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

Maria Muzik, MD, MSc[a] [Assistant Professor, Director, Women and Infants Mental Health Clinic], Menantalla Ads, BS[a] [Research Assistant], Caroline Bonham, MBBS, MSc[b] [Assistant Professor, Associate Training Director for Rural and Community Programs], **Katherine Rosenblum, PhD[a] [Clinical Associate Professor], Amanda Broderick, BA[a] [Research Assistant]**, and **Rosalind Kirk, PhD[a] [Research and Evaluation Specialist]**

Maria Muzik: muzik@med.umich.edu; Menantalla Ads: menatalla.ads@gmail.com; Caroline Bonham: cbonham@salud.unm.edu; Katherine Rosenblum: katier@med.umich.edu; Amanda Broderick: avbroder@med.umich.edu; Rosalind Kirk: roskirk@umich.edu

[a]Department of Psychiatry, University of Michigan

[b]Department of Psychiatry, University of New Mexico, USA

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 30's, shares her wisdom that individual responses to childhood trauma are unique and vary from one person to the next.

A history of childhood trauma is associated with a wide range of health problems in adulthood (Dube, Felitti, Dong, Giles, & Anda, 2003; Giles et al., 2006). Abuse survivors are at greater risk of developing psychiatric problems, including depression (Allen, 2008; Fergusson, Boden, & Horwood, 2008; Sachs-Ericsson, Kendall-Tackett, & Hernandez, 2007; Widom, White, Czaja, & Marmorstein, 2007; Heim, Shugart, Craighead, Nemeroff, 2010) 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, 1998a; Buist & Janson, 2001; 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,

Corresponding author Maria Muzik, MD, MSc, Department of Psychiatry, Rachel Upjohn Building, 4250 Plymouth Road, Ann Arbor, MI 48109, 734-232-0205 (phone) or 734-846-8027, 734-615-8739 (fax), muzik@med.umich.edu.

Disclosures of Conflicts of Interest
None for any author

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.

METHOD

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.

Measures

Mothers reported on their current PTSD symptoms using the National Women's Study PTSD Module (Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993); the 26-item scale yields a total score and an algorithm follows DSM-IV-TR criteria to derive a PTSD diagnosis. Mothers reported on their current depressive symptoms using the 35-item Postpartum Depression Screening Scale (PDSS; Beck & Gable, 2001), yielding a total score of 35 to 175, and with a cutoff of greater than 80 indicating clinically significant major depression. Mothers also provided demographic information. Table 1 summarizes demographic and mental health sample characteristics. Abuse history was assessed by the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998), a commonly used 28-item self-report inventory yielding information on abuse type and severity (see Table 2) with good psychometric properties.

We developed a semi-structured interview guide asking about health care preferences, ideas for programs that promote wellness, influences of being a new mother and thoughts about possible names for programs serving trauma-exposed mothers. Sample questions are: *Do you see any value in having a women's health place where trauma-related needs and problems are taken into account?; What sorts of things do you think trauma survivors (like you) might need for their health care?; What about their mental health? What about just lifestyle and well-being? What about something in particular for being a mom of an infant? What do you think we should call such a place? etc.* (see Table 3 for full list of interview questions). This interview was conducted during the 7-months postpartum home visit. Although this interview guide was used to elicit the discussion with the participants, the trained interviewers also encouraged free association and creativity, minimizing efforts to impose logical structure on participants' thoughts (Britten, 1995). This therefore expanded the content of responses as women elaborated freely and without any time-restriction. All interviews were audio-taped and transcribed. In efforts to systematically reduce the complexity of the data and manage the identification of emerging patterns and themes (Glaser & Laudel, 2013), content analysis was then applied to the transcripts. Adapted from grounded theory perspectives (Charmaz, 2006; Creswell, 2013; Strauss & Corbin, 1998) we developed a coding framework. As next step, using N-Vivo (QSR International, 2010), we identified an initial list of themes through a process of "open" coding to define each code and ensure codes were applied consistently (Miles & Huberman, 1994), we created detailed memos linking codes to emergent themes. Although interpretation is very important in qualitative analyses, the reliability of the process is as well, and was enhanced through independent double coding of each transcript by the second and third authors, who met regularly to resolve any discrepancies. Topical coding (Richards & Morse, 2013) as part of the analysis process helped focus results from the semi-structured interviews.

RESULTS

Throughout the interviews, many participants indicated ambivalence about seeking help but also a sincere desire for healing and hope for the future. One mother described how

ambivalence about seeking help can be connected to a sense of personal shame, a feeling also identified by 37.6% of other interviewees:

> "It took me a while to get to the point where it really wasn't my fault and I wasn't to blame really for what happened and it was okay for me to feel what I was… When it first happened, I was sort of embarrassed. I didn't want anyone to know, even though I did nothing wrong, it was sort of embarrassing that it happened to me at all. So, I think a lot of people don't seek help for that reason".

