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# ABUSE-RELATED POSTTRAUMATIC STRESS AND DESIRED MATERNITY CARE PRACTICES: WOMEN'S PERSPECTIVES

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Qualitative research participants who self-identified as having a history of childhood sexual abuse and abuse-related posttraumatic stress during the childbearing year were interviewed for the purpose of determining what these women perceive as optimal maternity care. Using a process of narrative analysis, desired care practices were identified. With the exception of one woman, all of the study participants wanted their maternity care provider to be competent to address trauma-related needs. Three groups emerged from the data, providing a useful structure for informing providers on how best to respond to diverse abuse-survivor clients: 1) women far along in recovery, 2) women who were not safe, and 3) women who were not ready to "know." The first group had the best trauma-related and maternity outcomes and the best childbearing experiences. For these women, having a provider who was a "collaborative ally" seemed beneficial. The second group had safety needs that required a "compassionate authority figure" who offered referral and follow-up care. Women in the third group were not ready to address trauma-related symptoms or issues overtly and appeared to need a provider who was a "therapeutic mentor." Four assessment factors help providers determine how to respond. *J Midwifery Womens Health* 2002;47:360-70 © 2002 by the American College of Nurse-Midwives.

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## INTRODUCTION

Posttraumatic stress disorder (PTSD) affects an estimated 12.3% of women (11.8 million) in the general population of the United States during their lifetime, with 4.6% meeting diagnostic criteria for PTSD at any given time (1). The prevalence of PTSD is higher among women who are victims of violence, ranging from 27% among women molested in childhood to 80% in battered women and/or survivors of rape (1-4). Routine screening for lifetime history of abuse has become a standard of care during pregnancy (5-7). All forms of childhood or adult abuse, rape, or battering meet the American Psychiatric Association criterion for trauma exposure that can lead to development of PTSD (8). However, screening for the long-term posttraumatic stress sequelae after disclosure of abuse is not currently a consistent practice. Health care providers encounter women affected by posttraumatic stress very frequently, probably daily. One study found that pregnant women who disclosed abuse

histories were present among nurse-midwifery clients at a higher rate than among obstetricians' clients (12.2% versus 8.5%) (9). Clinical literature has included descriptions of women with a history of abuse who struggle with trauma-related issues and posttraumatic stress symptoms throughout the childbearing year, suggesting that assessing for and responding to posttraumatic stress in maternity care may improve the process and outcomes of childbearing (10-12). However, some women may not be aware of how their trauma history and posttraumatic sequelae might affect their general health or pregnancy. Furthermore, many do not disclose this history to health care providers for a variety of reasons, including fear, shame, and concerns about confidentiality, traumatic amnesia, or lack of trust. Therefore, eliciting a history of trauma and referring for mental health services is both more complicated and less adequate than it might initially appear.

Women with trauma histories, including those who have survived childhood abuse and those experiencing abuse as an adult, present for health care with a wide range of trauma-related sequelae, which include frequent physical symptoms that are distressing, poorer perceptions of health status, lower physical functioning, more health risk behaviors, greater use and higher health care costs, more chronic pain conditions, and perhaps even more disease, in addition to mental health sequelae including depression, anxiety, and posttraumatic stress disorder (7,13-19). Although the prevalence of PTSD can be quite high in this subgroup of women, the proportion who access mental health services and are diagnosed is much smaller (20-22).

Posttraumatic stress disorder is a syndrome that involves symptoms of intrusive reexperiencing of the trauma, avoidance and/or emotional numbing, and autonomic hyperarousal (8) (Table 1). Although a proportion of abuse survivors clearly meet diagnostic criteria for the disorder, many experience symptoms, or a "partial PTSD," at a level below the diagnostic threshold. In this article, the term "posttraumatic stress" is used in the more inclusive sense, referring to the experience of symptoms or associated features whether or not these meet the diagnostic criteria. Among women abused in

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**TABLE 1**  
**PTSD Symptoms, Associated Features, and Comorbid Conditions**

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PTSD core symptom clusters
Reexperiencing
Avoidance and numbing
Increased arousal
Associated features found among women survivors of severe or early abuse
Dissociative symptoms
Somatic complaints
Interpersonal sensitivity
Impaired affect modulation
Loss of previously sustained faith
Self-destructive and impulsive behavior
Substance abuse
Disordered eating
Revictimization
Comorbid disorders
Major depressive disorder
Panic disorder
Phobias
Obsessive-compulsive disorder

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Adapted from: American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 4th ed. Washington (DC): American Psychiatric Association, 1994. Herman JL. Trauma and recovery: the aftermath of violence—from domestic abuse to political terror. New York: BasicBooks, 1992. Roth S, Newman E, Pelcovitz D, van der Kolk B, Mandel FS. Complex PTSD in victims exposed to sexual and physical abuse: results from the DSM-IV Field Trial for Posttraumatic Stress Disorder. *J Trauma Stress* 1997;10:539–55 (8,23,24).

childhood and other survivors of prolonged, inflicted trauma, additional problems co-occur, which have been conceptualized as a Complex PTSD or Disorder of Extreme Stress (23,24). PTSD is a biological as well as psychological and interpersonal syndrome. Neuroendo-

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crine alterations include dysregulations in the hypothalamic-pituitary-adrenal axis, including cortisol dysregulation, which could interact with neuroendocrine processes of childbearing (25). The associated or comorbid behavioral alterations seen in persons with PTSD include health risk behaviors that could affect pregnancy: substance use, disordered eating, high-risk sexual behavior, self-harm, and revictimization (23,26).

