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Digital storytelling as critical narrative intervention with adolescent women of Puerto Rican descent

Aline Gubrium¹, Alice Fiddian-Green¹, Sarah Lowe¹, Gloria DiFulvio¹, and Jeffrey Peterson²

¹University of Massachusetts Amherst, Amherst Massachusetts 01003, United States

²Washington State University, Pullman, Washington 99164-1009, United States

Abstract

This article focuses on findings of a two-year pilot research study focused on addressing sexual and reproductive health inequities faced by adolescent women of Puerto Rican descent living on the mainland United States. Working with three groups of young women, in the pilot study we gathered ethnographic data in and around a group-based digital storytelling process to inform the development of a larger intervention. Digital stories are short (1–3 minute), participant produced videos that synthesize still and moving image, a voiceover recording of the participant telling her story, and background music and text to document personal experiences. Based on narrative analysis of digital stories and field notes written in and around the digital storytelling workshop process, as well as follow-up individual interviews with workshop participants, our findings center on the ways that trauma has specifically shaped participants' sexual and reproductive health experiences. We argue that digital storytelling serves as a critical narrative intervention, whereby participants' engagement in the storytelling process enables them to collaboratively interrogate and potentially address prior trauma, bolster a sense of social support and solidarity, and potentially recalibrate stigmatizing conversations about them. We introduce our project methodology, and then present key findings on trauma as it informs sexual and reproductive health practices, with digital storytelling showcased as a modality for critical narrative intervention. We conclude by discussing implications for critical public health research and practice.

Keywords

adolescent women of Puerto Rican descent (U.S. mainland); critical narrative intervention; digital storytelling; sexual and reproductive health; trauma

Introduction

This article focuses on key methodological findings of a two-year pilot research study, entitled Let's Talk About Sex: Digital Storytelling with Puerto Rican Latina Youth, that the authors recently conducted in Western Massachusetts in the United States. Working with three groups of adolescent woman of Puerto Rican descent, the majority who were born and currently living on the mainland United States, we gathered ethnographic data in and around a group-based storytelling process. Our first aim was to document cultural paradigms of sexual health—identity constructions informed by social relationships and broader life

experiences that shape understandings of sexuality—that could inform the content and design of an intervention to address sharp reproductive and sexual health inequities experienced by young women of Puerto Rican descent in the project community. Our second aim was to explore how the process of building personal stories around these paradigms works as a tool for intervention.

Narratives are the stories that people tell: ‘the primary scheme by which human beings take form’ (Polkinghorne, 1988, p. 123). Storytelling and narrative approaches are increasingly taken up in community-based participatory public health research efforts. Digital storytelling (DST) was used in the project as a method for data collection and pilot intervention.

Through what we term ‘critical narrative intervention,’ we came away with a rich understanding of the ways that trauma specifically shaped participants’ reproductive and sexual experiences, and further, the ways they made sense of and collectively addressed this trauma. Trauma is an umbrella concept that includes often overlapping intergenerational, interpersonal, and structural levels of experienced violence. To date, scant research focuses on multiple levels of trauma in the lives of adolescent women of Puerto Rican descent, how it is embedded in sexual and reproductive lives, and ways it is embodied in health outcomes.

We differentiate critical narrative intervention from narrative therapy, which is part of mental health and clinical practice where the therapist works with individual clients to ‘...elicit... raw experience and then helps the client to narratize that experience to make it easier to articulate, understand, reconcile, and revise’ (Petraglia, 2007, p. 496). It is also different from standard narrative-based public health intervention, in which the ‘...health professional generally provides narratives and asks the audience [a collective population of potential beneficiaries] to understand their own experience in light of them’ (p. 496). As a distinct approach, *critical narrative intervention* focuses on 1) rendering otherwise discounted local knowledge as relevant by working with marginalized communities to produce their own stories, 2) bolstering social support and solidarity in the process, and 3) critiquing and recalibrating damaging and disempowering conversations on social health and wellbeing, ultimately to create more supportive policies with and for marginalized communities. Because otherwise potentially marginalized narrators are supported and valued in knowledge production, the DST process is profoundly useful for critical public health research.

In this article we argue that DST serves as a critical narrative intervention, whereby participants’ engagement in the storytelling process enabled them to collaboratively interrogate and address experiences of interpersonal and structural violence and embodied trauma. We begin by introducing our project methodology, present key findings on violence and trauma in the project, and then showcase DST as a modality for critical narrative intervention as participants collectively contended with these experiences. We conclude by discussing implications for critical public health research and practice.