Based on responses to the interview questions (outlined in Table 3) about their desires for trauma-informed care, many mothers (94%) welcomed the idea of access to a range of multi-disciplinary, holistic, healing and well-being services that meet their needs as trauma survivors, as women, and, particularly as parents. Some participants articulated how these might be offered collaboratively in a health and wellness center. Specifically, mothers highlighted several requirements for adequate health care services, enumerated below with subsequent elaboration in the text. Trauma-informed health services should: 1. be based on respectful communication and trust; 2. demonstrate diversity to enrich communication and understanding; 3. adopt a team approach to the delivery of mental health care and support; 4. provide a range of family-focused tailored mental health services, including individual and group therapies, education and counseling (e.g., life skills and parenting education groups); 5. demonstrate improved accessibility and coordination of physical and mental health services. Furthermore, the service facility should 6. be easily accessible with flexible office hours providing a relaxed, safe, and welcoming atmosphere; 7. embrace a family-centered approach and provide complimentary, high-quality care and activities for young children accompanying mothers; 8. facilitate strengthening of social support networks; 9. structurally enable a holistic approach to wellness and finally, 10. have an uplifting, discrete name.

1. Respectful communication and trust

It is very important that those who provide services, whether professional or volunteer, are trusted by those who use services. Relationships built on "*trust*" and "*respect*" are fundamental. Where these positive personal values and skills underpin service delivery, a supportive and healing climate can be established and nurtured. Some mothers highlighted the importance of building trust with staff or other service participants. For example, Amber, a mother in her mid-twenties who was sexually abused in childhood, elaborated:

> "I'm sure some people probably need to be medicated for posttraumatic stress but I think probably most people - just talking about it - especially if they've never brought it up or addressed before - just need to—ah actually get it out and discuss it with someone that they can trust in."

A majority (63.5%) of women interviewed gave priority to the identification of specific personal attitudes, skills, and characteristics that promote positive relationship-building. Maura, from whom we had "heard" at the beginning of this article about the uniqueness of each woman's life journey following childhood maltreatment, shared her experiences of vulnerability and strength as she strives towards healing, successfully completing her bachelor's degree, securing a well-paying job and raising her son as a single mother. Maura shared that even today she was still very aware of the powerful influence the abuse experience had on her trust and relationships with others, and she remembered clearly communication and the quality of relationship with various counselors throughout the years. Maura remembered one person in particular:

> "I've met, like, one man in my life who was very non-judgmental. He'd help you and talk to you and he never once, I mean I've never seen him once, judge anybody for anything that they did wrong; And that's the kind of people that you'd need to

> work there, because they couldn't, you know I mean, you can't make somebody feel bad for something that they've maybe, they didn't have, any control over."

Similarly, Megan, another participant said:

> "People who believe them. People who validate [what] they're experiencing; who don't compare them to other people who… help them take responsibility for their role but… don't blame them for it; I think like, ya know, try to relate to your population."

Megan reinforced Maura's view and others' (80.8%) that a responsive, validating and non-judgmental therapeutic stance is paramount. Often, comments were made by mothers about the necessity of "*good listening skills*" and that staff should be *"helpful," "friendly", "respectful"* and *"courteous*".

2. Valuing diversity to enrich communication and understanding

Interviewees (11.5%) shared views supporting gender and racial diversity among providers of a service unit, and the openness to match providers with the preferences of help seekers. A relatively small percentage (10%) expressed a preference for female staff. An example of this view was given by Shauna when she remarked:

> "I think that's really key, to have other women helping women cause, I mean, it's hard to open up to a man if, you know, you had some kind of trauma; I think, I mean, I know men should be able to help but I think it's really difficult for people who've experienced trauma. You know? So I think [you need] a large staff of women."

As discussed in the prior section, great emphasis was directed to the listening qualities of staff and their ability to create a validating and non-judgmental environment, and this ability was, for most interviewed women, not unidimensionally equated with female staff.

3. Team approach to mental health care and support

It was recognized by several mothers that having both paid and unpaid staff, such as volunteers, could be enriching for a service unit and add to staff diversity; however, there was also a strong call for staff being "*knowledgeable*" and "*skilled*" including being good communicators. One interviewee suggested that voluntary, skilled support is often positive and may make running a center more *"financially feasible"*.