The PTSD conceptualization has been used to frame descriptions of how some women with trauma sequelae experience pregnancy and the postpartum period in the clinical literature (10,12). Newer research has begun to document the incidence of complications noted in such clinical articles that are consistent with biological theories about PTSD (22). Women diagnosed with PTSD seemed to have greater incidence of ectopic pregnancy, miscarriage, hyperemesis, preterm contractions, and concerns about maternal and fetal weight gain (22). It would seem logical to offer psychological treatment or referral to women whose pregnancies are affected by posttraumatic stress symptoms and concerns. Yet, most maternity care clients are not seeking mental health care. Furthermore, the services that are most desired and acceptable for women affected by posttraumatic stress during pregnancy are unknown. Different women likely want different care from their health care providers. There is a need to begin formulating best care practices that can guide clinicians working with diverse women affected by posttraumatic stress during the childbearing year. In an attempt to unravel some of the uncertainty and complexity health care providers might encounter when providing care to such women, it seemed critical to ask them directly about their needs and desires. The study reported here was designed to answer the research question: "What do pregnant women who have experienced abuse-related posttraumatic stress during their maternity care experience want from maternity care providers?"

## METHODS

To answer the research question, an exploratory descriptive study was designed by applying narrative analysis to the stories of women whose childbearing was affected by abuse-related posttraumatic stress (27). Telling childbearing stories is a form of narration that both women and caregivers engage in, and we hoped that a storytelling format (rather than a question and answer one) would facilitate the participants' task of integrating abuse history and posttraumatic stress content into the story of their childbearing year. For a narrative study, a research team approach is valuable for minimizing bias. Our team consists of the nurse-midwife primary investigator whose research focuses on PTSD and childbearing, a family nurse practitioner with background in qualitative methods, and two additional perinatal researchers (one a

nurse-midwife, one a maternity nurse and anthropologist) who have conducted multiple qualitative research projects.

### **Recruitment and Safety**

The recruitment and enrollment process for this study was designed by following guidelines for research on violence against women to maximize the confidentiality and safety of the participants and the researchers (28). The project was approved by the Institutional Review Boards of both the University of Iowa and the University of Michigan. A federal confidentiality certificate was obtained to safeguard against subpoena of data, which could be used against any participant in child custody or criminal proceedings (eg, drug use). A targeted convenience sample of women was recruited who self-identified as having a history of abuse and posttraumatic stress that affected their pregnancy and childbirth experiences. Some had a history of childhood sexual abuse only. Some also told of adult rape and battering. All volunteers were interviewed, whether or not they were ever formally diagnosed with PTSD. Furthermore, it was not a requirement that the women understood the effects of the trauma during their pregnancy; the only requirement was that they could speak to its effects retrospectively. As women responded to recruitment ads, they were also asked if they knew other women who might be interested in the study. Through this process of self-selection and snowball sampling, a total of 15 women were recruited. It is important to note that no diagnostic assessment was performed as part of the study because the purpose was to hear their stories of their childbearing year. The goal was to focus on understanding the experiences from the woman's perspective. Women affected by PTSD are often never diagnosed; therefore, limiting recruitment only to women with diagnosed PTSD would limit the data obtained to a small subpopulation of the women experiencing posttraumatic stress rather than reflecting the larger population of women affected by posttraumatic stress that clinicians actually see in practice.

### **Participants**

Fifteen women responded to the recruitment process, and all gave interviews. Their experience with childbirth occurred from 1 week to 26 years before the interview. Although this range is broad, prior investigators have noted that women recall their birth with great accuracy, so that time alone is not a criterion for judging trustworthiness (29,30). Data about their abuse histories; socio-economic status; general health; mental health, including posttraumatic stress symptoms; and their pregnancies is limited to the information provided within their stories. Some of these women framed their childbearing stories

by using knowledge about themselves and posttraumatic stress gained after pregnancy. Often this knowledge was gained via subsequent individual or group therapy, which gave them a vocabulary to describe their experience. Nine of the interviews were conducted in women's homes, three were performed in a university office, two were performed via telephone, and one was performed in a residential drug treatment center. The participants had experienced a wide range of abuse, recovery approaches, and childbearing situations. The women had given birth to between one and six children. Birth outcomes varied from stillbirth after an intimate partner's assault to positive health outcomes. Negative psychosocial outcomes included severe postpartum depression and protective services involvement resulting in losing parental custody. One difficult outcome was a mother's choice to relinquish her infant for adoption after birth. Health care provider relationships also ranged from negative (leading sometimes to changing providers) to very positive. Birth experiences extended from high risk and traumatic to idyllic and empowering, taking place in hospital, birth center, and home settings, with physicians, nurse-midwives, or direct entry midwives in attendance.

