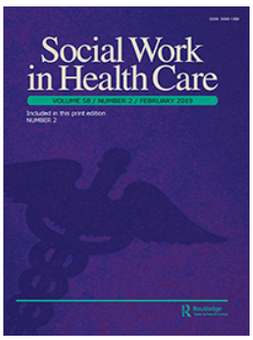

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Trauma-informed care with women diagnosed with postpartum depression: a conceptual framework

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ABSTRACT

Postpartum depression (PPD) is a mental health disorder that affects approximately 20% of all new mothers. PPD frequently co-occurs with and is exacerbated by trauma, particularly for women from vulnerable populations. Trauma-informed care (TIC) is a best practice that recognizes the importance of, and takes steps to promote recovery from, trauma while preventing retraumatization. Despite its potential utility, there is limited research published on TIC, including how TIC is operationalized across practice settings. Further, despite the prevalence and negative effects of untreated PPD, to date there have been limited articles published on TIC and PPD. The purpose of this article is to provide a TIC framework for service delivery for women diagnosed with PPD including explicit strategies for how TIC should be structured across roles, settings, and systems. Implications for health practice, policy, and future research are provided.

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Approximately 20% of mothers will experience postpartum depression (PPD; O'Hara & McCabe, 2013) and particular groups, such as women of color and rural women, will have even higher prevalence rates of PPD (Mollard, Hudson, Ford, & Pullen, 2016; Rouland Polmanteer, 2017). Women who are pregnant or parenting are also likely to experience stress, trauma, or Posttraumatic Stress Disorder (PTSD) symptoms (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Sperlich, 2014), which can increase the risk for or exacerbate PPD (Grekin, Brock, & O'Hara, 2017).

Trauma-informed care (TIC) is a best practice that recognizes the long-lasting effect that trauma has on people who have sustained traumatic life experiences (Elliott et al., 2005). Despite research indicating that PPD is frequently associated with and exacerbated by trauma (Seng & Taylor, 2015), few medical services, particularly during the perinatal period, are informed by and use a TIC perspective (Kezelman, 2016; Reeves, 2015; Seng & Taylor, 2015). Adopting a TIC approach ensures that all aspects of a healthcare organization recognize the relevance of trauma in providing

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services and in achieving treatment outcomes (Knight, 2015; Wolf, Green, Nochajski, Mendel, & Kusmaul, 2014).

One of the barriers that likely limits the adoption of TIC with women diagnosed with PPD is the lack of a framework demonstrating how TIC should be structured in organizations or service delivery systems. To address this gap in the literature, the concepts of PPD, trauma, and TIC will be reviewed. Next, a conceptual framework of TIC for use with women diagnosed with PPD, which can be used across healthcare roles and practice settings, will be presented. Finally, implications for practice, policy, and future research will be provided.

Postpartum depression

PPD is a type of major depressive disorder that occurs during the post-birth period (O'Hara & Wisner, 2014). The dominant symptoms include extreme sadness and loss of interest or pleasure in things previously enjoyed (American Psychiatric Association [APA], 2013). Although the length of the postpartum time period is medically defined as two to six weeks post-birth (APA, 2013), most researchers and practitioners have found that PPD symptoms appear anywhere from two weeks to 1 year after the infant is born (O'Hara & McCabe, 2013; O'Hara & Wisner, 2014). Various biogenetic, psychosocial, and socioeconomic factors have been found to exacerbate the risk of PPD (Martini et al., 2015; O'Hara & McCabe, 2013; Yim, Stapleton, Guardino, Hahn-Holbrook, & Schetter, 2015).

If not properly treated, PPD can affect the mother's overall functioning (Logsdon, Wisner, Sit, Luther, & Wisniewski, 2011) and, in rare cases, contribute to maternal suicide or infanticide (Letourneau et al., 2012). Untreated PPD is associated with health and development problems for the infant and other children as well as depression in the mother's partner, relationship conflicts, and poor family functioning (Letourneau et al., 2012). Untreated PPD is also costly to society, resulting in increases in health and mental healthcare service use (Greenberg, Fournier, Sisitsky, Pike, & Keesler, 2015).