Methodology

The digital storytelling process and participant recruitment

Digital stories are short (1–3 minute), first person visual narratives that synthesize still and moving images, a voiceover recording of the participant telling her story, and at times

background music and text to document personal experiences (Lambert, 2010). Use of the method ‘supports our stance to privilege research as a process that positions traditionally silenced and objectified participants as active and legitimate knowers of themselves and their circumstances’ (Peterson, Antony & Thomas, 2012, p. 3). DST promotes active sense making among participants about past (and often hidden) experiences by engaging them in supportive story production process (Gubrium, Fiddian-Green, Lowe, DiFulvio, & Del Toro-Mejías, 2016). Participants take part in a group-based workshop that situates them as storytellers in their own right—they are given the tools and techniques to assemble and produce their own digital story. This stands in contrast to hiring trained professionals to collect from, and tell the stories of, community ‘subjects’. Participants, who may otherwise be objectified in traditional research methodologies, are situated as participant observers of their own lives as they reflect on and make sense of their experiences and construct an object—a digital story—in the process (Gubrium & Harper, 2013).

We followed a DST workshop process guided by the [StoryCenter](#) approach. Briefly, workshop participants each write and tell a story about an important moment/experience in their lives, collect images to visually narrate the story, and learn to use basic video editing software to produce a final digital story. Storytellers also take part in two group-based storytelling activities. On the first day of the workshop, participants share the stories they are contemplating writing. The conversation happens in a supportive group ‘story circle’ activity, as they individually receive structured feedback from group members and facilitators on their stories, while collectively analyzing common threads in their lives—political, economic, socio-cultural, and historical—and the ways these are woven in daily practice. A ‘story screening’ occurs on the last day of the workshop. Each participant introduces and screens her final digital story, with facilitators leading a group discussion around the stories.

Three DST workshops were conducted with 30 young women of Puerto Rican descent living and/or receiving services in a post-industrial city in Western Massachusetts [Table 1 available as supplementary material here]. Participants were recruited by staff at partnering agencies that serve community youth, as well as through direct contact by research assistants who visited the agencies. Ten participants took part in each four-day workshop. Enrollment criteria included: 1) self-identification as a female of Puerto Rican descent; 2) living or receiving services in the project city; 3) being between the ages of 15–21; and 4) being pregnant, parenting, or neither (i.e. nulliparous), depending on the workshop. Informed consent to participate in the project was obtained from all participants. Participants aged 18 or over signed a written consent form and participants under 18 signed a written assent form, with a parent/guardian completing a written consent form. Our university Institutional Review Board approved the project protocol. Of the 30 participants enrolled in the study, 29 completed digital stories.

Workshops, which were held in the offices of a community-based partner organization and facilitated by two staff well experienced in DST facilitation, were structured to consist of participants with a similar fertility status—one group with women who were neither pregnant nor parenting, a second group with women who were pregnant and/or parenting, and the third group a mix of both. One facilitator, a white woman fluent in Spanish, was

hired from the [StoryCenter](#). A second facilitator, hired from a local public television affiliate, was a woman raised in the local Puerto Rican community and a fluent Puerto Rican Spanish speaker. Story prompts were used to encourage participants to write about one of the following ‘moments’: when they learned about sex and sexuality, experienced pleasure and desire, understood what love is all about, felt really strong or really helpless in a relationship, learned about contraception or tried to get or use it, were afraid that they had an sexually transmitted infection, found out they were pregnant, were scared to ask about reproductive or sexual healthcare, or knew they were in a good or bad relationship. We have used similar prompts in previous workshops and found them helpful in guiding storytellers to pinpoint a topic for their stories.

We recognize the thorny politics of research in the field of sexual and reproductive health that is focused on young women of Puerto Rican descent, which are inevitably informed by a long history of positioning Puerto Rican communities in Puerto Rico (i.e., the island) and the U.S. mainland as in need of sexual and reproductive control or management for the purposes of economic development and modernization (Acosta-Belen & Santiago, 2006; Chavez, 2008; Lopez, 2008). This colonial logic relies largely on representations of Puerto Rican women as hyper fertile and hypersexual (Asencio & Acosta, 2010; Vargas, 2010). Given this awareness, our project sought to challenge rather than intensify these colonial legacies. Most study participants had moved frequently with their families, back and forth between the island and the mainland, in pursuit of a better existence in the face of a legacy of trauma. This includes dispossession from land and resources, medical experimentation, as well as intergenerational and current social inequality—including high rates of un(der)employment, housing and food insecurity, lack of transportation, intense surveillance by social services, and limited access to affordable health insurance, healthcare facilities, and high quality care (Brown, 2009; De Jesus & Xiao, 2014; Kaltman, Hurtado de Mendoza, Serrano, & Gonzales, 2016; Lopez, 2008). Further, while teen birth rates have decreased in the U.S. in recent years, including within the mainland U.S. Puerto Rican population (Hamilton, Martin, Osterman, Curtin, & Mathews, 2015), our study site contains one of the largest Puerto Rican communities in the U.S. and continues to experience a high adolescent birth rate, four times higher than the state average (Mass CHIP, 2013). High teen birth rates in the local context are magnified in public health efforts, which telescope the bodies of young women of Puerto Rican descent in the community as being ‘at risk’ for teen pregnancy and target them with narrow, shame-based prevention strategies predicated on a neoliberal logic of individual choice. In visual strategies, young women’s pregnant bellies are at the center of attention—their heads are cut out of the images, they are literally disembodied (Barcelos & Gubrium, forthcoming). In a recent prevention campaign, young women and men of color are depicted as toy animals and puppets, with their babies dragging them around by their tails or wearing them on their hands, controlling their every move. In another prevention strategy, long-acting reversible contraception (LARC) is prioritized as a first line approach for those deemed ‘at risk’ for teen pregnancy, without due consideration paid to social inequality and a racist U.S. history of negative eugenics that has discouraged reproduction among social groups seen as unfit to parent, for the presumed benefit of the larger population/body politic (Collins, 1998).