However, half (50%) of comments on staff proposed that support should be provided primarily by qualified professionals. Interviewees had no difficulty identifying a range of health professionals who may staff such a facility for childhood trauma survivors and their young children. These included a multi-disciplinary range of mental health professionals, including psychologists, psychiatrists, social workers, nurses, therapists, counselors, skilled volunteers and other physicians for diverse physical ailments. One woman also thought it important that a pastor be available on staff.

4. Providing a range of family-focused tailored mental health services

LaTonya had reached 39 years of age and was now the mother of a baby girl. Her childhood had been difficult and she had lived with adults who abused and neglected her in many ways. Her insights were helpful as she outlined the unique nature of mental health needs, often dependent on personal circumstances and coping strategies. She contributed to the awareness of needs for a range of services from individual psychiatric care and therapy, counseling to group work as a complement to informal supports.

"I think people need to start looking at more the feelings that it [childhood trauma] creates and based on those feelings and the belief system because it certainly changes what you feel and believe about people in the world around you and when you have a different view it affects how you deal with those things - men and relationships and other children and people in authoritarian/authoritative positions; how to deal with...social situations and people, ya know, cause I mean it can make you very bitter and distrusting and not just in intimate relationships - just work relationships social relationships, friendships. It affects all of that; I mean it's different approaches...it definitely is something that's an individualized program… you can't just say everybody in one group let's all deal with this the same way; Group sessions definitely are a plus cause, ya know, learn other coping mechanisms, you see some people really are worse off than you and some people you have to, I think, need to understand that their's wasn't as bad as your's but it still affected them the same way".

While nearly all women interviewed in the study described the benefit of individual counseling or having access to an empathetic listener who was sensitive and responsive to the women's trauma experiences, not all identified group therapy as a preferred option. All participants commented on entry to motherhood as a time to address mental health concerns in order to be better parents. Some also described the postpartum period as a time of heightened awareness in regards to their social skills deficits, as they reported that these skills had not been passed on from their own families. For many, a group was identified as an ideal venue to offer such educational experiences regarding those social skills, as group participation enhanced opportunities to share, identify, and learn from other group members. Nearly a third of mothers (30.8%) also described how the trauma experience profoundly shaped their identities and confidence as mothers. One mother stated:

"[I want to learn] how to parent with healthy fear because I think that anyone who has had one of those traumatic events is going to have fear of it happening to their child and there has to be a line between protecting your child and overprotecting… learning how to let them live but still protect them and teach them".

Another participant indicated that she sometimes felt confused about routine childcare and appropriate responses to her daughter's body. She also expressed a desire to understand what "*normal*" parenting might look like:

"Sometimes I worry…I don't want to touch her in a way that scars her…I only do things like give her baths and change her diapers but…I feel…nervous about letting other people do that…I trust her dad [but] I just feel like I would rather no men change her diaper or…give her baths."

Some mothers (36.5%) worried that their own childhood experiences undermined their intuition and sensitivity as a parent. They were concerned about possibly hurting their children and clearly wanted to assure themselves to create a safe environment. Thus, they asked for parenting education classes that address safe parenting practices in the face of their traumatic experiences. For example, one woman wanted:

"classes that…show you how to cope with toddler years and dealing with the terrible twos where you are not emotionally abusing them…[and] classes that show…how to cope with your own emotions…When I find myself getting mad at [my son] I can almost hear my mom and what she used to do to me and my brother. I try to block it out but it is so hard to block it out because it was embedded in my brain and mind for so long."

5. Accessibility and coordination of maternal physical and mental health services

Some women (19.2 %) reflected on practical barriers such as transport and accessing services indicating that services may be delivered in a way that reflects more organizational rather than family needs. Ideas were proposed about how to alter this. Amber, like others, emphasized a need to make sure that women who have been traumatized are not put in the position of repeating their issues repeatedly to various health providers. This included co-location or integration of physical and mental health services, and of shared medical records. She stated:

> "I think it would just be helpful if it could all occur in the same place - if you could deal with the same network of people - you didn't have to run around to go here to see a doctor to get a medication and retell your story all over again. Ya know, just so you're in one place, you have a file everybody's familiar with you. They know your situation and what kind of help you need".

Comments were made not only about being able to access maternal mental health services but also about their physical wellbeing as new mothers, and that of their infants and young children. This led to multiple suggestions for establishing a one-stop "trauma-informed health center" with integrated care across all mind-body needs, and for well-coordinated medical staff on-site, such as pediatricians, primary care doctors, obstetricians and gynecological specialists, as well as mental health providers. Participants proposed ideas about various programs at such a trauma-informed center that would promote the wellness of a mother and her children. Only a small number of women (4) thought that, although they conceptually agreed with the benefit of such a center and would support it, that they would not necessarily utilize it because they considered their personal crises to be in the past or perceived that they did not need any additional support at this time.

