Development of a Trauma-Informed Approach in Home Visiting

The Home Visiting Applied Research Collaborative (HARC) advances innovative methods in home visiting research and the translation of findings into policy and practice.

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Background

Research has demonstrated that experiences of trauma and violence are prevalent in mothers participating in home visiting programs. For example, Mersky and Janczewski (2018) reported that 85% of mothers in a home visiting experienced a childhood trauma or adversity.[1] Trauma, particularly when it is experienced early in life, contributes to later problems in psychological adjustment, interpersonal relationships, physical health, and parenting.[2] Recognizing the importance of trauma, many home visiting programs have educated home visitors about its impacts on mothers and children. Although these programs increase awareness and understanding, there is a need for specific strategies and approaches that support mothers who have experienced trauma. In the absence of such interventions, this sizable subgroup of mothers is less likely to fully benefit from home visiting services.

Specifically, we examined how home visiting programs and home visitors address **trauma history**, **depression**, and **low social support** in mothers. The overarching goal was to inform the development of intervention strategies and supports that specifically target these three areas to improve outcomes in this subgroup of mothers served by home visiting. The project had three phases: (1) a national survey of home visiting programs to understand how they address trauma history, depression, and low social support; (2) qualitative interviews with home visitors to obtain a deep understanding of how home visitors handle these issues; (3) development and piloting of a brief intervention approach to support mothers experiencing these concerns with an emphasis on feasibility, acceptance, and engagement. This project was guided by the principles of precision home visiting in that (1) we sought to ascertain the experiences of home visiting programs and home visitors to develop approaches that are salient, meaningful, and impactful; (2) the unique needs of a subgroup of mothers were identified and interventions were developed that target important areas of maternal adjustment; and (3) established behavior change approaches with clear theoretical grounding were selected and piloted for feasibility and relevance.

Methods and Samples

Survey. Home visiting programs that participate in HARC were surveyed to estimate the prevalence of practices related to the measurement of trauma and related psychopathology and protective factors, elements of curricula that address trauma, and practitioner perceptions of the trauma burden and adequacy of mitigation strategies. We

invited 221 HARC member programs to participate in a 70-item web-based survey to characterize trauma-informed home visiting practices and perceived needs.

A total of 135 respondents representing 128 home visiting programs responded to the survey during November and December 2018. Among the respondents, 114 completed the full survey and 21 partially completed the survey. Respondents reported the home visiting model used by their organizations including the following: Healthy Families America (33%), Parents as Teachers (31%), Early Head Start (1%), Nurse-Family Partnership (7%), and others (12%) such as Family Connects and SafeCare. The sample represented several states across the United States with a higher concentration of program participation in the Eastern states.

Interviews. We recruited 27 home visitors to participate in 30-minute qualitative interviews. Participants were drawn from Every Child Succeeds (Cincinnati, Ohio) and programs around the country from those sites who participated in the Phase 1 survey. Three models were represented: Healthy Families America, HANDS, and Early Head Start. The interview guide mirrored the survey questions, seeking to elicit a rich, personal description and perspective from home visitors about their experiences working with mothers with depression, trauma histories, and low social support. The interviewer used a guide with initial questions in these areas, which in turn were followed-up with additional queries designed to expand upon revealing observations and insights. Interviews were audio-recorded and transcribed. A codebook was developed reflecting areas described, and each transcription was reviewed and rated for content and themes; these were synthesized for common elements and topics.

Development and Feasibility Testing of Modules. Building upon findings from the survey and qualitative interviews, we developed five modules to address clinical issues common to mothers with trauma histories, depression, and low social support. Based upon input from home visitors, we focused on skills-building approaches that would be feasible and readily incorporated into ongoing home visiting. The development process was conducted with an experienced home visitor, and in an iterative way such that after each mother received the module there was a debriefing session to determine how the module could be improved. The modules were piloted with seven mothers who varied in terms of depression symptoms, social network size, and trauma experiences. Mothers participated in brief interviews after all modules were completed and rated the usefulness of each. The goal was to have modules that were theory-based, had a clear mechanism of change, and were practical, feasible, engaging, affordable, and scalable.

Findings

National Survey

Prior research in home visited populations has demonstrated a significant association between maternal trauma history, maternal depression and low social support, and the outcomes of parenting stress and child social-emotional development.[3,4] Our group also recently reported prenatal social support as a mediator in the relationship between maternal childhood trauma and postpartum depression risk.[5] This emerging literature supports maternal depression and social support as important constructs to address with the context of trauma-informed approaches in home visiting. The results from the survey are summarized below.