Data collection and analysis

Two researchers and two research assistants, who also observed and assisted with each DST workshop, wrote field notes in and around the workshop activities and follow-up interviews. Research assistants conducted individual interviews with participants after they had completed a workshop, which included discussion on: meaningful people in participants' lives; home/housing and place; sexuality/love and safer sex; schooling; parenting and support; and the future. Finally, participants re-viewed their digital stories and were asked to discuss their perspective on the digital storytelling process. Story circle and story screening activities in the DST workshops, and follow-up individual interviews, were audio-recorded and transcribed verbatim.

We used an intertextual transcription method, combining still images from the digital stories along with transcription of the voiceover recording, notes on affect, features of visual objects, text on screen, music, and special effects to 'begin to understand how people make meaning across the different modalities of visual, chronological, aural and oral, emotional, gestural, and textual elements found in a digital story' (Gubrium & Turner, 2011, p. 478). Three research team members independently reviewed the corpus of data, including the digital stories in whole/video and intertextual transcript format, and took notes on generative themes elicited in the stories, as well as use of imagery, text, and sound. We analyzed themes by storyteller to explore emerging patterns and themes within individual cases, and then across the stories, to consider how emerging themes played out across the set of stories. We composed a composite list of free codes based on the themes identified by each researcher. The research team then shared their free codes and reached consensus on the emergence of a second-level "tree code" structure. Of particular interest were the shared values, beliefs, and practices ("cultural paradigms") found within the free nodes. Collectively, and over multiple iterations, we reviewed the data using the tree code structure to guide further analysis and interpretation. Our analytical strategy entailed an examination of narrative content and context (Morse & Field, 1995). Content analysis focused on local cultural paradigms of reproduction and sexuality elicited as key themes in the data. Contextual analysis focused on perceptions and structural circumstances (i.e., historical, political, economic) surrounding the themes.

The DST process notably involves the co-construction of knowledge and, in this respect reflexivity was an essential part of our approach. As researchers and co-facilitators in the process, we supported participants with script editing and special effects, including consideration of camera angle used in still and moving images, image layering, voice quality, music and/or sound effects, and transitions from scene-to-scene. Our work with participants inevitably informed the data produced in and around the workshops, as well as our analysis. Each research team member bracketed their perspectives from observations in field note writing during data collection, such that, as much as possible, our interpretations or reflections were kept separate from descriptive material. Debrief meetings with the research team and co-facilitators were held at the end of each day of a workshop to discuss our experiences and perspectives in the workshop, with notes typed during the meetings.

Findings

Participants shared about layers of violence and trauma in their lives during the DST workshop process, as well as in follow-up interviews. Interpersonal and structural violence were commonplace, as was the embodiment of those traumas by participants, and in some cases by their children. Pseudonyms are used to protect participant confidentiality.

Interpersonal violence

Exposure to interpersonal violence—operationalized as violence (including emotional, financial, physical, sexual or intimate partner, or psychological) occurring between individuals or small groups of people—was routinely discussed in the three DST workshops. Experiences with abandonment and neglect, as well as physical and sexual violence, figured most prominently in participants' references to interpersonal violence.

Abandonment and neglect.—Our findings on abandonment and neglect are contextualized by a historic lack of systemic support—in terms of affordable housing, living wage jobs, nutritious food, and a school-to-prison pipeline—for people of Puerto Rican descent living in the study community. For some participants, systemic neglect has ironically resulted in a co-dependent reliance on institutional systems as a means for support. For Valeria, her parents' inability to 'handle' her mental health issues resulted in her being shuffled between multiple foster homes as well as residential in-patient programs. Similarly, Rubi's grandparents, who felt that she was too 'out of control' and on a trajectory to become a 'ho on the streets...like her mother', placed her in the foster care system for a short time. When Dalia came out as gay to her aunt, who was her primary care giver, her aunt also 'sent' her to foster care because of her discomfort with Dalia's queer identity, which conflicted with her own conservative religious beliefs.