6. A relaxed, safe and welcoming atmosphere with flexible hours

An important aspect featured often was the need for safety, security and a sense of informality in contrast to traditional clinical sterility in order to promote wellness. When prompted to imagine the physical location of where desired services would be offered, women made comments such as "something homey" and "not clinical", describing comfortable settings with sofas, cushions, and gardens; a safe place where they could bring their pets and children.

> "I think a place that's nice and kind of cozy…that doesn't necessarily feel like a doctor's office or a hospital so that you feel like you want to be there. I think that's also important so that you might choose to go rather than sort of hide away…I think that's important…a comfy atmosphere so that you really feel safe."

Maura, for example, highlighted the need for opening hours that reflect the realities of women's lives:

> "just easily accessible. Some place that they'll feel comfortable and welcome - open it not all hours but, ya know, where people if they work during the day could go, or if you work odd shifts you could go there at any time basically…people know that they're not alone and it's just somethin' that happens in life and it's ok that it happens. It's ok to talk about it - just know how to prevent it in the future so that it doesn't happen again. A laidback type of place; just so that women feel comfortable there."

7. Embrace family-centered delivery of services: high quality care and activities for young children accompanying moms

In a similar vein to flexibility regarding opening hours, over two thirds (67.3%) of interviewees identified additional practical supports that enabled attendance at such a center, including flexibility of the setting (e.g., family-friendly facility) and focus (e.g., child-care). This included a whole-family approach to healing and services, reflected in the comments stating that it was easier to seek help when programs included informal activities involving children:

> "…some sort of play group…because it can be intimidating to go to a counselor or go to a group that has a label but children are great icebreakers [and can be] a great way to get to know people and make friends -something low key like that."

This function of child-focused activities as an "ice-breaker", point of connection and trust-building with the providers was complemented by the very concrete notion that women also have a tangible need for childcare. Many women (48%) asked for childcare on-site, both for convenience reasons but also as reassurance that their children were cared for in a safe environment while they were getting help themselves.

8. Extending and strengthening social support networks

Although all participants wanted one to one counseling opportunities available, 19.2% of mothers also described the importance of enabling an atmosphere for peer socialization in a safe environment. For example, some women asked for informal opportunities to meet other women with similar traumatic experiences and to create informal outlets to discuss parenting challenges. Overall, it became obvious that some women described feeling frequently like outsiders in other contexts and that they were yearning for social connection with other trauma survivors. The following participant, like some others, articulates how past sexually traumatic experiences constantly shape her interactions with others:

> "One thing for me is that I feel, like, not just everybody else and I still haven't found the answer to that question. I join groups, I volunteer and they just love it. They love it that I volunteer but they don't invite me to anything… you wonder why and it comes up in your head. Why is that guy looking at me in this restaurant? Does he know what I did? Does he think I'm a slut? Do I still look like a slut?…I guess we just need a lot of reassurance that [we] are ok and you still have to decide what normal is…the hardest thing about this type of trauma is to feel like [I belong] in some way and to feel normal."

Some of the most commonly requested services were group counseling sessions with other trauma-exposed mothers. Some mothers suggested that they might be able to learn life and parenting skills from other mothers. They were aware that they often had difficulty trusting others and wanted to ensure that they did not pass on this sense of distrust to their children. When imagining a healing setting, they described a place where they could begin to cultivate supportive relationships and friendships with others.

9. Enable a holistic approach to wellness

As they imagined healing from traumas that cause ongoing distress, 25% of the women identified activities that helped them feel better about their bodies, such as yoga, exercise, dancing, nutrition, salon services and, perhaps surprisingly, massage. Although at least one woman mentioned that they felt uncomfortable with physical touch, she also imagined that massage had the potential to be both healing and relaxing, if provided in a safe environment. *"Something that makes your body feel good and clean – just treating your body – the whole body."*

10. An uplifting, discrete name for a trauma center

Finally, almost all participants responded to the question about a possible name for a trauma-informed center for mothers with a history of childhood maltreatment. In general, women envisioned that the name should be "*benign*", "*encouraging*" and "*uplifting*". They were concerned that an overly clinical name may exacerbate stigma. Only four participants felt that the name should incorporate the word "*trauma*". All other women specified that they would be less likely to attend a program that included the word "*trauma*". A few provided as rationale the fear that the open label of "*trauma*" is associated with stigmatization and would push them even more into silence and shame. Many clearly expressed that they did not want other people to know about their abuse experience and reiterated profound shame about needing to seek help:

> "It has to have a safe name because people who go [and] who would want to seek out these things [but] don't necessarily want everybody to know that, I'm going to the traumatic stress center…I think most people want to deal with these things in private so it shouldn't be too revelatory."