### **Interview Process**

The interview had four components. First, the woman oriented the interviewer to her childbearing story by telling the "two-minute version" that she would tell a casual acquaintance. Second, she told a more "in-depth version, with anything about the abuse history or PTSD that may have entered in," focusing particularly on whether she disclosed her history to her health care provider and what the provider did that was helpful or not helpful. Third, we focused on the elements of the story that addressed the care she would want ideally from her health care provider, and we asked her to formulate these desires as "bullet points" or "take home messages for providers." The "take home messages" validated that we had included her main points and understood them correctly. Finally, the next day, the interviewer called the participant to assess her well-being after telling her story and to ask if she had anything she wanted to add. Interviews lasted between 45 minutes and 2 hours and were recorded and then transcribed verbatim for analysis. Interviewers' field notes recorded information about nonverbal elements, emotional communication, and verbal tone of the interview.

### **Analysis**

In keeping with a narrative approach, the unit of analysis was the woman's story as a whole. In the initial, descriptive phase of analysis, life history chronology was developed for each participant relating the abuse history,

**TABLE 2**  
**Examples of Low and High Ranges on the Four Assessment Continua**

<i>Assessment Area</i>	<i>Low</i>	<i>High</i>
1. The extent of the woman's knowledge about trauma and traumatic stress in general and in relation to her own life in particular.	"I realized [later] there were pieces that had been floating around for a long time that I wouldn't acknowledge prior to [postpartum]."	"When I was pregnant, I had years of recovery behind me."
2. The extent of knowledge about how abuse and traumatic stress are affecting her childbearing.	"It's hard to put into words because I'm not quite sure what is going on, but I feel really super vulnerable."	"I think one of the reasons [my birth experience] was so good was because of things that I realized that I needed related to my [abuse] experience."
3. The extent of her ability to advocate openly for herself.	"I don't want to ask anybody [for help] because I was already carrying around enough shame and guilt and embarrassment."	"I think that a doctor or a nurse or whomever needs to work with the patient because I think the patient has the key to what they need."
4. The extent of her current safety and well-being.	"He moved me away from my family...he was also involved with drug activity, so that made it very hard because I had to worry about the safety of my life too."	"I had a safe place in my home, so it was easy for me, and I was ready to heal myself."

pregnancy, and abuse recovery. Contextual factors, including her family-of-origin and family-of-creation relationships, material circumstances, and apparent social support were noted. Descriptions of PTSD symptoms, associated features, comorbid conditions, and wording about how her history or posttraumatic stress interacted with pregnancy were compiled for each woman. Finally, the bullet points were abstracted from each story, and both the bullet points and field notes were used as an audit to verify that respondents' messages were not selectively left out or misrepresented.

In the interpretive phase of the analysis, we focused on the primary research question "What do pregnant women who have experienced abuse-related posttraumatic stress during their maternity care experience want from mater-

nity care providers?" We first focused on ways in which these women differed and how they expressed different desires. From this analysis on how they differed, four assessment factors emerged that distinguished among the women. Women ranged from low to high on these factors (Table 2). By assessing all 15 women's stories, consistent and evident patterns sorted the women into three groups (Table 3). The groupings provide a useful structure that suggests how providers might best respond to the needs of diverse abuse survivors. After the individual stories were reviewed in light of the four assessment factors and placed into one of the three groups, common desires and messages were explored within each of the three groups. The women's desires, or messages, then had commonalities and make sense in light of these

**TABLE 3**  
**Distinctions Among Three Groups of Women with Abuse-Related Posttraumatic Stress**

	<i>Women Far Along in Trauma Recovery</i>	<i>Women Who Were Not Safe</i>	<i>Women Who Were Not Ready to "Know"</i>
Assessment	Knowledgeable, Well able to advocate, Safe	Knowledgeable, Limited ability to advocate, Not safe	"Knowing and not knowing" Cannot disclose or discuss, Uncertain safety
Context	Safe and well, with adequate material and social support	Not safe, not well, and inadequate material and social support	Not safe enough due to less than optimal circumstances
Collaboration	Open conversations, able to advocate for herself, wanting to share power	Conversations fettered by stigma, but willing to disclose problems to knowledgeable provider who can access resources	Communications via signs and symptoms, showing distress but not ready to confront trauma issues directly
Provider role	Ideal provider is a collaborative ally	Ideal provider is a compassionate authority figure	Ideal provider is a therapeutic mentor
Outcome goals	Ideal outcomes include integrated development along maternal and posttraumatic growth trajectories	Safety given priority over developmental goals	Maternal development given priority and groundwork laid for later trauma recovery efforts

**TABLE 4**  
**Summary of Participants' Messages to Providers**  
**Framed as "Desired Practices"**

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ASK about abuse history, about how it is affecting her generally and in pregnancy, about what she needs from you, and, at each visit thereafter, ask truly open-ended questions and allow open time to discuss how she is doing with regard to posttraumatic stress concerns (eg, "How *are* you?")

ACKNOWLEDGE that trauma has long-term effects on some people, that she is not the only one, and that you are willing to work with her to address trauma-related needs or are able to refer her to a more appropriate provider.