Alternatively, fear of institutions also resulted in a weary avoidance of these limited 'supports'. At age 7, when Flor's mother 'disappeared' from her home, leaving Flor responsible for the care of her younger siblings, Flor recalled not wanting her neighbors to know that her mother was gone: 'I didn't want them to know that we were by ourselves. I know my mom would get in trouble...' "'She's at the store", I said. I'd seen kids getting taken away from their families.' It was only years later when Flor and her mother regained contact that she learned that her mother 'was kinda forced...her boyfriend was part of a drug thing that happened in Florida'. By the time they were reunited, Flor had left high school, gotten married at age 18, and started her own family to fill 'that void—that hole there' marked by abandonment.

During the DST workshop, Priscilla told of experiencing neglect as a child. In an interview, she elaborated on the all-pervasive sense of insecurity that she felt as a child. Sometimes she and her sister and mother lived with her mother's boyfriends. Other times they lived in a shelter. Priscilla recalled often being hungry and that '[she] wanted to live with [her] dad because [she] had no clothes, no underwears, no nothing' when living with her mother. Her father, however, faced mental health challenges and lived with his own mother. In her digital story Priscilla, sounding wise beyond her 15 years, speaks to her daughter, resolving to be a different kind of mother: 'I'm going to show you every day of my life how much I love you

and care...I will always make sure you're happy. I will talk to you every day and tell you the things nobody told me. I'm not gonna leave you home with nothing to eat. I'm not gonna choose a guy over you' [Figure 1 available as supplementary material here]. Priscilla uses stock visual 'characters' commonly found in teen pregnancy prevention campaigns, including a bare belly disembodied from its owner's head, in her digital story. What is spoken is markedly in contrast, as she reveals prior trauma to background her own pregnancy and talks back to the expectation that she will be just another irresponsible teen mother.

Physical and sexual violence.—Several participants spoke of witnessing physical violence in their own families: inflicted on Jenna's sister, Amara's mother, and sisters Tasha and Ana's mother. Participants also spoke of experiencing abuse themselves—Pilar recalled being hospitalized at three months pregnant after her boyfriend 'put his hands on' her. Relating the memory of this event during the DST workshop, it was clear that she was trying not to cry as she rhetorically asked the group: 'why did that have to happen to me, you know? Like, I'm a really sweet girl.'

Participants also commonly referenced experiences with sexual violence. Amara was 16 years old and had a nine-month old son when she participated in the third DST workshop. During the story circle, she recalled several memories of childhood sexual abuse, which would ultimately become her final digital story. Amara's story begins: 'They say talking about something will set you free, make it better'. A short video clip aligned with the voiceover segment shows Amara wearing a white mask and curled up against a brick wall with her head buried in her chest. Visual indications are that her experience was contrary to what she has just said. Amara continues, 'Where I come from, you don't talk about it' and follows by viscerally conjuring her experiences with sexual violence: 'Night after night I was sexually abused 'til the point where I would black out. I would wake up, my body covered in sweat and I would jump in the shower and scrub my skin feeling the sponge burn 'til I almost bled...I gave up on myself. I felt useless. I felt like I deserved it'.

Dawn also produced a digital story about being sexually abused as a child. In her story, 'A Scared Little Girl', the viewer sees a picture of Dawn as a child, smiling happily at the beach, as she narrates: 'There was a man who I considered family who lived with [my grandparents]. He was a much older man. He was always nice to me while people were around, but when I was six he called me into his room'. She continues, relating that he 'asked me to touch him in a place I didn't want to. He kept asking—I felt pressured. He showed me things I didn't wanna see. He used to try and touch me in places I didn't wanna be touched. He asked to see places I didn't wanna show'. During her follow-up interview, Dawn explained that she used her digital story as a device to communicate with her mother and grandmother about what had happened. She had connected with her mother after learning that she too was a survivor of sexual abuse as a child.

Structural violence

Structural violence—operationalized as violence invisibly woven into social institutions, which manifests as social stratification, inequality, and insecurity (Scheper-Hughes, 2004)—

was commonly referenced during the DST workshops and in follow-up interviews with participants. References to structural violence focus on participants' sense of dispossession from valuable resources, including adequate housing, and disenfranchisement from services, including schooling and reproductive healthcare.