Although evidence-based treatments, including pharmacological and psychotherapeutic interventions, are available to address PPD symptoms (O'Hara & McCabe, 2013), many mothers are reluctant to seek help due to problems recognizing mental health symptoms and accessing care (Byatt et al., 2012). Mothers of color, of low-income, or from rural areas experiencing PPD are the least likely to receive treatment (Gamble & Creedy, 2009; Kozhimannil, Trinacty, Busch, Huskamp, & Adams, 2011) and are more likely to have histories of trauma (Roberts, Gilman, Breslau, Breslau, & Koenen, 2011).

Trauma

Trauma is defined as an event or situation that an individual witnesses or experiences (directly or indirectly), perceives as threatening (APA, 2013), and

which overwhelms the individual's coping mechanisms (Kezelman, 2016). A trauma response is a maladaptive reaction to trauma that can include physical, behavioral, cognitive, emotional, or social changes (Kezelman, 2016; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014b). Not all individuals exposed to trauma will have a trauma response (Altmaier, 2013; Kezelman, 2016) as the same event experienced by two different people may be perceived as traumatic by neither, both, or only one.

Some studies report that nearly 90% of the USA population has been exposed to a traumatic event (Kilpatrick et al., 2013). The majority of clients receiving healthcare services are likely to have experienced trauma (Elliott et al., 2005; Levenson, 2017) and many meet the diagnostic criteria for post-traumatic stress disorder (PTSD; Kilpatrick et al., 2013). Certain populations are likely to have higher rates of trauma including women with mental health histories (Elliott et al., 2005). These groups are also the least likely to seek treatment for trauma and related symptoms (Roberts et al., 2011) because of the barriers in accessing care (Kozhimannil et al., 2011).

Trauma, postpartum depression, and the perinatal period

Perinatal trauma symptoms are estimated to affect between 10.2% (Sorenson & Tschetter, 2010) and 12.5% (Wenz-Gross, Weinreb, & Upshur, 2016) of mothers with approximately 2.0% of women meeting the criteria for PTSD during the postpartum period (White, Matthey, Boyd, & Barnett, 2006). Women may experience stress or trauma before or during the perinatal period and such experiences can contribute to postpartum mental health concerns, including depression.

A history of trauma, including childhood abuse or trauma, has been associated with postpartum mental health conditions such as depression and post-traumatic stress disorder (Grekin et al., 2017). Some research suggests that PTSD symptoms are more predictive of PPD than other mental health symptoms including antenatal depression (Sperlich, 2014). Mothers with a trauma history may be influenced by feelings of guilt, shame, and loss which can influence their caregiving abilities (Elliott et al., 2005), contribute to parenting stress, and lead to an increased risk of PPD (Grekin et al., 2017).

Unfortunately, trauma may go unresolved among women overtime and can be triggered or exacerbated during the pregnancy or postpartum periods (Seng & Taylor, 2015). For example, the birth process may be perceived as a traumatic event and can trigger a trauma response particularly for women who have trauma histories (Beck, 2009; Gamble & Creedy, 2009). For some mothers, traumatic losses may occur during the perinatal period such as infertility, miscarriage, stillbirth, neonatal loss, or death of a young child (Blackmore et al., 2011). These losses can have mental health implications during the perinatal period including anxiety, depression, and PTSD (Blackmore et al., 2011).

During the perinatal period, women may also experience a traumatic event such as intimate partner violence (Hauff, Fry-McComish, & Chiodo, 2016), substance use problem (Grekin et al., 2017), or injury or loss of a significant person in their life. Such challenges often are cumulative (Hauff et al., 2016) and can contribute to the onset of perinatal depression (Grekin et al., 2017). Stress and trauma related to the perinatal period, irrespective of timing of onset, can continue to influence women's mental health across their lives if not properly addressed (Beck, 2009).