ASSESS repeatedly her risk for associated problems that are critical to perinatal outcomes: substance use, revictimization (current abuse), high-risk sexual practices, disordered eating, self-harm, postpartum mood and attachment disorders, and safety for her infant.

ASSUME, in the absence of disclosure but in the presence of posttraumatic stress reactions, that the client could be a survivor and respond to her therapeutically but without forcing the issue.

AVOID triggering posttraumatic stress reactions by learning individual clients' triggers specifically and by increasing awareness of aspects of maternity care that are generally triggering (eg, pelvic examinations, being touched without permission, feeling out of control).

ARRANGE more extensive contact that meets her needs via longer or more frequent visits with the main care provider or appointments with team members, and be ready to arrange connections to domestic violence programs, substance abuse treatment, or mental health services as appropriate.

ADVOCATE for appropriate program and financial resources to meet these clients' trauma-related needs, and consider using a secondary diagnosis of posttraumatic stress (or other appropriate related disorder) for clients who meet diagnostic criteria.

ASCERTAIN by follow-up of individuals and evaluation of practice over time whether trauma-related outcomes are being met in concert with perinatal goals.

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groupings. The "desired practices" are summarized in Table 4.

## FINDINGS

In this study, the following four areas of assessment were useful in identifying commonalities among what might initially appear to be very diverse individuals. The assessment process can aid the maternity care provider in determining how they might respond to individual clients to enhance initial rapport. In these women's stories, being responded to in the most desired way at the start of the relationship facilitated additional assessments, diagnosis, and mutual planning to meet the individual woman's desired health care needs. Within these 15 women's stories, change and movement happened within each of the four assessment areas, reflecting a dynamic process occurring along a continuum. This movement along the

assessment continua occurred across the woman's life span and, for some of these women, within the childbearing year.

Assessment 1: the extent of the woman's knowledge about trauma and posttraumatic stress in general and in relation to her own life in particular. At the time of pregnancy, some women had years of psychotherapy in which they became extremely knowledgeable and articulate about effects of abuse trauma. Others had only vague understanding of abuse effects (eg, fleeting flashbacks they were trying to ignore, memory of episodes without any affect) or of psychosocial problems (eg, being a "sex addict," being suicidal starting at age 5). How much an individual woman knew about trauma generally and about the effects of her trauma history on her life influenced her ability to seek the health care she wanted.

Assessment 2: the extent of knowledge about how abuse and posttraumatic stress affected her childbearing. These 15 women varied in the extent to which they experienced abuse-related difficulties or posttraumatic stress symptoms during their pregnancies. However, what really seemed to matter was, how much they were aware that their trauma history might affect childbearing and whether they could bring this trauma knowledge to bear on what they were experiencing during pregnancy. For example, a woman who knew she dissociated when in stressful or painful situations seemed not to apply that self-knowledge when anticipating labor. The women's knowledge of and understanding about the potential effects of their trauma histories on childbearing influenced many of their choices related to childbearing care, including the type of health care provider, setting for birth, and some lifestyle choices.

Assessment 3: the extent of her ability to advocate openly for herself. Some women did not get the initial response they needed from a provider, and they changed providers until they found one who could be responsive to their expressed needs. These women could firmly and clearly say what they needed in relation to their trauma history. Others could not. The forms of coping that some women used included dissociating during prenatal visits or coming to the hospital for "premature labor" when their abusive partner became angry. Although this form of coping may provide some relief, these strategies were not usually recognized as such by providers, so the woman remained alone with the problem. Misinterpretations of the methods women used to cope as a result of their posttraumatic stress or trauma history could also result in negative responses by the health care provider. This was particularly evident in relationship to the woman's desire for control over the experience.

Assessment 4: the extent of her current safety and well-being. If the woman was being battered or raped, was using drugs, or was a homeless runaway, her

survival needs were the priority for the health care provider. Half of the 15 women were safe, had a reasonable level of well-being, and wanted support to maintain and enhance their well-being while making the transition to motherhood. Others were more at risk. For example, one woman experienced fetal demise at 6 months of gestation after being battered by her husband. Two were addicted to cocaine. Others were still dependent on abusers in their families of origin for housing.

The role of health care providers depends on where on the continuum the woman falls in each of these four assessment areas. It is not so much “who” the woman is that should drive the provider’s response, but “where” she is in the life span process of recovering from the negative impact of past or current abuse trauma.

Based on the four assessment areas, three groups that reflected where the women were in their recovery process emerged: 1) women far along in recovery from trauma, 2) women who were not safe because they were being battered and/or were abusing drugs, and 3) women who were not ready to “know” and acknowledge the effects of childhood abuse on their lives. Where the woman was in her recovery from trauma then significantly affected both what her goals were and how she negotiated the many changes and challenges of the childbearing year.

### **Women Far Along in Recovery from Trauma**

The women in this first group were knowledgeable about the effects of abuse on their lives, had worked at recovery before or during pregnancy, and were well able to advocate for themselves with health care providers to get their trauma-related needs met. These women could focus on the developmental crisis of pregnancy because they were safe from current abuse and were managing posttraumatic stress fairly well.

