s own childhood history of loss and trauma, loss of custody of previous children, family’s exposure to trauma, and/or potential risk for child neglect and abuse. The poverty group of mothers came from this GABI clinical pilot sample (M. Steele et al., 2010). The community sample, the middle/high SES group, also from New York City, was recruited using postings on electronic listservs, flyers in local schools and daycare centers, and word of mouth. Assessments were conducted at the Center for Attachment Research, New School for Social Research, New York, New York.

Institutional review board approval for the study was obtained both from the New School for Social Research and from Albert Einstein College of Medicine. Clinical sample participants were given \$25 and a metro card to enable train travel to/from the research lab. Funding for the work came from Einstein–Montefiore Institute for Clinical and Translational Research.

## Measures

**ACE Questionnaire.** The ACE Study was a large epidemiological study of adults using a cohort from the Kaiser Permanente

managed care health group in California. The study showed the long-term deleterious physical and mental health effects of child maltreatment (Dube et al., 2003; Felitti et al., 1998). The ACE Study questionnaire (Dube et al., 2003; Felitti et al., 1998) was adapted and used to assess retrospectively forms of abuse, neglect, and household dysfunction in the current study. Scores range from 0–10, with the latter representing full exposure, at some point in the first 18 years of life, to all 10 forms of household dysfunction and abuse detailed in the questionnaire and summarized below.

**Abuse variables.** Emotional abuse was defined by two questions from the Conflict Tactics Scale (CTS; Straus, 1979): “Sometimes parents or other adults hurt children. While you were growing up, that is, in your first 18 years of life, how often did a parent, stepparent, or adult living in your home (1) swear at you, insult you, or put you down? (2) act in a way that made you afraid that you might be physically hurt?” Responses of *often* or *very often* to the first question and/or responses of *sometimes*, *often*, or *very often* to the second question contributed to a binary score (yes) for exposure to emotional abuse in childhood.

Physical abuse was similarly defined by two questions from the CTS (Straus, 1979): “While you were growing up, that is, during your first 18 years of life, how often did a parent, step-parent, or other adult in your home actually (1) push, grab, slap, or throw something at you? (2) hit you so hard that you had marks or were injured?” Responses of *sometimes*, *often*, or *very often* to Question 1 and/or *once/twice*, *sometimes*, *often* or *very often* to Question 2 contributed to a binary (yes) score for exposure to physical abuse during childhood.

Sexual abuse was determined by four questions from Wyatt (1985):

“Some people, while they are growing up in their first 18 years of life, had a sexual experience with an adult or someone at least 5 years older than themselves. These experiences may have involved a relative, family friend, or stranger. During your first 18 years of life, did an adult, relative, family friend, or stranger ever (1) touch or fondle your body in a sexual way, (2) have you touch their body in a sexual way, (3) attempt to have any type of sexual intercourse with you (oral, anal, or vaginal), or (4) actually have any type of sexual intercourse with you (oral, anal, or vaginal)?”

Answering yes to any of the four questions defined sexual abuse.

**Neglect variables.** For physical neglect, three items from the CTQ (Bernstein et al., 1994); were used: “While you were growing up, how true were each of the following statements? (1) You did not have enough to eat, (2) You had to wear dirty clothes, (3) There was someone to take you to the doctor if you needed it, and (4) Your parents were too drunk or high to take care of the family.” Responses of *sometimes*, *often*, or *very often* to the first, second, or fourth question, and/or *never*, *once/twice*, or *sometimes* to the third question determined physical neglect.

**Household dysfunction variables.** Witnessing domestic violence (battered mother) was assessed using four questions from the CTS (Straus, 1979): “Sometimes physical blows occur between parents. How often did your father (or stepfather) or mother’s boyfriend do any of these things to your mother (or stepmother)? (1) Push, grab, slap, or throw something at her, (2) kick, bite, hit her with a fist, or hit her with something hard, (3) repeatedly hit her for over at least a few minutes, or (4) threaten her with a knife

or gun, or use a knife or gun to hurt her.” A response of *sometimes*, *often*, or *very often* to Question 1 or 2, or any response other than *never* to either the Question 3 or 4 defined exposure to domestic violence.