Inadequate housing.—The search for secure housing was referenced in several digital stories and elaborated upon in more detail during follow-up interviews. For Annalise, her attempts to secure placement in shelter housing were routinely thwarted when she shared with shelter staff that she had family living in the area. Annalise's voice was loud as she remembered being turned away from a shelter after confirming that she had parents living in the area: 'Obviously I'm not gonna lie [when they ask]. "Oh, well try to work something out with them, that's it". That's all they told me'. Annalise's digital story is about having a pre-term birth. She describes being forced to go on bed rest at the hospital at 22 weeks pregnant: 'I'm not going to lie. I liked being there. I got taken care of. They gave me medicine and food. I got to watch TV'. As the only foster child in a family of biological siblings, Annalise shared that she was sometimes invited over for dinner, but never allowed to spend the night; her family had yet to meet her son, who was over one year old at the time of the study.

On the last day of the workshop, the first author brought in a cake to celebrate Annalise's 16th birthday. She had lost custody of her son at birth as a result of her unstable housing situation, the father of her child was in jail, and she was seven months pregnant during the workshop. At the time of the follow-up interview Annalise was contemplating moving in with her biological grandparents who lived in a town over an hour away by car. She knew that living with her grandparents would provide a stable home environment, which would increase her chances of regaining custody of her son, and not losing custody of her soon-to-be-born baby. The idea of being so far away from her son scared her. She related, "so, it's like, I'm hoping that I get into a shelter." Shelter housing represented hope and security.

Annalise remained in contact with the second author for a few months following the workshop. She had moved in with her grandparents, however the bus back to the City was inconvenient and not in sync with the weekly visitations that were scheduled for her to see her son. She missed one visit due to lack of transportation and her caseworker noted it as evidence of poor parenting. Annalise moved back to the City, couch surfing as she waited to go into labor.

Schooling.—Participants also told stories about their disenfranchisement from the public education system. The dominant narrative around schooling and teen pregnancy and parenting perpetuates a chronological trope of underachieving students who drop out and become pregnant soon after (Luttrell, 2003). Yet, parenting participants highlighted the reality of being 'pushed out' of school and *then* becoming pregnant (Fine, 1991). The day of her anticipated graduation Flor received a call from her guidance counselor, who told her: 'don't bother showing up.' Although Flor had earned more than the required number of credits to graduate, and had attended and paid for night classes under the guidance of the same counselor, she was told that she was still short on requirements. She did not graduate and soon after was married and again pregnant. After enrolling in an alternative high school

program for young parents, Flor was on track to finish her last few credits at the time of the study.

Seventeen years old at the time of the DST workshop, Paola began her digital story—entitled ‘It’s Not Over’—with the seemingly proverbial response of a young person: ‘I didn’t think it could happen to me’. She continues, reviewing the questions that were running through her head—‘Do I quit school? Do I get a job? What do I do?’ Rather than giving up, she ‘did what [she] had to do’ to be actively involved in her pregnancy. Viewed without context, the digital story might be seen as one of many redemptive stories of triumph and perseverance. In her follow up interview, Paola elaborated on her decision to leave school, describing her experience of racist bullying by a teacher:

The white kids and whatever...she would like, favor them. But if we were like Puerto Rican she would be like, “you’re gonna drop out, you’re gonna be homeless, you know, you’re never gonna find success”. And then I got pregnant, and...she was even worse, like, she was like “you’re, um, father of your child’s gonna leave you, or... you’re not gonna be a good mom, or, you don’t know how to sacrifice, you don’t even know how to take care of yourself”...and all this... really hurtful stuff. She even told me like, you know, I’m extremely lazy ‘cause—I decided to take maternity leave.

Reproductive healthcare.—Participants also told stories about receiving inadequate or coercive reproductive healthcare. Priscilla gave birth at age 14 in a large teaching hospital in the City. Her entire birth story was framed by a sense of surveillance. In her interview, she recalled ‘so much doctors...oh boy’ coming in and out of the delivery room, and her awkwardly asking, ‘Are you guys following me?!’ Immediately postpartum, Priscilla was enrolled in a research study in which Implanon—a long-acting reversible contraception (LARC)—was inserted under the skin of her upper arm. When asked if the procedure was part of a research study, Priscilla seemed uncertain: ‘Um...probably. They like—they do it—to everybody to see how the birth control really is with people’, she responded.

Natasha, 17 at the time she gave birth, echoed this experience when asked about her birth experience: ‘Yeah they really like—they really like, um, interrogate you, they’re like, “you, you’re gonna get it [some form of LARC], right?” [In a more aggressive tone]... And I was like “well, I don’t really want that one”, and so they like really pressure you into getting it’. The stories were disconcerting not only because of the vulnerability experienced by new mothers in the immediate postpartum period, but also in recalling the history of coerced sterilization routinely conducted on women of Puerto Rican descent on the island and mainland for over three decades (Briggs, 2002; Lopez, 2008).