Respondents reported that an estimated 25% (Interquartile Range, IQR: 10-50%) and 50% (IQR: 20-80%) of mothers experienced current and past trauma (i.e., history of abuse as a child, past partner violence, or other family violence), respectively. This compares to previous research in home visited populations that have reported approximately 70% of mothers have experienced past interpersonal trauma.[3]

Screening

Survey Item	Yes	No	Not Sure
Trauma assessment tools are used to…			
Refer mothers to external resources	90.8%	6.7%	2.5%
Initiate trauma-informed strategies (e.g., resilience planning, mindfulness, reflective strategies)	37.2%	42.6%	20.2%
Our program uses a standardized screen for maternal depression?	90.5%	6.0%	3.5%
Our program would be *more effective in helping depressed mothers* if it had stronger training and support regarding specific skills and techniques to support depressed mothers.	78.1%	21.9%	N/A
Our program uses a standardized screen for maternal social support?	34.5%	60.3%	5.2%
Our program would be *more effective in helping socially-isolated mothers* if it had stronger training and support regarding specific skills and techniques to support socially-isolated mothers (e.g., how to talk to mothers about need to create strong supportive networks)	80.7%	19.3%	N/A

Approximately two-thirds (67%) of respondents indicated visitors are required to ask about parental childhood trauma. A large majority of respondents indicated the use of screeners for maternal depression (91%), while less than half used a standard screening tool for maternal social support (35%). The 10-item ACE questionnaire was the most commonly used tool by home visiting programs to measure parental childhood trauma. When rating the effectiveness of the ACE questionnaire at identifying trauma on a scale of 0-10, with 10 being the most effective, the mean score was 5.8. The Edinburgh Postnatal Depression Screen (EPDS) was used to measure maternal depression by 81% of respondents whose programs screen for depression.

Respondents indicated that their program uses trauma screening results for the following purposes: referrals to internal resources (69%), referrals to external resources (91%), discussing results with the parent (83%), discussing results during supervision (83%), and guiding the screening for conditions such as PTSD (66%).

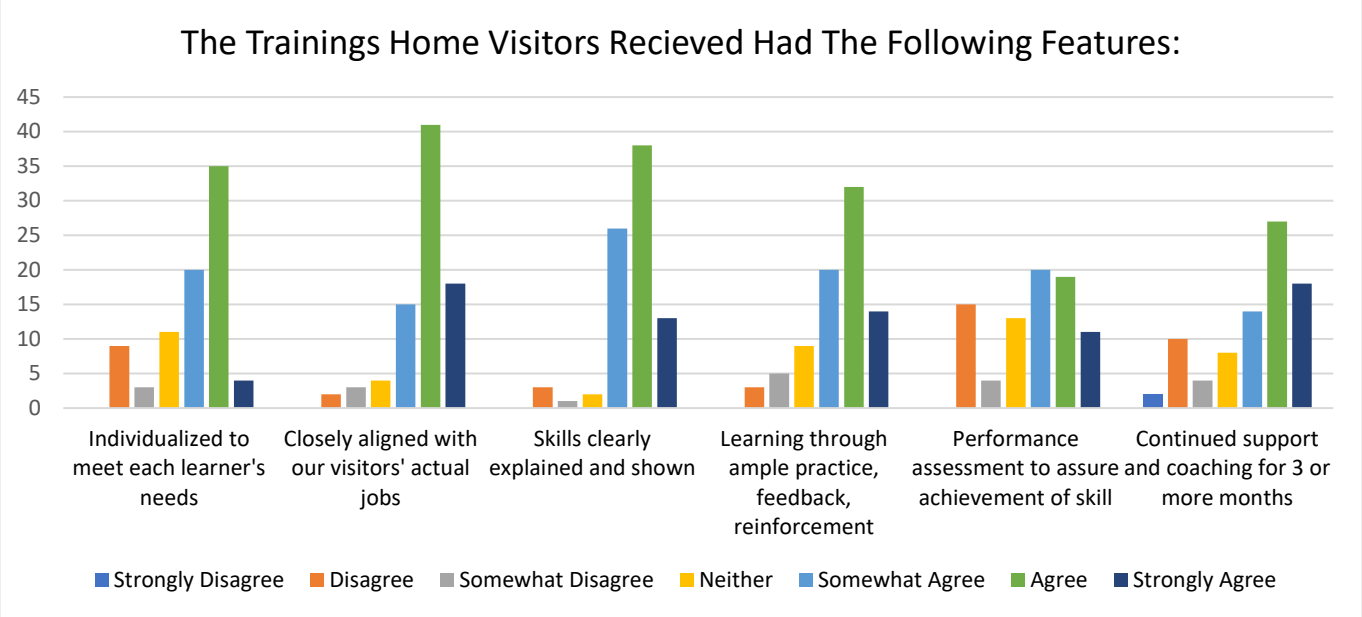
Approximately two-thirds of respondents reported trauma assessments were used to initiate specific trauma-informed strategies (see table above). Just over half (53%) of respondents indicated that their programs had services available to support mothers with trauma experiences and/or mental health needs such as counseling with varying therapy options. Over half of the respondents reported that elevated depression scores are used to explain depression to mothers and make a referral to a mental health treatment center in the community. Among 102 respondents who provided data, an estimated 40% of mothers received a visit/session from a mental health professional among those referred by home visitors; the standard deviation of 25% indicated a wide program variation in the estimated referral follow up by mothers. The majority—78% and 81% of respondents reported that their programs could be more effective in addressing maternal depression and social-isolation, respectively.