As this overview suggests, stress and trauma can contribute to poor postpartum mental health outcomes, including PPD. In fact, women who experience three or more traumatic events in their lifetime are at a fourfold increased risk for antenatal depression compared to women with no trauma history (Robertson-Blackmore et al., 2013). However, the mechanisms by which trauma contributes to or causes perinatal depression are not well understood due to minimal research, methodological limitations of existing studies, and the tendency of studies to focus on one disorder at a time. However, the high comorbidity of trauma symptoms and PPD (Grekin et al., 2017) shores up the need for the TIC approach to postpartum mental health, particularly among women experiencing PPD.

Trauma-informed care

Although recognized as an important issue in healthcare (Kezelman, 2016), trauma is rarely acknowledged in service delivery systems. Because providers have no overt way of differentiating trauma survivors from those who have not experienced trauma (Elliott et al., 2005), service recipients may be at risk of being retraumatized (Kezelman, 2016; Reeves, 2015; Seng & Taylor, 2015). To prevent retraumatization, researchers have recommended that all service delivery systems operate from a TIC framework (Kezelman, 2016; Reeves, 2015; Seng & Taylor, 2015).

TIC is most appropriately defined as a best practice approach to service delivery where the importance of trauma, victimization, and survivorship are recognized and, consequently, service delivery systems implement accommodations to limit or eliminate the influence of trauma on well-being and overall functioning (Elliott et al., 2005). TIC involves the awareness that most individuals could be or have been victims of trauma and, therefore, service organizations should be aware of how past trauma can affect current functioning (Knight, 2015; Wolf et al., 2014). Consequently, organizations should operate from a trauma-informed perspective that values the short- and long-term influence of trauma (Knight, 2015; Wolf et al., 2014). A trauma-informed approach to services views the client-provider relationship as necessary in lessening the influence of trauma and aiding in processing traumatic events (Knight, 2015; Reeves, 2015). Adopting a TIC approach

requires providers to develop positive working relationships with the client focused on positivity, respect, validation, and healing.

TIC involves integrating trauma principles into organizational settings (Kusmaul, Wilson, & Nochajski, 2015). Some of the main TIC principles include recognizing the impact of trauma and coping; using an empowerment perspective where recovery from trauma is a primary goal; and engaging in collaboration, respect, safety, and acceptance (Elliott et al., 2005; Levenson, 2017). The integration of TIC within organizations requires that all service elements, including the physical environment, are supportive and relevant for service recipients who have experienced trauma (Kusmaul et al., 2015). Further, TIC requires that all individuals within the organization, including support staff, direct care providers, and administrators, are educated on trauma and its effects (Elliott et al., 2005).

Using a TIC approach when working with pregnant or parenting women can help the women maximize their parenting skills, minimize isolation associated with being a new mother, and learn to apply skills specific to trauma healing and recovery (Elliott et al., 2005). Whereas normative practices can be oppressive to marginalized women during the postpartum period and can contribute to further oppression (Searle, Goldberg, Aston, & Burrow, 2017), TIC improves health and well-being and promotes care between mothers and their infants and other children (Seng & Taylor, 2015) particularly for mothers from diverse groups.

Despite the utility of trauma-informed services with women during the perinatal period, there is little research published on this topic (Reeves, 2015), including how TIC should be structured across practice settings (Kirst, Aery, Matheson, & Stergiopoulos, 2017). The purpose of this article is to provide a conceptual framework for TIC involving women diagnosed with PPD informed by existing literature.

Trauma-informed care framework for women diagnosed with postpartum depression

One of the most commonly used and strongly valued frameworks for TIC was put forward by the SAMHSA (2014a) Trauma and Justice Strategic Initiative. Based on this framework, TIC requires the recognition and integration of six principles including (1) safety; (2) trustworthiness and transparency; (3) peer support; (4) collaboration and mutuality; (5) empowerment, voice, and choice; and (6) cultural, historical, and gender issues (SAMHSA, 2014a, p. 10). Given the wide use and empirical support of the SAMHSA TIC principles, we recommend that these principles be considered and expanded to inform a TIC framework for women diagnosed with PPD. The developed framework is presented in Figure 1.