Women in this group told stories of experiencing mutually synergistic growth along both childbearing and posttraumatic growth trajectories when they succeeded in getting their needs met. Being pregnant posed some posttraumatic stress challenges (eg, coping with intrusive vaginal examinations), and their trauma history presented challenges for maternal development (eg, how to limit an abusive grandparent’s access to the infant). However, to experience this growth, the women needed to avoid triggers for posttraumatic stress reactions. They worked to meet this need via two main efforts. First, they sought knowledgeable providers and had sufficient self-advocacy ability to change providers if they were dissatisfied. Second, they worked to maintain as much control as they could over aspects of care that could be triggering. Examples of such efforts at control include negotiating to keep men out of the delivery room, telling the midwife how to avoid areas of painful scar tissue remaining from a childhood rape, and trying to prevent “people doing

things to my body without my consent.” The woman’s need for control was a priority within the maternity care relationship between the woman and her provider.

Some women struggled with dissociation when PTSD reactions were triggered. As one woman described when she found she was pregnant,

*“I was really excited...but at the same time, I was pretty frightened because I knew, you know, I wasn’t sure if all the exams and all that stuff was gonna trigger a lot of things.” “So we decided to go with a midwife, and we started off at one place and then went to another place...and [the midwife] assured us that she had dealt with this before...and we just really laid down.... ‘This is what we want. This is what we’re gonna do. Can you provide this for us?’ And they were very receptive, and things progressed actually really well.”*

Being aware of how a woman might be affected, even if she is triggered and then cannot articulate her concerns initially, can be of critical importance in soothing rather than exacerbating a posttraumatic reaction. This woman’s experience with preterm contractions illustrates what a difference this awareness on the part of the provider can make:

*“...and by this time I could tell I was teetering on the brink of having everything rush back. And I was visibly shaking, my voice was very shaky, I sounded like a little kid when I talked. And she, the midwife, really picked right up on it, and she said before she examined me...she sat down and she explained exactly what was going on...she said the same thing six different ways until I physically...you could physically watch me relax. And then she said, ‘Why don’t we just take a peek and see what’s going on?’”*

Other women used pregnancy as an impetus for intensive posttraumatic growth. One connected unhealthy behaviors to her history of past abuse and was ready to make drastic change during pregnancy. She placed emphasis on how preparing to have a child moved her forward in posttraumatic growth,

*“I went to college and I, I had a very promiscuous life...I just was not good to myself...so [pregnancy] comes along, and I quit all the things I was doing...I quit drinking beer, I quit smoking cigarettes, I quit smoking pot, I just...healed myself.”*

This woman was able to advocate for herself, saying, “I think that a doctor or nurse or whomever needs to work with the patient because I think the patient has the key to what they need.”

Confidentiality in abuse history disclosure was another consideration for abuse survivors. Women were concerned confidentiality would not be maintained. As one explained,

*"When she gave me the initial, you know, the history form...when I saw 'Were you abused?' I said no. There was no way I was going to tell her."*

Needing an ally in labor prompted disclosure later in pregnancy as noted,

*"...at the very end of my seeing her...I needed to tell her so that if I were to get stumped in the middle of delivering [the baby] she would understand why."*

So telling or disclosing the history of abuse was not something that was performed easily. Instead, several encounters were often required before a sense of trust and safety was developed with the health care provider.

### **Women Who Were Not Safe**

Three women interviewed disclosed both past abuse and abuse occurring during their pregnancy. However, their needs in maternity care were different because their trauma was ongoing. This group wanted providers to find out about and intervene in their domestic violence and substance abuse crises but expressed difficulty asking for assistance. Factors such as being "pregnant and not married...not living up to 'society's norms'," stereotyping and stigmatizing by health care providers, and feelings of fear, shame, guilt, and embarrassment from lifelong abuse were barriers to disclosure of current abuse. Pregnancy also negatively affected the ability to leave the abusive partner, because "it made me more vulnerable, more insecure...really afraid to leave when I was pregnant."

Women in this study who were not safe experienced inadequate health care provider responses when they disclosed partner abuse to health care providers. One noted,

*"I did talk to my doctor [about ongoing physical abuse]. So the only thing he really did was he called him into his office and had a conference. He talked to him, and all he [the abusive partner] said was, 'Okay. I'm not going to do it anymore.' So how many times have you heard that?...Once it was addressed, it wasn't addressed again. I mean, you have no other choice but to think that they really don't care, you know?"*

She resorted to covert uses of the health care system to protect herself, for example, "I remember one day he was mad. I had to fake like I was [in labor prematurely]...and I had him take me to the hospital...I was going to tell somebody...But I still ended up going back."

One participant initially received an effective response from her obstetrician when she wanted help to leave her abusive partner. However, there was no offer for referrals for substance abuse treatment or ongoing assessment of safety from intimate partner abuse once the woman's

substance abuse was discovered. She explained the initially helpful response,

*"She [the physician] had offered that she would make the phone call and had me sign a release paper so she can talk to somebody, and she set it up right away. So, like the next appointment they were there (the staff worker from the domestic violence program)."*

Although this woman had been trying to stop her substance abuse, after her urine tested positive for cocaine, she was not referred for treatment, and health care providers never assessed her safety at home again. "I kind of feel like they didn't follow up...like maybe they were just like in disgust with me for the fact that I had been using drugs..."