A response of yes to the question, “Were your parents ever separated or divorced?” defined parental separation or divorce (Dube et al., 2003). Mental illness in the household was defined by answering yes to either one or both of the following: (a) “Was anyone in your household mentally ill or depressed?” (b) “Did anyone attempt to commit suicide?” (Felitti et al., 1998).

Similarly, substance abuse in the household was defined by two questions (Schoenborn, 1991): “During your first 18 years of life did you ever live with anyone who was a problem drinker or alcoholic?” or “used street drugs?” A yes response to either question determined childhood exposure to substance abuse. An incarcerated household member (Felitti et al., 1998) was defined by a response of *once/twice*, *sometimes*, *often*, or *very often* to the question: “Did anyone in your household go to prison?”

**Test-retest reliability.** Because ACEs provide retrospective reports of one’s ACEs, assessment of validity is challenging. However, the ability to establish test–retest reliability of the ACE measures provides indication that the measures will lead to stable responses over time. Once an adverse experience, such as abuse or exposure to alcoholic parent, has occurred, it cannot be changed or removed. Therefore, in the absence of substantiation and validation of maltreatment, the best psychometric property that can be used in retrospective self-reported exposures is test–retest reliability. Dube et al. (2003) found that the retrospective reports of ACEs had good-to-excellent test–retest reliability. In addition, the measures used to assess ACEs were highly interrelated, and greater exposure to ACEs has been repeatedly correlated with adverse adult health outcomes (Dong, Anda, Dube, Giles, & Felitti, 2003; Dube et al., 2003).

**Parenting Stress Index–Short Form.** The PSI-SF (Abidin, 1995) is a 36-item self-report measure assessing the level of stress experienced in parenting. The PSI-SF provides a Total Stress score based on the sum of three subscales that assess different components of parenting stress related to the parent, the child, and the relationship: Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child. The PSI-SF has adequate internal reliability (Abidin, 1995; Anthony et al., 2005; Reitman, Currier, & Stickle, 2002) and retest reliability (Abidin, 1995; Haskett, Ahern, Ward, & Allaire, 2006).

For the current study, we relied on the Total Stress score, which is based on the three 12-item PSI subscales, which have 5-point scale response categories. This Total Stress score is used to identify those parents in the clinical range (at or above a raw score of 82) in order to report on this clinical outcome in Table 1. Regression results were based on using the Parental Distress subscale as the dependent variable, commonly considered the most revealing aspect of the PSI scores, with all questions directly tapping into stress experienced by the parent.

## Results

We organized results into two sections: (a) demographics of the two samples and (b) inferential results predicting parenting distress from ACEs after controlling for SES/poverty.

Table 1 shows the demographic data and study variable statistics for the mothers from the clinical and the community-based samples. Table 1 reveals that there was more ethnic diversity in the clinical group. The most striking difference between the groups related to income: All participants in the clinical group earned less than \$30,000 annually, placing them in poverty, compared with the community group in which all participants indicated income either higher or considerably higher than this poverty threshold (some in the community group did not answer this question). We therefore refer to the two groups as the poverty and the middle-income groups. Most notably, in Table 1 (bottom), 70% (23 of 33) of mothers in the poverty group reported clinical levels of parenting stress while only 14% (12 of 85) of the middle-income group reported this level of parenting stress,  $\chi^2(1) = 35.20, p < .001$ . Table 1 presents the threshold of four or more ACEs, and the clinical level of parenting stress, for illustrative purposes because so much prior published research has relied on these thresholds. Table 1 also indicates that the poverty and the middle-income groups differed significantly in terms of their exposure to four or more ACEs, with 25% (21 of 85) of the middle-income group in this high ACE group and 79% (26 of 33) of the poverty group of mothers in this high ACE group. Table 2 relies on the dimensional scoring of parenting stress and ACEs to maximize power for the standard linear regression model used to test the main study hypothesis that, even after controlling for SES, exposure to ACEs leads to parenting stress.

To test the study’s main hypothesis, a linear regression was computed with Parenting Distress subscale as the dependent (outcome) variable, and mothers’ ACE scores were entered as the predictor variable, after controlling for SES. These results are shown in Table 2.