Principle	Trauma-Informed Care Actions
Safety	*Physical Safety*: • Convenient spaces • Accessible for infants • Secure for infants and children • Warm and welcoming settings *Emotional Safety*: • Approachability of staff and providers • Clear information regarding privacy and disclosure • Treatment of mothers with respect • Use of safety plans
Trustworthiness and Transparency	• Enhanced community engagement, education, and awareness • Clear and easy to understand information • Honest, open, and consistent communication • Providers' competency • Cultural competence and women-focused services
Peer Support	• Ongoing referrals to and information about available peer, mother-baby, and family-centered programs • Engagement of peer supports as appropriate
Collaboration and Mutuality	• Mothers and providers working together in service planning, intervention, and evaluation • Client-directed services supported by provider • Providers collaborating with and referring to other services
Empowerment, Voice, and Choice	• Mothers feeling a sense of control and opportunity for choice in services • Mothers being informed of their rights, risks and benefits, and options and opportunities for treatment • Providers supporting and empowering mothers to make service-related choices
Historical, Cultural, Racial, Ethnic, Gender, and Diversity Issues	• Providers helping mothers process through traumas related to oppression, vulnerability, and diversity • Providers helping mothers consider current experiences within context of previous victimization • Providers integrating cultural beliefs, values, and supports

Figure 1. Conceptual framework for trauma-informed care for women diagnosed with PPD.

Safety

Safety prioritizes the protection of individuals from physical and emotional harm (Kusmaul et al., 2015; Wolf et al., 2014). A barrier to care for mothers is that they may not feel safe accessing or participating in services (Muzik et al., 2013). Women's experiences of shame are positively associated with depressive symptoms and negatively associated with help seeking (Dunford & Granger, 2015) rendering mothers unlikely to seek care unless safety is promoted. Further, providers' behaviors, such as poor communication, are associated with both trauma and PPD symptoms (Sorenson & Tschetter, 2010), suggesting that mothers who have negative experiences may discontinue care. Therefore, service

providers working with mothers must promote a culture in which the women feel safe and validated (Muzik et al., 2013).

Promoting physical safety in an agency involves the location, hours, accessibility, appearance of physical spaces, and availability of security staff (Wolf et al., 2014). Locating service sites in convenient areas accessible by personal or public transportation can align with mothers' needs. A culture of safety is also established when settings are accessible to adults, children of all ages, and equipment such as strollers. Buildings should have inviting physical environments and provide a sense of security and confidentiality for mothers and small children (Levenson, 2017). Further, safety is promoted when organizations are in communities perceived to be safe, are well patrolled by local police or security, and have staff available to assist mothers upon arrival.

Emotional safety can be maximized in various ways including having warm and approachable staff and service providers (Levenson, 2017). Providing clear information about privacy and how specific information will be disclosed is critical (Elliott et al., 2005; Reeves, 2015). Mothers need to feel they are heard and understood by the staff (Muzik et al., 2013), have their experiences validated, and that service providers are competent and able to meet their service needs (Henshaw et al., 2011). Of additional importance are the identification of support systems, including agency personnel, and the use of safety plans, which document how mothers and their children will protect themselves and be safe in the event of a crisis (Elliott et al., 2005).

Trustworthiness and transparency

Some mothers, particularly those who identify as part of a minority group, mistrust healthcare service providers (Hannan, 2015). This mistrust may be caused or exacerbated by individual or familial beliefs; spiritual and religious backgrounds; language challenges; miscommunication; individual beliefs that are not aligned with healthcare system practices; or previous negative experiences with healthcare systems (Chandler, 2010; Hannan, 2015). Mistrust can negatively influence the treatment process and healthy mothering practices (Chandler, 2010; Hannan, 2015; Howell, Mora, Horowitz, & Leventhal, 2005; Kozhimannil et al., 2011), especially among mothers experiencing perinatal depression (Kopelman et al., 2008). For example, low-income women of color are even more likely to experience PPD due to environmental and socioeconomic factors (Howell et al., 2005), which often occur in a compounding, intersectional way (Chandler, 2010; Rouland Polmanteer, Keefe, & Brownstein-Evans, 2018). In response, providers should use techniques and strategies to ensure services are approachable and establish trust. Providers can promote trust through community engagement, education, and awareness as strategies to maximize visibility and availability of services (Taber,

Leyva, & Persoskie, 2015). Often, service agencies and providers are among the support systems, mothers need to develop when family members or friends are unsafe or unreliable.