Moreover, some women named another reason for their discomfort with the term "trauma" in the center's naming. Mothers indicated that the word trauma emphasized injury and damage rather than healing. They demonstrated a longing for an attitude of recovery and resilience rather than deficiency and injury. They suggested names that were fairly neutral but focused on healing and hope such as *Hope's Haven* or *Women and Family Health and Wellness Center*. The names suggested by participants are listed in Table 4. Several women struggled with choosing a name. Although only one woman suggested to explicitly use the word trauma in the naming, several others did point out that neutral names could be considered overly euphemistic and be misleading. For example, by avoiding the word trauma, it could make it difficult for other women to be aware of needed services:

> "I think it should be discrete, especially if they need to get other people to drive them there. You don't want a huge sign that says trauma…But then you want people to know about it so, I don't know. There's that paradox, hmm. Yeah, I'm not quite sure which is worse. Because, you know, the shame factor is huge with any type of trauma."

DISCUSSION

Childhood abuse or neglect can continue to impact survivors throughout the lifespan. The perinatal period is a particularly vulnerable time with serious implications for both mother and child if symptoms go untreated, yet trauma-exposed mothers have difficulty seeking and receiving help, partly due to the lack of appropriate services and in part due to internal barriers hindering help-seeking. First person accounts from women with histories of childhood abuse affirm that mental health symptoms are inextricably intertwined with the motherhood role (Bassett, Lampe, & Lloyd, 1999; Mockus et al., 2005; Savvidou, Bozikas, Hatzigeleki, & Karavatos, 2003), however, many service agency guidelines undervalue this fundamental aspect of women's lives (Becker, et al., 2005). More information is required about the unique needs of these women in order to build and sustain successful programs that keep families engaged.

Our study highlighted the importance of the parenting role in seeking healthcare as trauma survivors, finding that women see their children as powerful motivators for healing. Overall, mothers identified an internal conflict between ambivalence about seeking support and hope for healing, which is consistent with existing literature (Bacchus, Mezey, & Bewley, 2003; Clark & Power, 2005; Stenius & Veysey, 2005). The WCDVS guidelines state that appropriate care must be 1) integrated, such as combining mental health and substance abuse

services, 2) trauma-informed, 3) consumer-involved and 4) comprehensive, incorporating services like screening for mental health and medical disorders, parenting skills training, and crisis services (Huntington, Jahn Moses, & Veysey, 2005). Our results suggest that these guidelines are also appropriate for the early postpartum period. In addition, our participants emphasized a holistic approach to healing in a comfortable setting, consistent with Stenius' and Veysey's (2005) work. Identifying as a trauma survivor can be difficult for many women, but programs that recognize, but de-emphasize, their trauma history by focusing on hope for the future can be therapeutic. Finally, cultivating social support in a safe atmosphere appears essential to these families. Trauma survivors want a safe, comfortable space to interact with other women who understand their experiences (Becker, et al., 2005; Lewis et al., 2005; Markoff, Reed, Fallot, Elliott, & Bjelajac, 2005; Stenius & Veysey, 2005), and becoming a mother only intensifies this desire. However, women desire safe child care and suggest running groups in parallel, such as facilitating a mother's support group while their children are cared for nearby, addressing both practical need for childcare and sincere desire for parenting advice (Finkelstein, 1980).

The WCDVS project also stressed the importance of naming oneself in order to preserve often-silenced survivor voices (Mockus, et al., 2005). In our study, we asked women to offer possible names for a proposed interventional program. Almost all suggested names emphasized hope and recovery, not impairment. Previous work has used the term recovery to signify hope as a non-linear process, where survivors can find meaning in life through healing, not just a cure (Davidson et al., 2007; Onken, Craig, Ridgway, Ralf & Cook, 2007).

Limitations

Although this sample ($n = 52$) was drawn from a larger study and is broadly representative of its demographics and characteristics, it is not known the extent to which views expressed about health service preferences by women who have experienced childhood trauma are also reflective of those with childhood trauma who chose not participate in research or were not contactable at the time interviews were conducted. The women whose voices shaped these findings may not have been inclusive of other groups of mothers who have experienced childhood trauma, especially those who may be extremely mobile or not interested in research participation. However, despite this limitation we believe that results are consistent with other research on traumatized women, and confirm the demand for more family-centered, flexible approach to health service delivery for this target group.