As Table 2 reveals, with Parenting Distress as the dependent variable, at the first step SES/poverty was entered with a resulting  $F(1, 116)$  value of 38.3 ( $p < .001$ ), and 25% of the variance in parenting stress was explained. Table 2 also shows that, at the second step, mothers’ exposure to ACEs was entered,  $F(1, 115)$  change = 9.9,  $p < .002$ , with 31% of the variance in parenting stress explained ( $\Delta R^2 = 6\%$ ).

Not shown in Table 2, but relevant to the claim that ACEs may carry independent significant weight in predicting parenting distress after taking into account poverty, the correlations were significant between all pairs of variables. At the level of direct (Pearson) correlation, parent distress and SES/poverty were sig-

Table 2  
Summary of Linear Regression Results Modeling Influences on Parenting Distress From SES/Poverty and Exposure to Adverse Childhood Experiences in the First 18 Years of Life

Variable	B coeff	SE	$\beta$	<i>t</i>	$\Delta R^2$
Step 1					
SES/poverty	10.22	1.65	.50	6.19**	25%
Step 2					
SES/poverty	6.48	1.99	.32	3.26*	
ACEs	0.93	0.30	.31	3.15*	6%

Note.  $R^2 = 31\%$  at Step 2. ACE = adverse childhood experience; coeff = coefficient; SES = socioeconomic status.

\* $p < .01$ . \*\* $p < .001$ .

nificantly correlated ( $r = .50$ ), with both parent distress and ACEs ( $r = .49$ ) and ACEs and SES/poverty also correlating significantly ( $r = .60$ ). Thus, the regression model in Table 2 indicates that, even after controlling for the link between SES and parenting distress, exposure to ACEs in the first 18 years of life carries an independent significant influence.

## Discussion

ACEs are a risk factor for the intergenerational transmission of unhealthy parent–child attachments. The current study provides further support for use of a 25-item, 10 category questionnaire that measures parents' exposure to household dysfunction and abuse in their first 18 years of life (Murphy et al., 2014). That is, maternal report of exposure to ACEs during childhood is significantly associated with parental stress, even after controlling for poverty and being at-risk (i.e., clinical sample). The data indicated that, beyond the significant influences of poverty and clinical status, exposure to ACEs significantly contributed to mothers' reports of stress in the parenting role. Given long established links between parenting stress and adverse child outcomes, including lack of school readiness and child behavior problems, identifying significant correlates between ACEs and parent distress – as the current results do – could promote early identification of parents (and children) at risk who are most in need of support from health care providers. As John Bowlby (1951) never hesitated to suggest: “a society that values its children must cherish their parents” (p. 84).

It is not surprising that the data showed low levels of parenting stress among the middle-income (middle/high SES) community group, with significantly higher levels among the impoverished clinical group. Mounting evidence has documented income-related health disparities. For low SES parents, the stress of living in poverty creates worry about having resources to sustain family life. The data in the study have also demonstrated that, beyond the powerful influence of low SES on parenting distress, exposure to adverse childhood experiences makes an independent contribution to parenting distress. In other words, both lower income and wealthy parents may be carrying a burden of adverse childhood experiences and this alone may lead to parenting stress.

In our sample, poverty and adversity during childhood were highly comorbid. Yet, we cannot assume an isomorphic link between poverty and high ACE exposure, because we did not include in the present research a lower income nonclinical comparison group. But the observation that high ACE exposure impacted even the middle-income nonclinical group is chastening. ACE exposure, no matter what the family's ethnic or economic profile, is a risk factor for parenting in the next generation. In other words, while poverty makes parenting more stressful, ACEs add to that burden significantly, and lead to parenting stress even among well-resourced middle/high SES parents.

These results are consistent with previous findings, that have shown childhood exposure to trauma and poverty each predict higher parenting stress (Ammerman et al., 2013; Pereira et al., 2012). Yet, these are the first data to explore this relation using the ACE Questionnaire (Murphy et al., 2014), which was developed based on the seminal ACE Study, in consult with Shanta Dube, and identifies exposure to 10 different categories of adverse childhood experiences. The landmark 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 (Dube et al., 2001; Dube et al., 2002; Dube et al., 2003). Together with findings that have shown a threshold of four or more ACEs is significantly associated with unresolved states of mind with regard to attachment (Murphy et al., 2014), the results of this study provide further evidence for the impact that adverse childhood experiences have on adults' experiences of parenting.

