Poverty and Youth

Effects on Health & Well-Being and Opportunities for Change

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What we know…

Poverty has long been a significant risk factor for emotional, behavioral, cognitive, and relational difficulties for youth.

Many people associated with generational poverty do develop a sense of "learned helplessness" influenced by a number of factors.

Teen parenting and low school attainment are two of the biggest risk factors that children will be raised in poverty.

Other risk factors include:

- Underperforming schools
- Poor nutrition
- Distressed neighborhoods

Mechanisms of Effect

Poverty typically has three means by which detrimental effects occur:

1) Individual (or child) level: Mediating or moderating effects can include impact of poor nutrition or sleep deprivation
2) Relational level: Quality of relationships with parents and caregivers (i.e., exposure to repeated harsh, inconsistent parenting can be one example)
3) Institutional level: Includes systems of care/learning, such as educational institutions, daycares, neighborhoods, etc.

Effects are interactive and cumulative. For example, high level of viewing of violent content on screens coupled with violence in neighborhoods can create situations of desensitization and chronic inflammation (e.g. bodily system that struggles to return to a healthy physical/psychological baseline), which has detrimental effect on current and later health & well-being.

Psychological Outcomes of Poverty

Multiple studies have found that youth who have parents with lower SES and greater disruption in relationships were significantly more likely to have depression by adolescence

Higher rates of oppositional/conduct/delinquency and ADHD issues also present in these and similar situations

Parents in poverty are more likely to be depressed, thus leading to the following negative outcomes:

- Poorer attachment with children
- Inconsistent/harsh discipline
- Adolescent mood/anxiety conditions

One particular mechanism is job instability or loss, which increases the likelihood of parental distress, marital/relational difficulties, separation, and parental distress

Biological Outcomes of Poverty

Poverty has been consistently associated with negative neurological associations including the following:

- Decreased amygdala and hippocampal volume (associated with decreased emotional regulation and memory/recollection)
- Lower frontal and parietal gray matter volume (associated with problem-solving, if/then consequential thinking)
- Decreased frontal activity during emotional activities (critical for self-control, emotional awareness/regulation, executive functioning)

However, most studies are cross-sectional by nature, and found that effects are mediated (accounted for) by factors such as parent educational levels, adverse outcomes (e.g. child abuse), and/or chronic stress activation (e.g. household with high EE or CD)

Other physiological associations for youth in poverty include elevated cortisol levels and resting blood pressure

Biological Outcomes of Poverty

However, a recent longitudinal study (Holz et al., 2015) found that individuals exposed to early poverty (at 3 months of age) had a small orbitofrontal cortex (OFC) volume at 25 years of age even when statistically adjusting for the following factors:

Total intracranial volume	Sex
Parental education, pathology, delinquency	obstetric adversity
Current poverty	Personal pathology, like CD

So what were the mechanisms that resulted in lower OFC volume?

Was it Life Stress? Findings supported CD association, but not OFC volume

Smoking during pregnancy? It did mediate the link b/t poverty and CD, and suggests that exposure to substances is a direct link (although results regarding OFC were not clear)

Is it malnutrition (e.g. vitamin D deficiency)? Study wasn't able to examine, but other cross-sectional studies have suggested connection

Intellectual Outcomes of Poverty

It has long been documented that the intellectual/achievement gap between poor and middle class children emerges clearly by kindergarten

Many factors are at play (e.g. limited resources, poor nutrition), but parenting practices have emerged as one of the most significant correlates

Landmark study in 1980's (Betty Hart & Todd Risley from KU) intensively studied a group of families for over 2 years

By the age of 3, children from poor families had an average vocabulary of 1,100 words; children of parents on welfare averaged 525 words

Average IQ among middle class children was 117; welfare children was 79

Why?

