A Qualitative Study of Parenting Stress, Coping, and Discipline Approaches Among Low-Income Traumatized Mothers

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ABSTRACT: ***Objective:*** **The use of harsh discipline is a risk factor for child maltreatment and is more common among families in which mothers have previously experienced trauma. We sought to understand the stressors experienced by low-income traumatized mothers and the perceived impact of those stressors on their discipline approaches.** ***Methods:*** **We conducted 30 in-depth qualitative interviews with low-income mothers with a history of trauma. We triangulated the results with experts in behavioral health, and with a subset of the informants themselves, to ensure data reliability.** ***Results:*** **We identified the following themes: (1) Repetitive child behaviors are the most stressful. (2) Mothers commonly cope by taking time away; this can result in prolonged unsupervised periods for children. (3) Harsh discipline is used deliberately to prevent future behavior problems. (4) Mothers relate their children's negative behaviors to their own past experiences; in particular, those who have suffered domestic violence fear that their children will be violent adults.** ***Conclusions:*** **Our findings suggest that trauma-informed interventions to promote positive discipline and prevent child maltreatment should help mothers predict and plan for stressful parent-child interactions; identify supports that will allow them to cope with stress without leaving their children for prolonged periods; and explicitly address long-term goals for their children and the impact of different discipline approaches.**

*(J Dev Behav Pediatr 35:*189–196, 2014) **Index terms:** trauma, discipline, ethnographic interviews, qualitative research.

BACKGROUND

In recent years, there has been increased attention among researchers and practitioners to the concept of trauma-informed care.[1–3] Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. Experts in the field have published general guidelines for this approach[1]; toolkits have been developed[2]; and the Department of Health and Human Services Substance Abuse and Mental Health Services Administration has set up a National Center for information, training, and technical assistance as regards trauma-informed approaches to mental health and general medical care.[3] Despite this recent trend, guidelines on trauma-informed care remain largely devoid of specific recommendations.

One area in which specific guidelines on trauma-informed care are necessary is in programs to promote more effective discipline. The use of harsh discipline, including psychological aggression and physical punishment, has been associated with child maltreatment and poor child developmental outcomes,[4–7] and previous studies have demonstrated that harsh discipline is used more commonly by mothers with depression or a history of trauma.[8–10] Parenting interventions to teach positive discipline strategies and promote parent-child attachment have been shown to change parenting behavior and decrease risk factors for child maltreatment in the general population,[11,12] but such strategies have been less effective among mothers who have previously experienced trauma.[1,13,14] There are currently few practical trauma-informed interventions designed to address parenting practices in this high-risk population, which is estimated to constitute 40% to 80% of urban low-income mothers.[15,16]

With an eye toward intervention development, we sought to understand, through in-depth qualitative interviews, the parenting experiences of low-income traumatized mothers. We were particularly interested in learning about informants' coping strategies, factors influencing discipline approaches, and explanatory models linking previous traumatic experiences to these

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approaches. Knowing that many parenting interventions focus on parental emotional regulation, we sought to uncover other potential constructs that could augment these strategies.[11,12] Our ultimate aim was to inform the planning of culturally relevant trauma-informed strategies to promote the use of positive discipline and decrease the risk of child maltreatment among high-risk families exposed to violence.

DESIGN AND METHODS

We conducted in-depth, semistructured, one-on-one qualitative interviews with 30 low-income mothers with a history of trauma. We chose this approach as the interviews covered sensitive information not amenable to focus-group discussion. We opted to use semi-structured interviews, as opposed to unstructured interviews, as there were specific domains that we hoped to cover.

Participants and Recruitment

Purposive sampling was used to recruit subjects between July 2012 and December 2012 from a large urban pediatric primary care clinic and community offices of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) in Boston, MA. WIC is a federal nutrition program for low-income women and children under age 5.[17] These settings were chosen because they were felt to represent potential venues for future intervention with families. Subjects were recruited through the use of promotional flyers that advertised a study to learn more about stress among mothers of young children. Interested mothers contacted the study team at a telephone number provided on these materials. Study staff conducted a brief telephone screen for eligibility, based on child age, family income, and language, and subsequently met participants in person to obtain informed consent and conduct the interview.