Training and Curriculum

Trauma. A majority of survey respondents (75%) indicated that most or all of their program's home visitors have had training in trauma-informed approaches. Infant Mental Health was the most common trauma-informed training (74%) required by the home visiting programs within the last 5 years.

Although a majority of respondents indicated receipt of trauma-informed training, ratings of the trainings received suggests future work is needed to further develop these trainings. Respondents were asked to rate features of the trainings on a 1-7 scale, where 1 indicated strong disagreement, 4 as neutral, and 7 for strong agreement. While a majority of respondents strongly agreed that the trainings were individualized to meet each learner's needs and were closely aligned with the home visitor's job, areas where trainings need improvement include performance assessment and continued support and coaching for three months or more. Results are summarized in the figure below.

Improving upon trauma-informed trainings has the potential to support home visitors as respondents reported challenges working with individuals with trauma histories. Respondents were asked to indicate their agreement on a scale from 1 to 7, with 1 indicating strongly disagree and 7 strongly agree. Over half of the respondents indicated selected number 6 (Agree) or number 7 (Strongly Agree) that they find it difficult when mothers describe details of trauma experiences that are disturbing. Approximately 50% of respondents selected number 6 (Agree) or number 7 (Strongly Agree) that they find it difficult when mothers have intense emotions and report shame and guilt related to trauma.