This study has several limitations. Our community sample lacked a low SES nonclinical comparison group. Also, with respect to the middle SES comparison group studied, information on how many of these parents overcame poverty in childhood was not available to the research team. Across the SES spectrum, it is important to recognise that not all adults who experienced child maltreatment have high levels of parenting stress. Similarly, the present research did not examine how individual characteristics of the parent or child, such as personality or temperament, interact with past and present ecological factors to influence stress. The present study also could not take account of ongoing exposure to trauma in adulthood or other current stressors, aside from poverty, which may impact parenting stress. The contribution of racial discrimination to anxiety, stress, and feelings of self-efficacy, both in general and in the parenting role, would be an important factor to consider in ongoing work of the kind begun with this study, with its restricted focus on the impact of ACEs on parenting stress.

Despite these limitations, the present study provides further validation of the ACE Questionnaire initially validated by way of convergent validity with the AAI unresolved/can't classify (CC) disorganized status (Murphy et al., 2014). Thus the current results contribute to the body of evidence supporting greater and wider screening for ACEs in prenatal and pediatric services in order to identify risk factors for problematic parenting. This would permit the targeting of therapeutic trauma- and attachment-informed services to stem the intergenerational transmission of household dysfunction and abuse in the next generation. For example, parents scoring above the well-known threshold of ACEs (e.g., 4 of 10), known to put the individual at high risk for all range of adverse health outcomes, may be invited to participate in an AAI (Main et al., 2003; Main et al., 2008) so that a helping professional may gain insights into the meaning ACEs have for the parent and, therefore, be able to recommend an attachment-based intervention to best suit the parent's (and child's) needs. This may take the form of a group intervention (e.g., Murphy et al., 2015) or a range of tested individual interventions, clinic- and home-based, often focusing on improving the parent's reflective functioning and so his or her parenting (Slade, 2005). In any case, reliance on the ACE Questionnaire should be thought of as a valuable screening tool, permitting health professionals working with parents to know who is most at risk, or who is most in need of close observation and support. The attachment-informed clinician, with relevant training (Bowlby, 1988), will know how best to proceed in the interest of the parent, his or her child, and the wider family.

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## Résumé

Les expériences négatives durant l'enfance (ENE) sont associées à des problèmes de santé physique et mentale à l'âge adulte, ainsi qu'à des états d'esprit non résolus ou discordants au sujet de l'attachement qui ont des répercussions néfastes sur les comportements des parents. Actuellement, il n'existe aucune étude sur la

relation entre les ENE et les expériences subjectives d'adultes sur le plan du stress parental, dans laquelle la pauvreté reliée au statut socioéconomique (SSE) a été contrôlée, d'où le principal objectif de la présente étude. Nous avons examiné la présence d'ENE parmi 118 mères ( $n = 33$  SSE faible ou appauvri, et  $n = 85$  SSE moyen ou élevé) ainsi que la détresse suscitée par leur rôle de parent. Les participantes ont répondu à un questionnaire sur les ENE évaluant l'exposition à 10 expériences négatives durant l'enfance (par ex., abus, négligence, foyer dysfonctionnel), ainsi qu'au Parenting Stress Index\_Short Form. La détresse liée au parentage et les ENE étaient, de façon significative, plus fréquentes parmi le groupe du SSE faible. Toutefois, même après avoir contrôlé le SSE, dans un modèle de régression linéaire, les scores d'ENE ajoutaient des variations significatives expliquées dans la détresse des parents. La discussion des résultats porte sur le besoin d'administrer des tests pour déceler les ENE dans les milieux prénataux et pédiatriques en vue de repérer les traumatismes et d'offrir des traitements axés sur l'attachement, dans le but de réduire la transmission intergénérationnelle de risques associés au parentage déficient.

**Mots-clés :** expériences négatives durant l'enfance, stress parental, pauvreté, violence envers les enfants.

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