Mirabelle produced a digital story about coercive reproductive healthcare practices, based on her own experiences obtaining contraception. In her story, she recalls the extreme side effects she experienced from a long-acting method, and the concerted efforts she put forth to advocate for a method that would work better for her:

[The doctor] put me on Depo Provera. I said yes, but things got worse. I got severe headaches and vomiting everyday. I was due [for another dose] in three months and

I didn't want to be on it anymore. So I went back to the doctor's and told her to change me. She tried hard to keep me on the Depo because she said it was more effective. I had to say no like *8 times*.

During her follow-up interview, Mirabelle spoke openly about her history of depression and anxiety—severe enough that she experienced panic attacks preventing her from going outside and attending school. Under the care of the same doctor referenced in her digital story, she had a difficult time receiving mental health services. Asking for referral for a therapist, the doctor told her: 'you're in perfect condition... you're not disabled'.

Embodied trauma

Interpersonal and structural violence infused participants' stories and played out on and through their bodies as embodied trauma. We operationalize 'embodied trauma' as participant references to violence that call attention to the ways that they experience, feel, and internalize trauma, and which is felt, processed, understood, or experienced through the body. Amara recounted feeling like a 'pretend child, like, a child in the morning and then you know, disappear at night', referencing her sense of lost youth from experiencing sexual abuse as a child. Also abused as a child, her mother struggled to provide economically, despite working multiple low-wage jobs, and thus be present for her children. During the workshop story circle Amara situated her first pregnancy at the age of 13 as an agentic response to embodied trauma. She recalled feeling as if sex, even if it was violent or abusive, was the 'only way people can show you that they love you.' Explaining this pregnancy, she continued: '...I feel like that's why I got so involved with sex at a young age—I got pregnant'. Her decision to have sex at a younger age was a way to take control of her body. Amara elaborated: 'I ended up...doing it to experience more of what it was like to *choose* to do it', she said.

For Annalise, embodied trauma is well captured in her digital story when she speaks of feeling pleased with forced bed rest during her pregnancy. The viewer experiences a narrative shock, between the contrast in image shown on screen, which figures an innocent looking Annalise, tucked into a hospital bed, happily smiling; and her words, which describe her sense of isolation as she struggles with housing insecurity and a lack of support from her foster family. During the workshop story circle, Annalise shared her story idea with the group and spoke of the intense fear she felt at the time: 'before the baby even came I was so scared that something was gonna happen...like I was gonna have a miscarriage or if the baby was gonna die inside me...so I told my mom to have... the priest come in from my church and bless me... ..my son weighed two pounds, six ounces. He came out with heart and...breathing problems...'

For Tasha, witnessing her father abuse her mother shaped her sense of self and view on love and relationships. Tasha spoke of cutting herself from age 13 to 16, during her interview, as a way to 'process it [the past abuse] every day...to cope with your own things. And now that I'm in a relationship myself, whenever I argue, it brings back, it brings back memories for what my mom went through with the screaming and yelling'. Signaling that she was ready to move on to a new topic, Tasha concluded, 'everyone has their stories behind the scars that are put there'.

Pilar linked her experiences, including being sexually abused by a family member at age eight (her own mother was also sexually abused by this man), to her recent diagnosis of bipolar disorder, PTSD, and depression. During a workshop story circle, as she brainstormed with the group about what she might tell for her story, she remembered being pregnant: ‘...I started going crazy, kind of. ‘Cause- I was young I didn’t know how to... I was just really scared... ..if you guys want me to be honest with you I (quieter) started having...h-h...how do you say? Hallucinations (softly)...’ Pilar was not allowed to ‘be on meds’ during her pregnancy. Her baby now three months old, she had been ‘cutting’, the stitches in her arm evidence of embodied trauma. Pilar spoke of experiencing postpartum depression, but did not name it as such. The fourth participant to present to the group, following her turn subsequent participants opened up, many also relating their own experiences with sexual violence, most stating that they had not previously talked about this with others.

Digital Storytelling as Critical Narrative Intervention

Three DST workshops and 27 follow-up interviews elicited key findings on interpersonal and structural violence and related embodied trauma in the lives of participants. As a method of critical narrative intervention, the DST process provided a safe space for participants to open up about what were for many participants previously stigmatized and shaming experiences with violence and trauma, while encouraging them to reconfigure themselves in the situation. As they engaged in the process, participants realized commonalities or overlaps in their experiences, and supported each other while collectively contending with how they would make sense of and reshape these experiences into a digital story. They thus transformed experiences that had previously objectified them into an object of their own representation, which afforded them a sense of agency (and in our evaluation of outcomes, an increased sense of social support, self-efficacy and self-esteem).