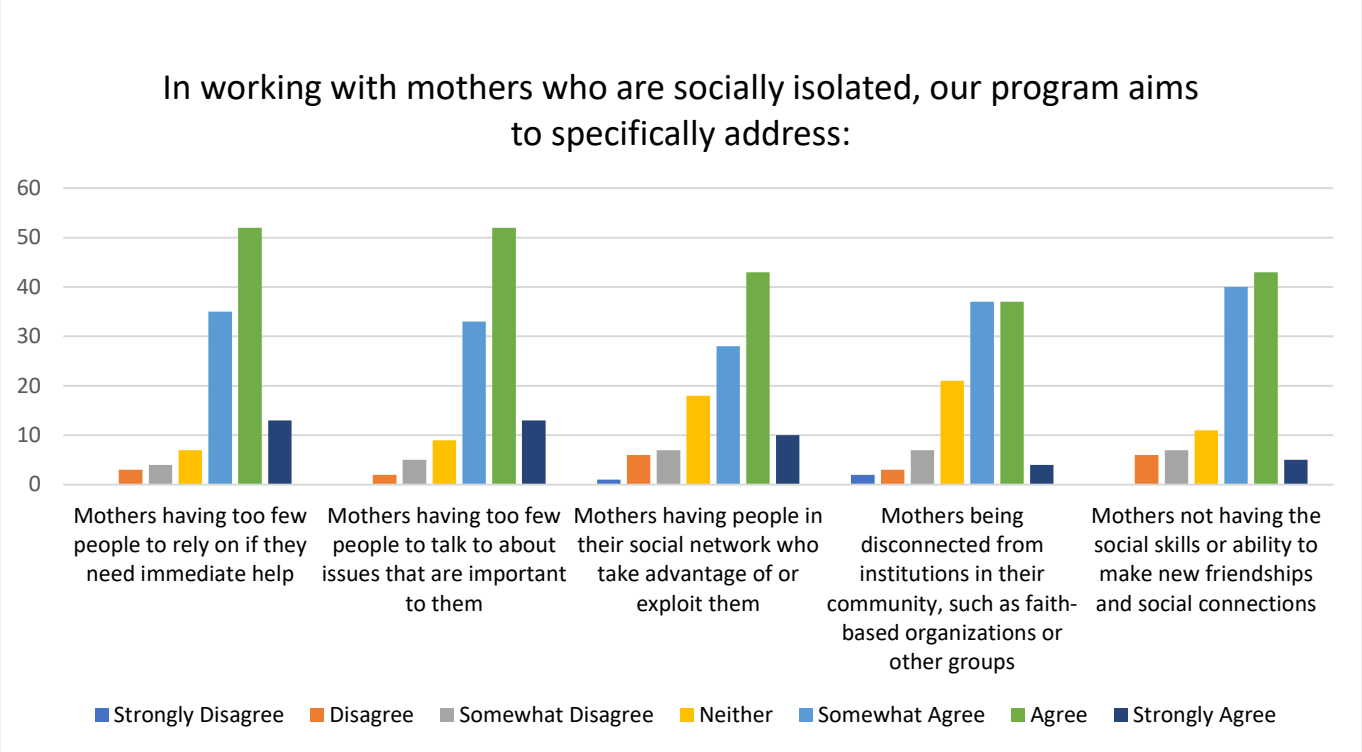


In addition to expanding trauma informed training, there are other opportunities for programs to improve their support for home visitors as approximately 30% of respondents reported they *somewhat agree* that their programs supports home visitors by giving them approaches to talk with mothers about trauma, provides home visitors with tools and knowledge to help mothers recover from trauma, and supports home visitors in their experiences with secondary trauma and burnout.

Maternal Depression. A large percentage (79%) of respondents indicated that their home visiting curriculum has specific guidance on how to address maternal depression. Approximately half of program representatives surveyed indicated that they either agree or strongly agree that their program has useful and effective guidance and resources in the home visiting curriculum or other tools available to address maternal depression.

Social Support. Respondents were asked to indicate on a 5-point scale (highest priority to not a priority) the degree their program prioritizes helping mothers build natural support networks. Among the respondents, 28% indicated this was a medium to low priority for the program. Just over one-half of respondents (52%) indicated their program has specific guidance about how to address social isolation and low levels of social support. Respondents were asked to indicate on a 7-point scale (strongly agree to strongly disagree) if their program has useful and effective guidance and resources within their home visiting curriculum to address social isolation and 29% either agreed or strongly agree (note that only 59 responded to this question).

To better understand how programs respond to social support needs, we asked respondents to indicate on a 7-point scale from strongly agree to strongly disagree if their program specifically addresses specific areas of social support. Results are summarized in the figure below.



Interviews

Interviews of home visitors lasted on average 30 minutes. Interview questions were designed to elicit perspectives, reflections, and experiences of home visitors in working directly with mothers who experienced trauma, struggled with depression, and were socially isolated. Home visitors were thoughtful in their responses. They acknowledged that, for trauma and depression in particular, recent trainings on these topics were helpful in increasing their understanding of how these issues affected mothers, children, and families. All home visitors saw themselves as trauma-focused in their providing of services. Yet, they also identified areas of need to strengthen home visiting curricula and provide them with new and more effective ways to support mothers.

Key Themes from Interviews

1. Recognition that trauma, depression, and social support are connected.
2. Mothers become "stuck" in efforts to move their lives forward.
3. Difficulty talking about feelings and trauma experiences.
4. Trauma and depression negatively impact parenting.
5. Social anxiety impedes establishing strong social connections.
6. Need for specific tools and strategies.

Six themes emerged from the qualitative interviews. First, home visitors uniformly recognized the interrelationships between depression, trauma, and social support. They correctly identified the bidirectional influences between these three areas and believed that there was a need for approaches in home visiting that addressed these areas collectively. Second, home visitors reported that mothers with trauma histories and depression were often "stuck" in their efforts move forward in their lives. They noted that mothers were often preoccupied by feelings of helplessness and struggled to identify ways to move from this paralytic state into one of active coping and action. These same mothers also had difficulty talking about their feelings and experiences, a third theme to emerge. Home visitors used different