Women who were not safe emphasized the importance of provider involvement and openness. They expressed feelings like "if there was somebody there I could talk to...I think things would have been better...I just think that what would help is for, like doctors and nurses to get more involved...And that's just the bottom line." They noted the importance of health care professionals in providing a support system to alter their situation, "I knew in the back of my mind I wanted to change something. I wanted to prepare myself for if...when...I do leave. But I had to get up to that point of strength to leave..."

Only one woman who participated in this study did not express a desire for any form of trauma-related help from maternity care providers. Even though she did not want any help for herself, she disclosed ongoing episodes of abuse that required an authoritative response from maternity care providers who would have reason to believe that the child will be at risk. Although she knew that she kept being hurt, and she knew that being raped or abused affects other people, she was unable to express insight into how elements of her situation, including ongoing revictimization by multiple perpetrators, were harmful to herself or to her child. In response to the question of what she would have wanted from her maternity care providers in relation to abuse issues, she said, "They just treat me like any other pregnant person...That part of my life doesn't bother me. I mean, I've been in therapy from four to sixteen. I don't need any special attention for it." This participant was unable to tell a coherent story in the interview. She had been fully involved in social service and legal systems for years including therapy, detention, homeless shelters, probation, and child protective services. Her maternity care provider's most effective response would be to engage with those systems to try to improve her safety and the safety of the infant while maintaining connectedness with the mother.

## Women Who Were Not Ready to Know

This group of four women wanted maternity care providers to assume that they are trauma survivors based on signs and symptoms alone, as if acting on a “presumptive diagnosis,” without the woman being able to say that abuse or posttraumatic stress is at issue. At the time of their pregnancy, they were not able to disclose any history of past or current abuse to their caregiver. By the time they participated in this study, they could reflect on that time in their lives with fuller awareness of what was going on. These women did not disclose their abuse history to their health care provider during pregnancy because they were not yet ready to disclose it fully to themselves. As one woman explained, “The [recent] rape thing was too much for me to take in probably because that would also include the other ones, when I was little.” Others knew they had been abused, but they did not yet recognize the full effect of these past experiences. One woman experiencing flashbacks in pregnancy said, “I’d always sort of belittle my experience of abuse and said it could have been a lot worse and just shrug it off.” Although they were experiencing long-term negative consequences of abuse (such as dissociation, disordered eating, compulsive sexuality, depression, and revictimization), they were not seeking help for these problems. These women told the story of how they did eventually name the abuse to themselves and understand its effects on them. For one, this happened during the pregnancy, whereas for others that movement to a knowledgeable, proactive stance happened in the postpartum period. For still others, it took several more years before they could seek help to address abuse-related problems.

Women who “were not ready to know” described compartmentalizing the abuse away from their everyday thoughts and lives. They depicted their childhood sexual abuse and pregnancy as being “in two separate spheres...[having] fleeting memories...working hard to keep them apart.” Although the women did not fully acknowledge the abuse, it still affected their childbearing. One woman noted,

*“I knew early that I was not going to deliver vaginally. I knew in my head that I was not going there. So that piece I connected...I don’t know that I drew a real direct line because of how vulnerable I felt. I wasn’t probably ready to acknowledge that...So it was knowing and not knowing at the same time [emphasis added].”*

The interpersonal and coping dynamics used during the abuse became automatically reactivated in maternity care, as she explains,

*“...my reactions to pregnancy, becoming submissive again...I was completely passive...I didn’t advocate for myself at all...[were a reaction to the triggering familiarity of] a lack of control and someone else in authority calling*

*the shots no matter what I really wanted...and my prenatal care, I think I dissociated during my visits. I don’t have good recall with what exactly went on.”*

Dissociation was also noted by women in this group as an important coping mechanism, both with stressors in pregnancy and while in labor. One participant noted tearfully,

*“I think I was trying to soothe myself...and that is probably the survivor of abuse...that you kind of have a place you can go...and, especially I think at that time in my life, I probably visited that place more often. I might not go there too much any more, but...it’s from being little.”*

The women in this group of participants had not experienced any recovery from past abuse before having to deal with the crisis of pregnancy. Although signs and symptoms could have been discernible to a health care provider who “had it on their radar screen,” the women had reasons for trying to maintain a fragile equilibrium by dissociating their awareness, maintaining a delicate balance of “knowing and not knowing at the same time.” For example, these women felt there were losses associated with dealing with posttraumatic stress they did not want to incur: “I couldn’t really enjoy the pregnant princess scenario,” and “...I was really looking forward to the cuddling time with the baby and breast feeding...I didn’t expect this whole other ugliness,” and “I felt cheated,” and “It just gets exhausting...these flashbacks and stuff...and I just broke down crying...and I’m just sick of having to deal with it.” One woman talked about having to change to a midwife after 6 months because “the doctor was kind of cold, not personable at all, and those feelings [emotional memory of being abused, shame, vulnerability, nakedness] would come back to me in his office, and I found myself crying at every visit...” She moved from not really understanding the impact of the childhood sexual abuse on her (starting off like the women in this “knowing and not knowing” state) to confronting what was happening and arranging the care she needed with a midwife and a therapist. She described this begrudging but accomplished shift,