Once women with perinatal depression engage in services, healthcare delivery systems must acknowledge and plan for the chance that women may feel uncomfortable with the approaches to care particularly during the beginning of treatment (Elliott et al., 2005). Initial assessment information, including screening questions, may be challenging for those women with a trauma history to answer (Elliott et al., 2005). To promote trust in initial service delivery, clear communication about a woman's right to privacy and confidentiality is important to convey before any service is offered (Elliott et al., 2005; Reeves, 2015). Discomfort can be acknowledged and difficult questions can be revisited at a later time.

Once a mother with PPD engages in formal services, developing trust with her treatment providers is essential (Henshaw et al., 2011; Gamble & Kreedy, 2007). Without trust, mothers are less likely to perceive professional interactions as positive (Henshaw et al., 2011). As such, providers should proactively encourage mothers to voice any concerns regarding trust issues as a way to build a strong working relationship. From a trauma-informed perspective, trustworthiness and transparency mean being honest, clear, and consistent in communication (Wolf et al., 2014). Through transparent communication, ambiguity is minimized and trust can be established (Levenson, 2017). Providers across interprofessional teams must follow through with any plans developed with mothers to demonstrate that professionals mean what they say, can follow through, and are supportive.

Peer support

Peer support, built on empathy, respect, and shared power, involves individuals from varied backgrounds who have common experiences coming together and offering validation, coping skills, and social connections (Blanch, Filson, Penney, & Cave, 2012). Peer support can be offered individually, in small groups, or large groups and may be social, educational, or activity or advocacy based (Blanch et al., 2012).

Peer support groups help mothers adjust to motherhood (Leger & Letourneau, 2015) and are particularly efficacious for women with PPD (Leger & Letourneau, 2015) and trauma histories (Muzik et al., 2013; Seng & Taylor, 2015) who are less likely to have existing support systems (Seng & Taylor, 2015). Mothers report that meeting with other mothers with PPD (Leger & Letourneau, 2015) or trauma histories in a child-friendly environment helps promote recovery (Muzik et al., 2013).

To promote peer support from a trauma-informed perspective, service organizations should refer mothers to available and appropriate peer, mother-baby,

and family-centered support programs, checking on each mother's comfort with meeting new people and trusting in the safety of the group members and setting. If in-person peer support programs are not available, reputable online groups can be recommended, such as those endorsed by Postpartum Support International (2018). Connecting with a peer support and developing a strong relationship with a support network can be integrated into intervention planning. Providers should then follow-up with these mothers by asking for an assessment of the quality of these interventions and provide recommendations for how to improve them.

Collaboration and mutuality

Collaboration refers to the client and connected systems, such as healthcare providers, joining in pursuit of a common goal (Wolf et al., 2014) and is based on sharing power and alliances in the healing process (Levenson, 2017). Collaboration emerges out of client-centered services where clients are perceived to be the experts in their own lives (Wolf et al., 2014). A collaborative approach can involve the mother focusing on her thoughts, perceptions, emotions, experiences, and coping approaches with support from the provider (Gamble & Creedy, 2007).

