Mothers and Babies is an intervention to help pregnant people and new mothers handle stress in their lives. Some of the stress that individuals may experience can be classified as “trauma” or “traumatic stress.” This resource guide is intended to provide additional guidance and support when delivering Mothers and Babies to people who have experienced trauma.

Trauma is an emotional, psychological, and/or physiological response to an experience that an individual perceives as life threatening or distressing. Trauma can have a lasting adverse effect on an individual’s well-being, and it is especially common in low-income and structurally vulnerable communities.1,2

Here are a few prevalent sources of trauma in our communities:

- Fertility challenges
- Pregnancy loss (e.g. miscarriage, stillbirth, abortion)
- Child loss
- Loss of custody
- Obstetric violence or adverse medical experiences
- Assault (e.g. physical and sexual)
- Relational and childhood experiences
- Death of a loved one
- Witnessing community violence

MB alone is not sufficient for trauma treatment. Follow your agency’s protocols for referral to appropriate services should your client endorse a trauma history. While connecting to another level of care, your relationship with your client can be a place to model respect and trust, serving as a healing context in which they can grow and recover.

Secondary Traumatic Stress (STS), also called compassion fatigue, can negatively affect relationships between service providers and clients. STS is the emotional fatigue and distress that service providers can experience when hearing the trauma of another.3 Symptoms of STS include:

- Insomnia and chronic exhaustion
- Guilt and hopelessness
- An inability to listen
- Avoidance of families
- Anger and cynicism.3,4

We encourage providers to consider how working with families with trauma histories can impact their own well-being and seek support in this work.

As you deliver Mothers and Babies, it is useful to consider that a participant may have a trauma history. This practice of attending to trauma while providing services speaks to the idea of trauma-informed care. **Trauma-informed care (TIC) is a model of care that approaches all relationships and interactions with an awareness of the prevalence of trauma.**4,5 TIC assumes that everyone with whom you come into contact could have a trauma history influencing their behaviors, thoughts, and needs.5

The following pages have a series of recommendations for incorporating discussions about trauma into delivery of Mothers and Babies.
GENERAL GUIDELINES

**INTRODUCTION/BEGINNING OF SESSION**

When introducing yourself to your client, be very clear about your role. Follow your agency’s protocols for disclosing if you are a mandatory reporter.

Speak slowly and calmly (try using a “yoga voice”) and use a compassionate, soft gaze.

During virtual sessions, confirm client preferences (e.g. microphone volume levels, your proximity to the camera).

When clients disclose trauma during a session, thank them for trusting you with that experience. Affirm and validate what they have shared with you, emphasizing that you empathize and believe them.

Empathizing with a client can begin with reflecting back what you hear them sharing about their emotional experience. For example, “I’m sorry __ happened, and I can’t imagine how __ you might have felt.”

Use sessions to emphasize clients’ pre-existing strengths and resilience.

Trauma can lead to fragmented memory recall. Be patient with your clients’ storytelling process. You may need to provide more time for them to answer your questions.

Pregnant clients with trauma histories may have complicated fears surrounding labor and delivery.

Try creating a labor plan to cope with this stress.

Remind them that their body is still their own.

**DURING SESSION**

By noticing when clients seem more activated or “checked out” during a session, keep a log of your clients’ triggers to avoid.

Activation may look like: breathing irregularly, shaking/vibrating, feeling hot.

Dissociation may look like: flat affect, unable to respond or pay attention, feeling cold.

If you notice your client seems activated or “checked out,” you may want to introduce grounding exercises:

**Use of grounding stones:** encourage them to hold an object with weight in their hands, like a stone. The weight of the object helps the brain come back to the present.

**Use of the 5-4-3-2-1 grounding technique:** lead the client to acknowledge 5 things they can see, 4 things they can touch, 3 things they can hear, 2 things they can smell, and 1 thing they can taste in their surroundings.

**CLOSING/AFTER SESSION**

Toward the end of each session, help your client create an after-care plan:

After this session, when do they plan to eat, rehydrate and rest?

Who can they call if they need to continue processing the thoughts that surfaced during the session?

Pregnant clients with trauma histories may have complicated fears surrounding labor and delivery.

Remind them that their body is still their own.
Some mindfulness exercises in the curriculum may not be helpful for someone with a trauma history, because bringing consciousness to the body can be distressing for some (i.e. Worksheet 2.3, “The Body Scan”). Collaborate with your client to develop a toolkit of exercises that feel good for them.

When creating an inventory of pleasant activities (Worksheet 2.4), encourage the participant to think of activities that feel comfortable, and also help them to expand beyond activities that may feel linked to their trauma experience.

When goal-setting (Worksheet 6.2), be mindful of how past loss may make one fearful of planning for the future. In the case of custody loss, goal-setting may help clients plan for reunification or being able to see their child.

When mapping the client’s support system (Worksheet 8.1-8.2), assess whether they have access to relationships that feel like safe spaces for processing trauma. Ensure your client has a working concept of what healthy emotional support looks like. You might want to use this opportunity to refer them to peer support groups.
To learn more about embedding TIC in your organization, please review the following additional resources:

1. Administration for Children and Families Trauma-Informed Care Toolkit
2. Center for Health Care Strategies Trauma-Informed Care Resource Center
4. Thrive Washington Neuroscience, Epigenetics, ACEs, and Resilience (NEAR) Toolkit for Home Visitors
5. University at Buffalo Institute on Trauma and Trauma-Informed Care (ITTIC)

Sources


