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Perspectives on trauma-informed care from mothers with a history of childhood maltreatment: A qualitative study☆

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ABSTRACT

Women who experienced abuse or neglect as children are more likely to have health problems during pregnancy and postpartum, but can be reluctant to seek help due to a lack of trauma-informed services. As part of a larger mixed method study, this component aimed to obtain qualitative data from trauma-exposed new mothers about their health care preferences during the perinatal period with the ultimate goal to design personalized, supportive interventions. Fifty-two trauma-exposed mothers completed a semi-structured interview at seven months postpartum about health care preferences including ideas for programs that promote wellness, thoughts about the influences of being a new mother and possible names for a program serving trauma-exposed mothers. Interviews were transcribed and coded using N-Vivo. Participants described ambivalence about seeking help but also a sincere desire for healing, coupled with hope for the future. This tension was apparent in the discussions highlighting the importance of access to experienced, non-judgmental, and knowledgeable health and social care staff and volunteers, the wish for both formal, integrated physical and mental health services, and for informal opportunities to meet other trauma-exposed mothers in a non-stigmatizing, child-friendly setting. Finally, positive relationship-building, respect, and safety were identified as key elements of services critical to counteract trauma-related shame and mistrust in others. Services for trauma-exposed mothers should acknowledge the normal ambivalence surrounding seeking help, but promote hope-affirming practices in a family-centered, safe, non-clinical setting that involves children, builds social support, and provides peer interaction. Program names should reflect optimism and healing rather than trauma.

Introduction

"*Unfortunately in the everyday world, so many people look at you and go, "oh, that's nothin'", "oh, you're being silly," "oh, get over it," but, you know. . .every person – it doesn't matter woman or man – every person responds differently to different things and, you know, people have to realize that and accept that*" – Maura, an abuse survivor and now a new mother in her early 30s, shares her wisdom that individual responses to childhood trauma are unique and vary from one person to the next.

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A history of childhood trauma is associated with a wide range of health problems in adulthood (Anda et al., 2006; Dube, Felitti, Dong, Giles, & Anda, 2003). Abuse survivors are at greater risk of developing psychiatric problems, including depression (Allen, 2008; Fergusson, Boden, & Horwood, 2008; Heim, Shugart, Craighead, Nemeroff, 2010; Sachs-Ericsson, Kendall-Tackett, & Hernandez, 2007; Widom, White, Czaja, & Marmorstein, 2007) and posttraumatic stress disorder (PTSD; Cromer & Sachs-Ericsson, 2006; Schumm, Briggs-Phillips, & Hobfoll, 2006; Ullman, Filipas, Townsend, & Starzynski, 2007). Motherhood can be especially challenging (Cohen, 1995; Fitzgerald, Shipman, Jackson, McMahon, & Hanley, 2005), and a trauma history may increase risk of developing perinatal depression (Benedict, Paine, Paine, Brandt, & Stallings, 1999; Buist & Janson, 2001; Buist, 1998a; Seng, Low, Sparbel, & Killion, 2004). Mothers who experience trauma and subsequent PTSD are more likely to exhibit hostile/intrusive parenting behaviors (Lyons-Ruth & Block, 1996) and have children with behavior problems (van Ee, Kleber, & Mooren, 2012). Mental health interventions that address trauma are associated with clinical improvement (Morrissey et al., 2005; Vitriol, Ballesteros, Florenzano, Weil, & Benadof, 2009), yet it can be difficult for trauma-exposed women to engage in care for a variety of reasons, from lack of child care or transportation to debilitating psychiatric symptoms or fear of re-traumatization (Newman et al., 2000; Stenius & Veysey, 2005). Some of this difficulty in engagement may reflect patterns of ambivalence about the process of help seeking or reluctance to trust health care professionals.

The importance of trauma-informed care, or services that consider the unique vulnerabilities of trauma survivors which may be aggravated by traditional approaches, was introduced by the results of the Women, Co-occurring Disorders, and Violence Study (WCDVS; Clark & Power, 2005; SAMHSA, 2012). This project revealed a significant lack of sensitive and suitable services for trauma-exposed women, particularly those with comorbid mental illness and addiction (Becker et al., 2005). Less than 40% of women reported that their service provider (e.g., therapist, counselor, doctor) supported them as mothers (Clark & Power, 2005). Many of these women had lost custody of their children, indicating that under-emphasis of the importance of parenting has already seriously impacted these families. There is a call for mental health interventions to explicitly take the parenting role into account (Becker et al., 2005).

Trauma-exposed women are significantly more likely to visit health care providers during pregnancy and postpartum as part of routine care (Ellis et al., 2008), suggesting that this period is a critical opportunity for interventions that address intergenerational cycles of trauma and violence and the promotion of resilience (Buist, 1998b; Seng, 2002). A powerful component of the WCDVS project was asking women who might seek these services about their experiences in order to build better programs. However, only a few participants had recently given birth at the time of the interview, leaving a gap in the literature about their needs during this vulnerable time (Becker et al., 2005). Our study goal was to understand more about health care preferences of trauma-exposed women in the early postpartum period through qualitative interviews.

Methods

Approach

A mixed method approach was used for the overall research design and implementation, complementing the use of validated, standardized measures to describe the study sample with qualitative interviews to enrich and enhance understanding of health, wellness and underlying issues.

Sample

As part of a larger longitudinal cohort study (Maternal Anxiety during the Childbearing Years, MACY, NIMH MH080147, PI: Muzik) examining the effects of maternal childhood maltreatment on adjustment to motherhood, parenting, and infant development, a subset ($n = 52$) of women was invited to complete a semi-structured interview about health care preferences. Participants for the larger cohort ($N = 268$) were recruited in obstetric clinics and by posting flyers in the community; all were English-speaking, ages 18 and older, had delivered healthy, term babies. Two-thirds had experienced childhood maltreatment, but had not necessarily sought postpartum mental health treatment. MACY data collection occurs across the first 3 years postpartum; data presented in this paper are all collected at 7 months postpartum. Selected women represented a purposive sample with personal experience of childhood maltreatment relevant to our research questions (Johnson, 1990). There were no statistically significant demographic or psychopathology differences between the maltreatment survivors who provided the interview and those who did not, nor were there any statistically significant demographic or psychopathology differences between the maltreatment survivors who provided the interview and the full sample. Information on the full sample and overall MACY study design is provided elsewhere (Muzik et al., 2013).

All study procedures, including obtaining informed consent from all participants, were approved by our institutional review board and carried out in accordance with The Code of Ethics of the World Medical Association (Declaration of Helsinki) for experiments involving humans. Names associated with quotations have been changed to pseudonyms to protect participant confidentiality.