Mothers with a trauma history need providers working together to deliver services in a holistic and person-centered approach aligned with the mother's needs (Muzik et al., 2013). These collaborations can be empowering to new mothers who have experienced trauma and depression (Seng & Taylor, 2015). Promoting collaboration and mutuality encourages provider support for client-directed services (Elliott et al., 2005). Consistent with both evidence-informed practice and the TIC principle of collaboration and mutuality, the provider should work with and integrate the client's thoughts and perspectives on service needs before selecting a treatment approach or making a service referral. For mothers with PPD, promoting collaboration includes making sure providers are receptive to and engaged with the mothers. Mothers can also be encouraged to participate in the planning, intervention, and evaluation processes. Finally, the providers must be attuned to the mothers' feedback on how to improve collaboration skills that will enhance working with other mothers in the future.

At the organizational level, collaboration involves providers and agencies working together to promote client well-being (Reeves, 2015). Collaboration may involve formal service systems, faith-based organizations, peer support, and individual providers. Mothers with a trauma history report they want professionals to work in collaboration with other organizations and service providers (Muzik et al., 2013) in a seamless way. Agencies can demonstrate their collaborations with other agencies through various approaches including posting flyers, placing brochures in waiting rooms that promote other

services, creating and distributing referral lists, making referrals with the mother present, and introducing her to a new service provider if possible.

Empowerment, voice, and choice

From a TIC perspective, empowerment is conceptualized as the support for continued or new activities or goals (Kusmaul et al., 2015) and choice is understood as an individual's pursuit of self-determination (Wolf et al., 2014). Clients must be provided with the opportunity to have a voice in their treatment and the necessary information to make an informed decision. Promoting self-determination from an organizational perspective means that the individuals have options clearly explained to them, the opportunity to voice their decisions, and ability to have their choices honored (SAMHSA, 2014a; Wolf et al., 2014).

To promote empowerment, voice, and choice from a trauma-informed perspective, mothers experiencing PPD should be provided a sense of control and opportunity for choice; informed of their rights and the risks and benefits of treatment; and supported and empowered by treatment providers. First, within an organizational setting, clients may be able to choose the location where they receive services, which service providers they see, appointment times, and assessment and intervention approaches (Levenson, 2017; Wolf et al., 2014). If direct choice is not possible, mothers should be provided with as much control as permissible specific to the treatment and associated circumstances (Elliott et al., 2005). Second, mothers with PPD should be informed of their rights to privacy and confidentiality, and treatment options including the benefits and risks of each (Henshaw et al., 2011). Considering the importance of professional interactions and presenting clients with choice is imperative because any previous negative interactions with providers can deter future help seeking among women experiencing perinatal depression (Kopelman et al., 2008). Third, voice and choice can be promoted by positive provider engagement and interaction. During interactions, validation and affirmation of a mother's thoughts, feelings, and decisions (Searle et al., 2017; Wolf et al., 2014), while remaining nonjudgmental and respectful (Muzik et al., 2013), should be offered. Taking time to recognize a mother's hesitations or objections will promote trust, help address barriers, and lead to potential solutions.

Historical, cultural, racial, ethnic, gender, and diversity issues

Although SAMHSA (2014a, 2014b) frames the sixth and final principle as requiring a focus on cultural, historical, and gender issues, the framework acknowledges the importance of all tenets of diversity. In fact, the SAMHSA (2014b) framework emphasizes the compounding, intersectional nature of developmental, sociocultural, and historical factors operating at the individual, interpersonal, community, organizational, and societal levels.

To minimize the negative influence of racial, ethnic, and diversity factors on trauma (Kozhimannil et al., 2011), the provider should value the importance of diversity and work to understand sociocultural factors of relevance and importance to the client (SAMHSA, 2014b). To further promote diversity issues, cultural beliefs, values, and support systems should be integrated into care as a way to promote resiliency and recovery (Tummala-Narra, 2007). Then, within their role, providers can help clients address environmental and socioeconomic issues and process how these factors can lead to trauma and revictimization (Knight, 2015). Mothers of diverse backgrounds, particularly those experiencing PPD (Keefe, Brownstein-Evans, & Rouland Polmanteer, 2016), may have faith-based, cultural, social, family, and community supports that can be integrated into treatment (Tummala-Narra, 2007) or would benefit from referrals to social workers or related professionals. To promote a commitment to diversity, agencies may invite some mothers to serve as facilitators for peer support groups, on agency committees, or as a board member.