*“...I kind of knew in some way it was affecting me, but I just couldn’t connect the dots ever...but when I got pregnant it all just came out, came clear, and it was hard, and I’m grateful...and I think it’s going to help me grow past it and deal with it...but pregnancy is enough to deal with.”*

Another participant says she always “knew” about the abuse, but in an emotionally numb way. She described it this way,

*“Well, it was kind of like a piece of clothing, you know. You put on your shoes, you put on your socks, you’ve been abused. You put on your shirt, you put on your pants...I don’t even know how to describe it. There was no emotion to it.”*



But events occurring around the birth of her last child triggered a different kind of “knowing.” “That is when everything started falling into place,” and, as she says, “The *feelings* are what started coming back.”

These women stressed that it was a process to move from coping by “not knowing” to being ready to name it, to acknowledge the long-term negative effects, and to take steps to improve their well-being. During their maternity care experience, they wanted their health care providers to name their evident distress, but not their abuse. For example, it would have been useful to hear, “I can see that this exam is very stressful for you,” and then to go on to discuss how to make it less distressing, but not to talk about how the stress response could be related to prior abuse. They said that, in hindsight, it would have been useful over the course of maternity care for the provider to ask at each visit truly open-ended questions, such as “How *are* you?” and to leave genuine space for them to answer. Because the immediate response is to say, “Fine,” it takes asking habitually for the woman to expect the question and to decide to use the anticipated opportunity to disclose and seek help. Women in this group also stressed that the provider should assume they will be triggered by procedures (eg, internal exams) or relationship dynamics (eg, not asking permission before nonemergent procedures, not giving the woman maximum control) or aspects of the setting (eg, being half naked alone in a room waiting for someone to come in) that remind them of the abuse. These are women who will likely give “false-negative” responses to abuse history-screening questions. In this study, they encouraged providers to respond as we would in any other clinical situation in which we cannot completely confirm a diagnosis but in which the advantages of presumptive treatment are strong.

One participant emphasized that her need to “not know” fully about her incest history during pregnancy also stemmed from the fact that, nearly 20 years ago when she was first pregnant, no maternity care provider could have been expected to know how to help her. She thought that, with what is known now, a knowledgeable provider could incorporate routine screening questions, acknowledgment of violence against girls and women, teaching about posttraumatic stress, and support or therapy options. She said if that could have happened during her pregnancies, she would have then felt cared for, validated, and could have moved into getting mental health treatment sooner.

#### **PROVIDER ROLES FOR SUPPORTING WOMEN WITH ABUSE-RELATED POSTTRAUMATIC STRESS**

For all of these women, care processes were, or would ideally have been, directed toward both pregnancy-related and trauma-related outcomes of maternity care. In analyzing what these groups of women wanted from their

maternity providers, three ideal “provider roles” emerged. The participants also were specific about certain practices they believed providers could enact to be responsive to their needs. Many of these “desired practices” were common to all three groups, although the details of how they would be implemented would vary slightly, depending on which group the woman was in and which role the provider was assuming (Table 4).

For the women far along in recovery, preventing exacerbation of posttraumatic symptoms and supporting posttraumatic growth was important; these trauma-related outcome goals were interwoven with goals for maternal development and positive pregnancy outcomes. They seemed to need a “collaborative ally,” someone knowledgeable, egalitarian, and interested in facilitating posttraumatic growth along with focusing on the usual elements of maternity care.

For the women who were not safe, trauma-related (violence and drug use) outcomes and perinatal outcomes are inextricably linked at the levels of physiology and safety. These women seemed to need a “compassionate authority figure,” someone who understands revictimization and substance abuse in their relation to posttraumatic stress and coping and who will assess, intervene, refer to appropriate agencies, and follow up. For women who were not safe, the primary concern was to focus on interventions designed to promote maximum safety for the pregnant woman and fetus (5,6). Addressing other manifestations of PTSD was not as high a priority.

The last group is composed of the women that clinicians encounter in practice who do not disclose a history of abuse, yet they show signs of posttraumatic reactions and associated features in their presentation (7,11). In the study, the women in this group stated that they were not ready to acknowledge fully their abuse history. They did not feel ready to address trauma-related issues overtly during pregnancy. Trauma-related outcomes were subordinate to maternal development and perinatal outcomes but were nevertheless important. They were not comfortable in the “knowing-and-not-knowing” state; rather, it was their best attempt to maintain their equilibrium at the time of pregnancy. Their goals likely were similar to the recovered women but at a different level. The “women who were not ready to know” seemed to want what has been conceptualized elsewhere as a “therapeutic mentor” (31). This provider would respond therapeutically to signs and symptoms of distress in the moment but also know that the woman likely will need information or role modeling to prepare her to address abuse issues and posttraumatic stress eventually. Although the women wanted not to be triggered into worse posttraumatic stress symptoms by having to discuss trauma issues, they also wanted providers to recognize their discomfort or distress and to respond by laying groundwork for their future efforts at recovery.