Intellectual Outcomes of Poverty

Poorer vocabulary/intellectual outcomes seemed most connected to two factors:

1) The number of words children heard in the house
   - Professional parents directed an average of 487 utterance (of varying lengths) each hour; in welfare homes, the average was 178
   - By age three, it was predicted that professional kids heard more than 30 million words; for kids in welfare, it was around 10 million
2) The type of utterances
   1) Focused on discouragements (e.g. disapproval, prohibition) vs. encouragements (e.g. approval, praise, uplifting statements)
   2) By 3, the average professional child heard 80,000 discouragements and 500,000 encouragements; it was almost opposite for poor children to 80,000 encouragements and 200,000 discouragements
   3) The greater the number of words, the more the complexity of utterances did too (thus stimulating greater intellectual development)

How Do Children Process Poverty?

Children develop a different awareness of their poverty and that of others depending on developmental stages

~3-5 year-olds understand differences in race, gender, and unequal/equal. Are generally able to label self/others as poor by the age of 5

~5-8 year-olds see poverty as a true problem; develop perceptions regarding the behaviors/academics/occupations of those who are poor; are developing their own perceptions of self-efficacy (what they can do in specific areas)

~9-11 year-olds are very aware of stereotypes of poor (and how they do or do not apply to self); social comparison heightens; increasingly recognize psychological factors of poverty (not just physical characteristics)

Overall, kids from lower SES identify poor children more by thoughts/perceptions whereas middle/upper class kids perceive poor children more by traits

Concerns emerge about how status anxiety and stereotype threat among other schematic perceptions may affect behavior/performance of poor children

Absolute Poverty vs. Relative Poverty

Are the negative effects of poverty largely related to absolute deprivation or level of inequality?

Wilkinson & Pickett, (2009) among many other researchers, have looked at countries across the world and outcomes of poverty related to psychological, physical, and educational outcomes. Increasing research suggests that once individuals/families are above a certain minimum, negative effects are largely attributed to level of inequality between richest 20% and poorest 20%.

Countries such as the US, Portugal, UK, and Singapore had worst outcomes (and highest rates of disparity); Japan, Finland, Sweden had best outcomes; similar findings were noted within different U.S. states

Societies with best outcomes had increased social cohesion, community life, trust-building opportunities, and less differences in status (causing status anxiety), access, cultural opportunities, and social hierarchies.

Interventions

Evidence suggests that two types of intervention strategies can have positive effects on the emotional, behavioral, and cognitive effects of poor children. Broadly speaking, these include two types of programs:

Those that specifically target mechanisms (e.g. maternal depression) that mediate the effect of poverty on a child's development

- Parenting skills programs / Adult/Youth Mental Programs
- School-based social-emotional programs

Those that strive to reduce poverty itself (e.g. income tax credits, work incentive programs, conditional cash transfers

However, the large available body of evidence suggests that programs which 1) target the early childhood age 2) increase economic resources overall have the strongest impact on EBC outcomes

One study found that for every $5,000 incentive based on work effort over the course of 2-3 years was associated with a 0.5 to 0.6 SD reduction in externalizing symptoms for children

5 Target Areas (focused on mechanisms)

Based on a wide range of evidence, the following 5 areas of focus for intervention hold promise in reducing the EBC effects of poverty:

1) Programs (of all kinds) that specifically focus on creating awareness & treating substance addictions in pregnant and women with 0-1 year-olds
2) Emphasis on creative ways to promote better nutrition for pregnant women and children under the age of 1
   - One example is the Nurse-Family Partnership, which provided in-home nursing care to first time mothers. Reduced conduct problems even at age 15, reduced likelihood of child abuse & neglect, and improved parenting practices in some trials
3) Social-emotional programs that target the preschool age both at school and home, which are designed to improve self-control and increase resiliency (Self-control, IQ, and SES are best predictors of adult outcomes, but only SC has shown to be consistently malleable across lifespan)
4) School-age programs that specifically target biggest threats to EBC—poor nutrition, sleep deprivation, excessive screen time, and sedentary behaviors
5) Interventions that target school-age children's self-efficacy and sense of optimism, which appear to have a moderating effect on poverty in multiple areas

Selected References

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