strategies to help mothers in these areas, and many cited recent trainings in trauma-informed home visiting as helpful in this regard. A fourth theme was the impact of depression and trauma on parenting. Mothers were sometimes overly fearful for their child's safety, overprotective when others offered to help in childcare, and overwhelmed in the parenting role. Fifth, although home visitors saw inadequate social support as going hand in hand with depression and trauma, they identified social anxiety as significant impediments to accessing social support resources and growing supportive social networks. This was an area that home visitors thought was especially underrepresented in home visiting curricula, and several noted that the most common response by programs (e.g., groups for mothers) was insufficient to bring about meaningful improvement in social functioning. The sixth theme was a strong desire for specific tools and strategies to build maternal skills. This cuts across depression, trauma, and social support. Home visitors consistently articulated a need for better and more effective strategies that fit within the home visiting service paradigm.

Development and Feasibility Testing of Modules

Based on the survey and the home visitor interviews, we developed five modules designed to support mothers who have experienced trauma, depression, and social isolation. Creation of the modules was guided by five principles. First, the modules needed to be feasible and fit into the home visiting paradigm, so they are relatively brief, circumscribed, and targeted. Second, we sought to build specific skills and capabilities that would enhance coping with trauma and its effects and facilitate recovery. Third, we drew upon the existing behavior change literature to identify established approaches that are grounded in theory, previously tested, and with demonstrated efficacy. Although they had not been previously packaged together for mothers in home visiting, the likelihood of being helpful to mothers was increased given their established track records. Fourth, each module includes tools and accompanying exercises to facilitate presentation of material and skill acquisition. And fifth, the modules need to be seen as engaging, relevant, and easy to administer.

Seven mothers and one home visitor participated in the pilot development and testing. The modules were introduced sequentially, approximately every two weeks apart. Mothers and the home visitor provided feedback after each module, and refinements were made in content and delivery approaches over the course of the pilot. The five modules were: *behavioral activation, deep breathing, identifying social supports, building social skills,* and *future aspirations*. Behavioral activation focused on identifying pleasurable activities and planning ahead to ensure engaging in them on a regular basis. Deep breathing focuses on reducing stress and enhancing coping when tense and anxious. Identifying social supports consisted of reviewing existing social connections to identify individuals and groups that could be engaged for stronger and more meaningful relationships. Building social skills involved learning and practicing specific approaches to meeting new people with an emphasis on meeting other mothers as part of social groups provided by the home visiting site. Future aspiration focused on active consideration of the future and building hope for mother and her child. Each module was 30 minutes, included an experiential learning task or specific skill development, involved practice with feedback of skills in the session and outside, explicitly connected the topic with experiences of trauma and depression and social functioning, and was also reviewed at the next home visit. Each module was described on a single page for the home visitor with explicit steps delineated to make it easy to use. These standardized features were also developed to permit adding new modules at a later date.

Mothers were asked to rate the usefulness of each module on a 10-point scale. Scores across all modules ranged from 5-10, with most ratings 8 or greater. Mothers responded positively to the focus on self-care inherent in each module. This resonated with them and had the effect of giving them permission to work on their own emotional and behavioral adjustment. They liked the fact that they were learning specific skills. Importantly, most were able to recount times when they used the skill, providing support for mothers' applying what they learned outside of the home visit. Role-playing was part of several of the modules, and some mothers reported enjoying this activity.

Others felt uncomfortable role-playing, although all recognized its value. Several mothers noted that they appreciated the fact that the modules moved them out of their comfort zones, breaking the sense of helplessness and powerlessness that many of them otherwise felt. On the other hand, some mothers found the tasks to be difficult to complete. Some mothers also reported that they did not use some of the skills learned outside of home visits. The home visitor found the written guidelines and instructions very helpful. She would often extend the module more than 30 minutes, interweaving it into other issues discussed that were similar in content. She noted that the modules were highly structured, and she welcomed the opportunity to teach a specific skill and to see mothers learning how to do something new.

Next Steps and Reflections

Findings from this project underscore the importance of refining and improving how home visiting programs address depression, trauma history, and low social support. Using a precision home visiting lens, we examined how home visiting programs currently handle these issues and we developed and pilot tested a brief intervention comprised of five modules that were designed to support mothers with these experiences. Next steps include: (1) program prioritizing all three domains of maternal functioning, (2) more explicit linkage between screening and subsequent intervention, (3) development of tools and interventions that focus on skills-building, and (4) continued refinement and more rigorous testing of the five modules designed to help mothers achieve improved outcomes for themselves and their children.

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