The title of her digital story, ‘Set Me Free’, suggests that Amara turned her traumatic experience with sexual violence into a digital story that *she* herself had scripted, edited, and produced, and was ready to share. When asked in her interview to discuss why she had chosen to tell *this* story in the workshop, Amara said that her message was to encourage others—including fellow group members—to speak up and openly about these experiences and not allow what she sensed as local norms on stigma and shame around sexual violence to silence them. She further explained that, given her own context of parenting a son at the age of 16, her story could be used to cast adolescent motherhood in a more critically nuanced light. Pregnancy and parenting a son was her first step toward reconciling this trauma.

A second step was being afforded the narrative latitude to convey her experiences on her own terms in her digital story. The sense of solidarity developed from working together with a group of fellow pregnant and parenting young women from the same community (in workshop three) was another step, allowing Amara to, as she put it, ‘face her past demons’. Solidarity was evident during the workshop story circle. Amara began quietly, prefacing the reading of her script by saying that her story focused on ‘learning how to have sex that wasn’t scary, where something wasn’t done to her’. Fellow group member Flor responded, ‘Can I hug you, is that a possibility?’ Natasha and Pilar both chimed in that it felt ‘nice to

know' that they were 'not alone'. The story circle continued, with other participants telling their stories of trauma and fellow group members providing supportive commentary throughout. Paola, another group member, concluded at the end of the story circle that it is 'brave of us to share our stories—it teaches us as mothers, parents—that these are the things we can teach our children—about domestic violence, birth control. They don't have to go through the same thing. This brought us together as mothers and people'.

Shifting stories and a growing sense of solidarity were also evident during image production activities. Tanya, a 16-year old participant in the second (mixed) workshop group, produced a digital story about meeting a boy through Facebook and getting pregnant shortly thereafter. When he asked her to 'see the test' and 'what are *you* going to do about it?' she knew she would be raising her child on her own. In field notes from the first day of the workshop, the second author wrote that Tanya 'is used to being left to her own devices; she carries herself unconfidently, and keeps to herself with her head down...' On the second day, the first and second authors took a group of participants, including Tanya, outside to take photographs for their stories. Field notes record the moment:

Tanya makes a comment about the pictures being like professional portraits. She seems to really enjoy being photographed, and she eagerly looks through them all. It makes me think of how nice it is for her to enjoy those moments of taking pregnancy pictures and doing what many women do when they are pregnant. It makes me wonder if most of the talk around her pregnancy has been about the negative aspects of her situation, as opposed to letting her enjoy that time.

Reflecting on the photo taking session in her field notes the following day, the second author wrote: 'I had written [yesterday] that Tanya really wanted the bigger, fancier camera [for the photo shoot], but what I didn't note was that she carried and held on to [it] in a way that made me think she had never been trusted or given the opportunity to use something so valuable'. Having her photo taken in a professional manner, with her entire body figured in the photo to celebrate her developing pregnancy, positioned Tanya as a young mother to be visually cherished and seen in a new light. The image work represented a new (visual) space for Tanya, who said that she 'did not have any other [pregnancy] pictures'. The DST process allowed for a multimodal recalibration of conversations on teen mothers, shifting from dehumanizing images of young parents as puppets and pull-toys to ones of humanity, dignity, and respect.

Conclusion

Given established links between violence and trauma, inequality, and a range of reproductive health outcomes that include teen pregnancy and adverse birth outcomes (Erdmans & Black, 2015; Furstenberg, 2007; Geronimus, 2003; Lawlor & Shaw, 2002; Singh, Darroch, & Frost, 2001; SmithBattle, 2007), shame based programming targeted to young women like our study participants is unhealthy as it has the potential to perpetuate further trauma. Our findings highlight the interpersonal and structural violence and intersecting embodied trauma that marginalized adolescent women of Puerto Rican descent might carry with them in their daily lives and complement prior critical public health scholarship that considers structural antecedents to adolescent parenting. Digital storytelling can be used as a method

of critical narrative intervention, to work against myopic public health efforts focused narrowly on pregnancy prevention and instead encourages a more humanistic and holistic approach that values how those targeted make sense of their health and wellbeing. Indeed, in this study, we saw how one participant, Amara, positioned her own pregnancy and the birth of her son as a way to critically intervene against past trauma and bolster wellbeing.

The data collected in the DST process surfaced key themes of violence and trauma linked to sexual and reproductive practices among participants, including in the context of early pregnancy and young parenting. Trauma was embodied on physical and psychosocial levels. Clearly larger issues centered on interpersonal and structural violence and embodied trauma are seeded into decision-making, implicating the need for solutions that fall outside the realm of narrow health behavior change models. A critical narrative intervention approach, as taken in the DST process reviewed here, is one path forward for addressing health inequities and social inequality with marginalized young women. The DST process tapped into a broad range of written, visual, and perhaps most importantly, socially engaging activities that assisted participants with collaboratively unpacking their histories of trauma in a supportive space and developing social solidarity, while also developing digital stories that recalibrate the predominantly stigmatizing conversations about them as young women ‘at risk’ for pregnancy and motherhood, and collectively envisioning ways to move forward. Novel conversations and stories produced in critical narrative intervention efforts can and should be brought to bear in developing more sensitive interventions, policies, and public health messaging in collaboration with and supporting marginalized youth. Given the prior literature and our own findings on inordinate intergenerational trauma in the lives of these young women, a larger scale study is warranted that explores the ways that DST can improve psychosocial and physiological outcomes with young marginalized women. In tandem, the approach should be more deeply explored as a method for addressing social inequality and health inequities, serving as a tool for anti-oppression work, and for rebalancing our intellectual scale in public health with a shifted weight toward community-based knowledge production.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