Implications for practice, research, and policy

During the birth and postpartum periods, women interface with many professionals including social workers. During these interactions, women can have positive or negative experiences, the latter of which can contribute to various feelings and even trauma (Baker, Choi, Henshaw, & Tree, 2005). Yet in working with social workers and related professionals, mothers consistently desire to receive accurate information, make choices, have their physical, psychological, and emotional needs addressed (Baker et al., 2005), and have providers who demonstrate genuine care for them and their families (Keefe et al., 2016). As professionals committed to empowerment, person-centered practice, and dignity and worth of a person, social workers should strive to meet mothers' needs and expectations at all practice levels. Promoting such values is well aligned with a trauma-informed approach to healthcare and can help ensure that mothers are not triggered, traumatized, or retraumatized through the help seeking and treatment processes.

However, limited research exists to guide healthcare professionals, including social workers, desiring to operate from a TIC approach specific to women experiencing PPD. Approaches to treatment, such as interpersonal and cognitive-behavioral therapy, have been used with mothers with PPD (O'Hara & McCabe, 2013) but none have been studied using a TIC perspective. The framework presented in the current paper is the first of its kind to be developed to inform social work practice and service delivery across organizational systems and types of practice. Future research can evaluate the utility, feasibility, and effectiveness of the developed framework in practice particularly when employed in conjunction with existing empirically supported treatments for PPD.

Existing research supports that TIC should be integrated across service settings and all organizations and providers, including social workers, should follow its principles (Levenson, 2017). To promote high-quality practice and avoid retraumatization, we recommend that the presented TIC framework be adopted across settings and programs that help mothers with PPD. Adopting a TIC framework can maximize interprofessional collaboration between social workers and other professionals. However, universal TIC may not be feasible, especially in managed care settings, due to the increased time and resources that implementation requires (Reeves, 2015). Although providers and settings that serve postpartum mothers may be limited with resources, such as time or funding, TIC content and skills can be integrated with minimal investment. For example, Hall et al. (2016) found that a one-day training on TIC can contribute to change in knowledge and skills related to TIC for emergency department nurses. This finding suggests that the implementation of trauma-informed content, and use of a TIC framework for postpartum women as the current discussion outlines, can be seamlessly integrated with teams of social workers, midwives, nurses, physicians, and other professionals who promote health particularly from an interdisciplinary perspective. It is, therefore, recommended that providers and organizations work together interprofessionally to address barriers to TIC implementation.

In conjunction with adapting the proposed TIC framework and evaluating its feasibility and effectiveness, educating providers, particularly those who work with women during the perinatal period on trauma and TIC, is needed (Hall et al., 2016; Reeves, 2015). The current discussion provides a framework that can be used in higher education and continuing education curricula for competency development of social workers and related healthcare professionals. As all practitioners need to be competent and do no harm, being trained on the relevancy of a TIC framework in practice is needed. Service leaders and administrators should also be trained on TIC and its principles to ensure organizations are trauma-informed.

Additionally, state and federal policies should be informed by TIC principles (Bowen & Murshid, 2016) and changed to account for and reflect TIC (Reeves, 2015). Approaching macro-level practice and policy through a TIC perspective can help deter oppressive policies that negatively affect vulnerable groups, including women and diverse mothers. The developed framework can be used to inform policy planning, development, funding, and analysis specific to healthcare and related areas. The integration of TIC in policy and macro-level work can ensure developed programming supports the needs of mothers.

The current discussion has underscored the importance of integrating a TIC approach when working with women experiencing PPD. Healthcare professionals, including social workers, can be the change agents to identify the relevancy of trauma concepts to the mothering experience. Prior to the current discussion, providers wanting to integrate a TIC approach with

mothers experiencing PPD had little information from which to pull. However, this paper documents a framework for TIC when working with mothers experiencing PPD. Integrating the TIC approach specific to women with PPD across healthcare systems can promote recovery while improving the mental health and well-being of mothers, children, and families.

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