## DISCUSSION

The process of recovering from abuse and posttraumatic sequelae is often a long one. Where these women were along this recovery continuum dictated what they wanted from their maternity care provider. The ability to focus on recovery from trauma appeared to be related to contextual factors such as having adequate social support and sufficient material circumstances to engage in therapy or self-help strategies.

This pattern of being able to turn attention to recovery only after achieving some physical and/or psychological safety has been recognized and described before. Judith Herman, in her classic 1992 book, *Trauma and Recovery*, frames the psychotherapy treatment process in three stages: safety, remembrance and mourning, and reconnecting (to community and ordinary life) (23). For women who were not already in mental health treatment, safety and adequate affective and material social support played a role in moving them toward choosing to seek treatment or otherwise actively trying to recover.

In these women's stories, pregnancy represented an optimal time to address trauma-related issues and post-traumatic stress if it could be performed congruently with her needs. One contribution of this study is to provide an organizing lens to use to discern categories intermediate between an overgeneralizing stereotype of abuse survivors and a paralyzing level of diversity and complexity in client presentations. These categories can serve as a point of departure at the beginning of the relationship, enhancing the likelihood that appropriately detailed knowledge of individual clients can develop over time, building on a successful initial assessment and response.

With one exception, all of these women wanted their maternity care provider to be competent to address trauma-related needs from within their role as a health care provider. They did not expect the provider to function as a therapist, only to know about posttraumatic stress and to respond to them appropriately, following the woman's lead about what she needed. They preferred to disclose only when they saw signs (eg, support group posters, domestic violence shelter posters, screening questions, and interpersonal openness) indicating that the provider was competent to respond respectfully and therapeutically. The participants who were battered and drug abusing during pregnancy said they also would only disclose if they thought there would be resources to address their trauma-related needs. The women far along in recovery were willing to shop for providers until they found one who was interested in addressing trauma needs in addition to pregnancy needs, and they would have preferred that an unknowledgeable or unwilling provider validate their needs and refer them on to a colleague who was competent and interested in providing such care. Clearly, one implication is that providers should make

efforts to become more skilled and comfortable addressing trauma-related needs, or cultivate a team approach, or make referrals to other providers. According to these women, it is worse for the provider to ignore the trauma factors than to acknowledge them and recommend a more appropriate health care provider.

This study reaffirms that there is complexity inherent in providing care to women with a history of abuse who experience posttraumatic stress. Their presentations and goals for care vary. This study contributes to our efforts to manage this complexity by offering a way to organize the assessment process and then describes a corresponding role for the health care provider. Having these roles in mind, the provider can enact initial responses that may fit better with where the woman is in her process of recovery than a "one-size-fits-all" approach. Working with any of these 15 women might have occasionally taken more time than the customary limits of routine prenatal care allow. Just as diagnosis of a pregnancy complication (eg, gestational diabetes) allows for use of additional time and surveillance resources, arriving with the client at a diagnosis of posttraumatic stress disorder or risk for substance abuse or risk for domestic abuse also should facilitate longer appointments or additional visits with the provider or other team members to discuss trauma-related needs (eg, fear of labor, building trust, safety planning). More time spent in prenatal visits may be cost-effective if it also prevents or reduces need for unscheduled contacts or hospital services and may lead to better outcomes. Clients may make good use of referrals to other health care team members for therapy, medication, individualized childbirth education, doula support, lactation consulting, postpartum surveillance for mood and attachment problems, and parenting support, as desired by the woman.

Limitations to this study should be addressed with further research. Although seven of the participants had not had therapy before or during pregnancy, all of them did eventually seek some therapy. In this respect, they may differ in important ways from women who never seek professional help. These 15 women were diverse in many other ways, but generalizability from qualitative studies is limited. Additional exploratory and confirmatory research will be needed to expand on these findings. This was a retrospective study with no formal diagnosis of PTSD required for participation because the goal was to understand a range of women's concerns and desires for care without restricting participation to women formally diagnosed with PTSD. Some of the complications noted in initial research studies of pregnancy and child sexual abuse or PTSD occurred in this group of participants, including hyperemesis, multiple episodes of pre-term contractions, and also labor dystocia. Prospective studies with formal assessment of trauma and PTSD and with a comparison group will be needed to further

determine whether complications or negative outcomes occur in association with PTSD.

We need more research to learn more about the multiple aspects of PTSD—physiologic, behavioral, psychospiritual, and interpersonal—which could affect childbearing processes and outcomes so that we can design and test desired and effective interventions to promote women’s health and decrease morbidity. Effective therapies for PTSD already exist for people who seek mental health treatment (32). However, more than half of the women in this study did not seek mental health care before or during pregnancy. Therefore, this study is an initial step in understanding how maternity health care providers can best serve the range of women they see in clinical practice. Even those who did not need or want mental health care did want help from a “collaborative ally,” a “compassionate authority figure,” or a “therapeutic mentor” to address trauma concerns within the context of their childbearing experience.

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