CONCLUSION

Healing is a journey between ambivalence and hope. Services for trauma-exposed mothers should acknowledge the normal ambivalence surrounding seeking help, but should be designed around hope-affirming practices. Women in our study identified several hope-promoting features, such as peer support, group interventions, and safe, comfortable, service-integrated delivery sites. Finally, children and the motherhood role are chief motivators for hope, and therefore, child-friendly services are more likely to appeal to these families. Programs modeled upon these suggestions may be a powerful motivator to seek care, as well as a crucial anchor to engage in treatment long-term.

Acknowledgments

References

Allen B. An analysis of the impact of diverse forms of childhood psychological maltreatment on emotional adjustment in early adulthood. Child Maltreatment. 2008; 13:307–312. [PubMed: 18556593]

Bacchus L, Mezey G, Bewley S. Experiences of seeking help from health professionals in a sample of women who experienced domestic violence. Health & Social Care in the Community. 2003; 11:10–18. [PubMed: 14629228]

Bassett H, Lampe J, Lloyd C. Parenting: Experiences and feelings of parents with a mental illness. Journal of Mental Health. 1999; 8:597–604.

Beck CT, Gable RK. Further validation of the Postpartum Depression Screening Scale. Nursing Research. 2001; 50:155–164. [PubMed: 11393637]

Becker MA, Noether CD, Larson MJ, Gatz M, Brown V, Heckman JP, Giard J. Characteristics of women engaged in treatment for trauma and co-occurring disorders: Findings from a national multisite study. Journal of Community Psychology. 2005; 33:429–443.

Benedict MI, Paine LL, Paine LA, Brandt D, Stallings R. The association of childhood sexual abuse with depressive symptoms during pregnancy, and selected pregnancy outcomes. Child Abuse & Neglect. 1999; 23:659–670. [PubMed: 10442831]

Bernstein DP, Fink L. Childhood Trauma Questionnaire. CTQ. 1998

Britten N. Qualitative interviews in medical research. British Medical Journal. 1995; 311(6999):251–253. [PubMed: 7627048]

Buist A. Childhood abuse, parenting and postpartum depression. Australian and New Zealand Journal of Psychiatry. 1998a; 32:479–487. [PubMed: 9711360]

Buist A. Childhood abuse, postpartum depression and parenting difficulties: A literature review of associations. Australian and New Zealand Journal of Psychiatry. 1998b; 32:370–378. [PubMed: 9672726]

Buist A, Janson H. Childhood sexual abuse, parenting and postpartum depression: A 3-year follow-up study. Child Abuse & Neglect. 2001; 25:909–921. [PubMed: 11523868]

Charmaz, C. Constructing grounded theory: A practical guide through qualitative analysis. Thousand Oaks, CA US: Sage Publications, Inc; 2006.

Clark HW, Power AK. Women, Co-occurring Disorders, and Violence Study: A case for trauma-informed care. Journal of Substance Abuse Treatment. 2005; 28:145–146. [PubMed: 15780543]

Cohen T. Motherhood among incest survivors. Child Abuse & Neglect. 1995; 19:1423–1429. [PubMed: 8777693]

Cresswell, JW. Qualitative inquiry and research design. 3. Thousand Oaks, CA US: Sage Publications, Inc; 2013.

Cromer KR, Sachs-Ericsson N. The association between childhood abuse, PTSD, and the occurrence of adult health problems: Moderation via current life stress. Journal of Traumatic Stress. 2006; 19:967–971. [PubMed: 17195985]

Davidson L, Tondora J, O'Connell MJ, Kirk T Jr, Rockholz P, Evans AC. Creating a recovery-oriented system of behavioral health care: Moving from concept to reality. Psychiatric Rehabilitation Journal. 2007; 31:23–31. [PubMed: 17694712]

Dube S, Felitti V, Dong M, Giles W, Anda R. The impact of adverse childhood experiences on health problems: Evidence from four birth cohorts dating back to 1900. Preventive Medicine. 2003; 37:268–277. [PubMed: 12914833]

Ellis KK, Chang C, Bhandari S, Ball K, Geden E, Everett KD, Bullock L. Rural mothers experiencing the stress of intimate partner violence or not: Their newborn health concerns. Journal of Midwifery & Women's Health. 2008; 53:556–562.