References

- Barcelos C, & Gubrium A (Forthcoming). Bodies that tell: Embodying teen pregnancy through digital storytelling. *Signs: Journal of Women in Culture and Society*. Accepted for publication, 9 9, 2017.
- Briggs L (2002). *Reproducing empire: Race, sex, science, and U.S. imperialism in Puerto Rico*. Berkeley: University of California Press.
- Chavez LR (2008). *The Latino threat: Constructing immigrants, citizens, and the nation*. Stanford: Stanford University Press.
- Collins PH (1998). It's all in the family: Intersections of gender, race, and nation. *Hypatia*, 13(3), 62–82.
- Erdmans MP, & Black T (2015). *On becoming a teen mom: Life before pregnancy*. Berkeley: University of California Press.
- Fine M (1991). *Framing dropouts: Notes on the politics of an urban high school*. Albany: State University of New York Press.

- Furstenberg FF Jr. (2007). *Destinies of the disadvantaged: The politics of teenage childbearing*. New York: Russell Sage Foundation.
- Geronimus A (2003). Damned if you do: Culture, identity, privilege, and teenage childbearing in the United States. *Social Science & Medicine*, 57, 881–893. [PubMed: 12850113]
- Gubrium A, Fiddian-Green A, Lowe S, DiFulvio G, Del Toro-Mejías L (2016). Measuring down: Evaluating digital storytelling as a process for narrative health promotion. *Qualitative Health Research*, 26(13), 1787–1801. [PubMed: 27184518]
- Gubrium AC, & Harper K (2013). *Participatory visual and digital methods*. Walnut Creek, California: Left Coast Press.
- Gubrium AC, & Turner KCN (2011). Digital storytelling as an emergent method for social research and practice In Hesse-Biber SN (Ed.), *The handbook of emergent technologies in social research* (pp. 469–491). New York: Oxford University Press.
- Hamilton BE, Martin JA, Osterman MJK, Curtin SC, & Mathews TJ (2015). National Vital Statistics Reports. Retrieved from www.cdc.gov/nchs/products/nvsr.htm
- Lambert J (2010). *Digital storytelling cookbook*. Berkeley: Digital Diner Press.
- Lawlor DA, & Shaw M (2002). Too much too young? Teenage pregnancy is not a public health problem. *International Journal of Epidemiology*, 31, 552–554. [PubMed: 12055151]
- Lopez I (2008). *Matters of choice: Puerto Rican women's struggle for reproductive freedom*. New Brunswick: Rutgers University Press.
- Luttrell W (2003). *Pregnant bodies, fertile minds: Gender, race, and the schooling of pregnant teens*. New York: Routledge.
- Massachusetts Community Health Information Profile (Mass CHIP). (2013). Perinatal trends and health status indicators. Retrieved from www.mass.gov/eohhs/researcher/community-health/masschip/
- Peterson JC, Antony MG, & Thomas R (2012). “This right here is all about living”: Communicating the “common sense” about home stability through CBPR and photovoice. *Journal of Applied Communication Research*, 40, 1–24.
- Petraglia J (2007). Narrative intervention in behavior and public health. *Journal of Health Communication*, 12, 493–505. [PubMed: 17710598]
- Polkinghorne DE (1988). *Narrative knowing and the human sciences*. Albany: SUNY Press.
- Scheper-Hughes N (2004). Dangerous and endangered youth: Social structures and determinants of violence. *Annals of the New York Academy of Sciences*, 1036, 13–46. [PubMed: 15817729]
- Singh S, Darroch JE, & Frost JJ (2001). Socioeconomic disadvantage and adolescent women's sexual and reproductive behavior: The case of five developed countries. *Family Planning Perspectives*, 33(5), 251–289. [PubMed: 11804434]
- SmithBattle L (2007). “I wanna have a good future”: Teen mothers' rise in educational aspirations, competing demands, and limited school support. *Youth & Society*, 38, 348–371.
- Vargas DR (2010). Representations of Latina/o sexuality in popular culture In Acensio M (Ed.), *Latina/o sexualities: Probing powers, passions, practices, and policies* (pp. 117–136). New Brunswick: Rutgers University Press.