What are the social, economic and health outcomes of young parenthood for mothers, fathers and their children? What are the mechanisms through which these consequences arise? Researchers from the University of Southampton addressed these questions using innovative statistical techniques to analyse data from two large-scale longitudinal surveys. Their analysis took account of the tendency for young parents to come from disadvantaged backgrounds.
Key Findings

- Teenage parenthood continues to be a marker for social disadvantage. Amongst mothers, individual attributes measured in childhood, such as having a conduct disorder, having poor reading ability, and having a mother with low educational aspirations, increased the likelihood of teenage motherhood. This was over and above the effect of coming from a poorer background. Analysis amongst young fathers revealed generally similar factors, although these appeared to have a smaller effect.

- At age 30, those who had been teenage mothers suffered from higher levels of physical and mental ill health and only a small part of this difference could be explained by their disadvantaged backgrounds. Higher levels of partnership breakdown and a greater risk for teenage mothers to be in a workless family appeared to be the main cause. A greater likelihood of living in social housing, of being dissatisfied with their neighbourhood, and lacking emotional support also appeared to contribute.

- A higher risk of maternal anxiety and depression was associated most strongly with the lack of a co-residential partner and with poorer housing.

Background

Tackling teenage pregnancy is central to the Government’s work to prevent health inequalities, child poverty and social exclusion. This research had two key aims: to assess, over the medium to long term, the consequences of teenage births for mothers, fathers and children, and to use the results of this analysis to identify pathways by which the negative impact of teenage childbearing could potentially be minimised. This research updates earlier work on teenage mothers and fills in gaps in our knowledge by looking at outcomes for young fathers and for children born to teenage mothers during the early 1990s. The approach taken sees teenage childbearing as a result of a complex series of individual, family and societal factors. Consequences of early parenthood depend on these factors and on mediating factors (e.g. the presence of a co-residential partner, the mother’s mental health, levels of social support, financial circumstances) following the birth.
About the study

The study involved the secondary analysis of two data sets. The first used data from the 1970 British Birth Cohort Study (BCS70), following up around 15,000 individuals born in one week in April 1970, to investigate outcomes for young mothers and fathers. The second, the Avon Longitudinal Study of Parents and Children (ALSPAC) provided data from around 10,000 mothers and their children living in the Avon/Bristol area. The children were all born in 1991/92 and the latest available data were for children aged up to 42 months.

This study’s main aim was to elucidate the mechanisms whereby young parenthood is associated with poor outcomes, rather than quantify the absolute impact of young parenthood. Using the statistical techniques of graphical chain modelling and structural equation modelling, ‘path models’ were created to illustrate the complex ways in which the antecedents and consequences of teenage motherhood influence its impact. Teenage mothers were defined as 19 years and younger, whilst young fathers, were defined as 22 years and younger, since the majority of fathers of babies born to teenage mothers are older than the women themselves.

Findings

Who becomes a young mother and father?

As in previous studies, growing up in disadvantaged circumstances (for example, living in social housing and in low income households) was a predictor of young parenthood. In addition, individual childhood attributes such as poor reading ability, having a conduct disorder and having a mother with low educational aspirations for her child were also significant predictors among the 1970 cohort. The effects of the five factors found from statistical modelling to have the largest impact on the risk of teenage parenthood are shown in Figure 1.

These five factors (own mother was teenage mother, low social class of parents plus conduct disorder, poor reading or in social housing all at age 10) combined to increase the probability of having a teen birth from 1%, when none of these risk factors was present, to 31% when all five were present. In males they increased the probability of being a father at age 22 or under from 2% to 23%.

![Figure 1: Predicted probabilities of becoming a teenage (<20) mother and a young (<23) father according to the presence of risk factors](image)

Outcomes for young mothers

Analyses suggested that teenage mothers, compared to older mothers, suffered disadvantages in adulthood, including being
more likely to be in social housing, in receipt of benefits, to be dissatisfied with their neighbourhoods, to have experienced partnership dissolution and to be in families where no adult was in paid work. They were also more likely to be in poor physical and psychological health. These patterns resulted from a complex interplay of factors that predicted their entry into teenage motherhood as well as additional effects arising from being a teenage mother.

Although a small amount of the health disadvantage suffered by teenage mothers among the 1970 cohort was explained by their parental background and childhood characteristics, most of the difference was explained by the fact that teenage mothers were more likely to go on to experience partnership dissolution, live in a non-working family, be dissatisfied with their neighbourhood, be emotionally distant from their own mother and not have a confiding, supportive relationship. Therefore, age at motherhood is an important path by which inequalities in childhood are translated into social inequalities in adult physical and psychosocial health. However, there was little evidence that women who postponed their childbearing until their early twenties fared any better on these health outcomes. Both these groups of younger mothers fared less well than older mothers.

**Outcomes for young fathers**

Even after accounting for the factors predisposing some men to become a young father, those who became fathers in their early twenties were twice as likely to be unemployed at age 30. However, among those who were employed, earnings at age 30 were similar for younger (under 23) and older fathers (23 and over), once the entry into early fatherhood of men from poorer backgrounds, with low educational ability at age 10, and whose mothers had lower educational aspirations for them, was taken into account.