Fergusson DM, Boden JM, Horwood LJ. Exposure to childhood sexual and physical abuse and adjustment in early adulthood. Child Abuse & Neglect. 2008; 32(6):607–619. [PubMed: 18565580]

Finkelstein NE. Family-centered group care. Child Welfare. 1980; 59:33–41. [PubMed: 6244136]

Fitzgerald M, Shipman K, Jackson J, McMahon R, Hanley H. Perceptions of parenting versus parent-child interactions among incest survivors. Child Abuse & Neglect. 2005; 29:661–681. [PubMed: 15979708]

Giles W, Dube S, Perry B, Whitfield C, Walker J, Bremner JD, Anda R. The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. European Archives of Psychiatry and Clinical Neuroscience. 2006; 256:174–186. [PubMed: 16311898]

Glaser J, Laudel G. Life With and Without Coding: Two Methods for Early-Stage Data Analysis in Qualitative Research Aiming at Causal Explanations. Forum: Social Qualitative Research. 2013; 14

Heim C, Shugart M, Craighead W, Nemeroff C. Neurobiological and psychiatric cosequences of child abuse and neglect. Developmental Psychobiology. 2010; 52:671–690. [PubMed: 20882586]

Huntington N, Jahn Moses D, Veysey BM. Developing and implementing a comprehensive approach to serving women with co-occurring disorders and histories of trauma. Journal of Community Psychology. 2005; 33:395–410.

Johnson, JC. Selecting ethnographic informants. Newbury Park; London: Sage; 1990.

Lyons-Ruth K, Block D. The disrubed caregiving system: Relations among childhood trauma, maternal caregiving, and infant affect and attachment. Infant Mental Health Journal. 1996; 17:257–275.

Lewis SF, Resnick HS, Ruggiero KJ, Smith DW, Kilpatrick DG, Best CL, Saunders BE. Assault, psychiatric diagnoses, and sociodemographic variables in relation to help-seeking behavior in a national sample of women. Journal of Traumatic Stress. 2005; 18:97–105. [PubMed: 16281201]

Markoff LS, Reed BG, Fallot RD, Elliott DE, Bjelajac P. Implementing trauma-informed alcohol and other drug and mental health services for women: lessons learned in a multisite demonstration project. American Journal of Orthopsychiatry. 2005; 75:525–539. [PubMed: 16262512]

Miles, MB.; Huberman, AM. Qualitative data analysis: An expanded sourcebook. 2. Thousand Oaks: Sage Publications; 1994.

Mockus S, Mars LC, Ovard DG, Mazelis R, Bjelajac P, Grady J, McKinney J. Developing consumer/survivor/recovering voice and its impact on services and research: Our experience with the SAMHSA Women, Co-Occurring Disorders and Violence Study. Journal of Community Psychology. 2005; 33:513–525.

Morrissey JP, Ellis AR, Gatz M, Amaro H, Reed BG, Savage A, Banks S. Outcomes for women with co-occurring disorders and trauma: Program and person-level effects. Journal of Substance Abuse Treatment. 2005; 28:121–133. [PubMed: 15780541]

Muzik M, Bocknek EL, Broderick A, Richardson P, Rosenblum KL, Thelen K, Seng J. Mother-infant bonding impairment across the first 6 months postpartum: the primacy of psychopathology in women with childhood abuse and neglect histories. Archives of Women's Mental Health. 2013; 16:29–38.

Newman MG, Clayton L, Zuellig A, Cashman L, Arnow B, Dea R, Taylor CB. The relationship of childhood sexual abuse and depression with somatic symptoms and medical utilization. Psychological Medicine. 2000; 30:1063–1077. [PubMed: 12027043]

QSR International. NVivo 9 [Computer software]. 2010. Available from http://www.qsrinternational.com

Onken S, Craig C, Ridgway P, Ralph R, Cook J. An analysis of the definitions and elements of recovery: A review of the literature. Psychiatric Rehabilitation Journal. 2007; 31:9–22. [PubMed: 17694711]

Resnick HS, Kilpatrick DG, Dansky BS, Saunders BE, Best CL. Prevalence of civilian trauma and posttraumatic stress disorder in a representative national sample of women. Journal of Consulting and Clinical Psychology. 1993; 61:984–991. [PubMed: 8113499]

Richards, L.; Morse, J. Readme first for a user's guide to qualitative methods. Thousand Oaks, CA US: Sage Publications, Inc; 2013.

Sachs-Ericsson N, Kendall-Tackett K, Hernandez A. Childhood abuse, chronic pain, and depression in the National Comorbidity Survey. Child Abuse & Neglect. 2007; 31:531–547. [PubMed: 17537506]

SAMHSA. Welcome to the National Center for Trauma-Informed Care. 2012. Retrieved June 26, 2012, retrieved on from http://www.samhsa.gov/nctic/default.asp

Savvidou I, Bozikas VP, Hatzigeleki S, Karavatos A. Narratives about their children by mothers hospitalized on a psychiatric unit. Family Process. 2003; 42:391–402. [PubMed: 14606202]

Schumm JA, Briggs-Phillips M, Hobfoll SE. Cumulative interpersonal traumas and social support as risk and resiliency factors in predicting PTSD and depression among inner-city women. Journal of Traumatic Stress. 2006; 19:825–836. [PubMed: 17195981]

Seng JS. A conceptual framework for research on lifetime violence, posttraumatic stress, and childbearing. Journal of Midwifery & Women's Health. 2002; 47:337–346.

Seng JS, Low LK, Sparbel KJ, Killion C. Abuse-related post-traumatic stress during the childbearing year. Journal of Advanced Nursing. 2004; 46:604–613. [PubMed: 15154901]

Strauss, A.; Corbin, J. Basics of qualitative research: Techniques and procedures for developing grounded theory. 2. Thousand Oaks, CA US: Sage Publications, Inc; 1998.

Stenius VM, Veysey BM. It's the little things": Women, trauma, and strategies for healing. Journal of Interpersonal Violence. 2005; 20:1155–1174. [PubMed: 16162484]

Ullman SE, Filipas HH, Townsend SM, Starzynski LL. Psychosocial correlates of PTSD symptom severity in sexual assault survivors. Journal of Traumatic Stress. 2007; 20:821–831. [PubMed: 17955534]

van Ee E, Kleber RJ, Mooren TM. War trauma lingers on: Associations between maternal posttraumatic stress disbrorder, parent-child interaction, and child development. Infant Mental Health Journal. 2012; 33:459–468.

Vitriol V, Ballesteros S, Florenzano R, Weil K, Benadof D. Evaluation of an outpatient intervention for women with severe depression and a history of childhood trauma. Psychiatric Services. 2009; 60:936–942. [PubMed: 19564224]

Widom CS, White HR, Czaja SJ, Marmorstein NR. Long-term effects of child abuse and neglect on alcohol use and excessive drinking in middle adulthood. Journal of Studies on Alcohol and Drugs. 2007; 68:317–326. [PubMed: 17446970]

Table 1

Demographics (*n* = 52)

Characteristic	Frequency	%
Race/Ethnicity		
Caucasian	32	61.5
African American	11	21.2
Arab-Am, Native American & Asian	7	13.5
Missing	2	3.8
Infant Gender		
Female	24	46.2
Male	28	53.8
Maternal Current Depression diagnosis		
Yes	12	23.1
No	32	61.5
Missing	8	15.4
Maternal Current PTSD diagnosis		
Yes	16	30.8
No	28	53.8
Missing	8	15.4
Maternal Lifetime PTSD diagnosis		
Yes	29	55.8
No	17	32.7
Missing	6	11.5
Mother Age	*M* = 28.44 (*SD* = 5.59; *Range* 19-39)	
Partner Status		
Partnered	39	75
Not Partnered	13	25
Highest Level of Education		
HS degree	4	7.7
Some college/Assoc/Tech Degree	23	44.2
Bachelor's Degree	17	32.7
Graduate Degree	8	15.4
Annual Household Income		
Less than $25,000	16	30.8
$25,000-49,999	13	25
$50,000-99,999	14	26.9
More than $100,000	8	15.4
Missing	1	1.9

Table 2

Participants' Childhood Abuse/Neglect by Type

Type	%
Emotional Neglect	61.1%
Physical Neglect	38.9%
Emotional Abuse	68.5%
Physical Abuse	42.6%
Sexual Abuse	48.1%
Severe Abuse	42.6%

Table 3

Semi-structured Interview

We would like to ask you some more general questions about health care needs of trauma survivor moms. We are hoping in the future to create a place where trauma survivors can come to get help with their physical and psychological health needs. But there is no such place we know of yet. So we are asking trauma survivors in our projects to help us imagine what that would be like--to help us invent what women want.	
1.	Do you see any value in having a women's health place where trauma-related needs and problems are taken into account?
2.	What sorts of things do you think trauma survivors (like you) might need for their health care?
3.	What about their mental health?
4.	What about just lifestyle and well-being?
5.	What about something in particular for being a mom of an infant?
6.	What do you think such a place should be like (e.g., what sort of building? Services? Staff? Programs?)
7.	What do you think we should call such a place?
8.	If we called it a "Center for Traumatic Stress and Women's Health" do you think people would be put off by that?
9.	If we made that sort of center, do you think you would take advantage of it?
10.	Anything else you would like to add that we have not addressed?

Table 4

Proposed Names

Hope's Haven

Help is on the Way

Safe Haven

Mother and Baby Tranquility House

Women and Family Health and Wellness Center

The New You

Center for Women's Wellbeing

Open Hands

Women's Circle Center

Women's and Children's Facility

Horizons

People in Need

Safe Haven

Center for Dogs and their Humans

Baby Boot Camp

Women's Oasis

Women's Resource Health Center

Center for Women's Health

Traumatics Actions