Age at fatherhood had a strong effect on the likelihood of a father living with their first child at age 30. More than one-fifth of teenage fathers had never lived with their child, compared with 15% of those who became a father at age 20-22 and 6% of older fathers. Among both young and older non-resident fathers, around two-thirds saw their child at least once a month, and around two-thirds made some form of financial contribution towards their child’s maintenance. Payment of maintenance was much more common amongst those who had more regular contact.

**Frequency of contact and payment of maintenance**

For young fathers, contact was strongly affected to a greater extent by the length of time since the father last lived with the child rather than whether the father ever lived with the child. Those who lived with their child less than two years ago were five times more likely to see that child compared to those who last co-resided more than six years ago. The level of contact was reduced when either the mother or the father had formed a new co-residential partnership. In addition, a new partnership for the father, and especially new biological children with this new partner, reduced the likelihood of paying maintenance, irrespective of age of becoming a father.

**Outcomes for children**

Teenage childbearing increasingly takes place outside of any co-residential partnership: around half of the teenage births in the early 1990s were to lone parent
teenagers. One third of children born to teenage mothers within ALSPAC spent the first three years of their life living with both of their biological parents compared to 88% of children born to women aged above 19 years.

In general, the children born to teenage mothers within the ALSPAC study were doing well: they did not differ from the children of older mothers in their language development at 38 months; social development, gross motor or fine motor skills, or pro-social development (i.e., showing helping behaviours and empathy) at 42 months. However, children of teenage mothers did fare worse in two areas; accidents and behavioural problems.

The higher rate of accidents amongst the children (aged between 24 and 38 months) of teenage mothers appeared to be due to the fact that teenage mothers were more likely to suffer from anxiety and depression, not age per se. In turn, the higher risk of maternal anxiety and depression was associated with the lack of a co-residential partner and poorer living standards (as indicated by living in social housing, overcrowding, the presence of damp in their homes and a lack of amenities in the areas where they live).

Analysis showed that the children of teenage mothers were at a higher risk of all three types of behavioural problems examined; conduct, emotional and hyperactivity. Although better parenting skills were found to be associated with fewer behavioural problems, no significant differences were found in measures of parenting skills between teenage and older mothers. Instead, the child’s behaviour was related to the mother’s mental state. Lack of a co-residential partner and poor housing conditions were factors which identified teenage mothers most at risk of depression and anxiety.

**Conclusions and Policy Implications**

Policies aimed at reducing inequalities in adult health need to take a life-long perspective, tackling social disadvantages across the life course. Teenage motherhood is an important independent pathway through which poor socio-economic conditions in childhood translate into higher rates of both mental and overall ill-health in adulthood. The poorer mental health of teenage mothers has implications for the subsequent generation and hence contributes to the intergenerational transmission of disadvantage. However, women who delay childbearing to their early twenties do not seem to fare much better than teenage mothers on key health outcomes. This raises the question as to whether policy makers should consider a broader concept of young motherhood.

The pattern of results suggests that important areas for action to prevent the adverse consequences of teenage motherhood for the child are in relation to the mother’s mental health. Such policies need to be multi-faceted - addressing both the material deprivation suffered by teenage mothers and their lower levels of emotional support compared to older mothers. The significance of higher neighbourhood satisfaction in predicting good health also points to the importance of the wider community.

Partnership dissolution and lone parenthood appeared in both the BCS70 and ALSPAC surveys as having important consequences for both teenage parents and their children. We understand that the Government is in favour of generally
encouraging young couples to stay together but this research points to the possibility that some policies may, in effect, work against couples sustaining their relationships. The Government may want to consider how aspects of the benefits system, housing policies for young parents, particularly in relation to access to supported housing, and the youth justice system, impinge on the ability of young parents to sustain relationships.

For teenage fathers, policies need to recognise that at age 30 one half were not living with their child and that one fifth had never lived with their child. Nevertheless, two thirds of these non-resident fathers do have regular contact and do provide some sort of maintenance, albeit not necessarily maintenance through the Child Support Agency system. Policies need to support these young fathers, recognising this contribution, and at the same time also recognising that young fathers will go on to have new partnerships, to have new biological children and hence will take on new family responsibilities.

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How to obtain further details
The final report and some of the academic papers upon which it is based are available from http://www.s3ri.soton.ac.uk. Copies of this briefing and links to the working papers can be accessed at www.dfes.gov.uk/teenagepregnancy. Further copies of this briefing are available free of charge from Prolog, quoting reference TP/DH/RBN8 (telephone 0845 60 222 60; dfes@prolog.uk.com).

About the programme
The Teenage Pregnancy Unit (now located in the Department of Education & Skills), in partnership with the Research and Development Division, Department of Health commissioned a major programme of research under a number of themes in order to inform implementation, and development, of the Teenage Pregnancy Strategy.

Five themes were identified through consultation with the Teenage Pregnancy Unit’s policy team, other government departments, the research community and practitioners:

- The impact of growing up in rural and seaside resorts on the sexual behaviour and life chances of young people.
- Attitudes and behaviour of black and minority ethnic young people relating to sexual activity, contraceptive use and teenage pregnancy.
- Black and minority ethnic young people’s experience of teenage parenthood.
- Educational experiences of pregnant young women and young mothers’ of school age.
- Long-term consequences of teenage births for mothers, fathers and their children.

Reports and research briefings from all nine projects commissioned under these themes are now, or will shortly be, available from www.dfes.gov.uk/teenagepregnancy.

The views expressed in this report are those of the authors and do not necessarily reflect those of the Department for Education and Skills or the Department of Health.