Mothers were eligible to participate if they had a child between 0 and 36 months; were low-income, defined by eligibility for receipt of Medicaid (which in Massachusetts includes families up to 300% of the Federal Poverty Guidelines),[18] WIC, or Supplemental Nutrition Assistance Program (SNAP) benefits; and were fluent in English or Spanish. As we did not want to unduly influence the content of the interview, we screened for trauma exposure after, not before, the interview. For this reason, trauma exposure was not part of the inclusion criteria. We conducted 31 interviews overall and did not transcribe or analyze the single interview with a non-traumatized mother. Our sample size of 30, therefore, reflects only traumatized mothers.

Procedures

After completing informed consent, mothers answered demographic questions about their age, race, ethnicity, education, and which, if any, other adults lived in the home. They then participated in a qualitative interview that generally lasted approximately 45 minutes. The interviews took place in private rooms at the pediatric clinic or WIC offices. The interviews were conducted by a member of the study team (CJK) trained in qualitative methodology. All interviews were audio-recorded, and each subject was interviewed only once. Open-ended questions, such as "Can you describe a typical day for me?" were followed by more specific probes that focused conversations on mother-child interactions, stressful parenting experiences, maintaining versus losing control, and parental coping mechanisms (Table 1). The probe questions were developed collaboratively by the study team. We specifically sought to include probes related to maternal cognitive-behavioral processes, including the circumstances or setting of high-stress periods as well as maternal feelings and thoughts. There were no probe questions that specifically queried traumatic life events; therefore, any mention of trauma or violence in the interviews came up naturally in the course of conversation. When trauma was brought up by the participants, general probe questions, such as "tell me more" were used.

After the interview, participants completed the valid and reliable Stressful Life Events Screening Questionnaire,[19] which consists of 13 questions that assess lifetime exposure to potentially traumatic events (Table 2). Subjects were given the choice of taking the written survey themselves (2/30) or taking it with the interviewer reading the questions (28/30). Mothers who answered "yes" to any of the questions were classified as having a history of trauma, whereas mothers who answered "no" to all questions were classified as having no history of trauma.

Analysis

All qualitative interviews were audio taped and transcribed verbatim. The interviews were reviewed by a 3-member group (C.J.K., J.R., and Y.D.L.) with expertise in general pediatrics, child development, and maternal mental health. We used the Grounded Theory approach to qualitative analysis, building theory from the data through an iterative process of data collection and analysis.[20] To maximize the reliability of the analysis, 2 members of the group reviewed transcripts independently to identify tentative domains for coding and analysis. The group met weekly to decide on a coding structure for the narrative data before independently coding the transcripts and meeting again to assure uniform coding of each interview. Any disagreements were resolved through discussion. Coded transcripts were sorted into code-specific passages using Dedoose qualitative software.[20] Each coded passage was re-read by 2 members of the study team, studied for patterns of connection and grouped into broader themes. An iterative approach to data analysis allowed the team to continuously refine probe questions, develop themes, and monitor for thematic saturation. Data collection ended

Table 1. Examples of Probe Questions Used as Needed for Qualitative Interviews

Domain	Probe Questions
General	Can you describe your typical day for me?
Parenting stress	Can you think of a time with your child when you felt like you were going to lose it?
Setting	What was going on? What were you doing? Where did this occur? When did this happen? Did you respond the way you wanted to?
Feelings	How were you feeling before this happened? How did you feel while it was happening? What mood were you in after this happened? When your child cries or misbehaves, what sort of emotional reaction does it bring about in you? Why do you think that is? How do you try to figure out what your child is thinking or feeling?
Thoughts	What was going through your mind before you started to feel that way? What made you feel that way? Did you have any other thoughts? What bothered you the most? What thought bothered you the most? Have you ever wished you reacted differently when your child cried or misbehaved? What do you wish you would have done? What do you think other people expect you to do when your child cries or misbehaves? Do you ever feel like people are judging you when you are taking care of your children?
Other stressors	Most people feel stress at some point in their lives. What else in your life stresses you out?
	What do you do to deal with stress?
	What did you used to do to deal with stress before you had children?
	Who helps you out?

when the group established a set of themes and no new ones were identified.

To ensure data reliability, the study team triangulated findings with experts in behavioral health who independently reviewed both transcripts and themes and provided feedback to the study team. We also engaged in member checking, where we reviewed the results with a subset of 7 study subjects and asked for their feedback on the results and interpretation of the data. The methodology, coding approach, and identified themes were also presented to a group of pediatric health services researchers for feedback.

Human Subjects

Approval was obtained from the Boston University Medical Center Institutional Review Board before the initiation of the study.

RESULTS

Population

We conducted 31 interviews with low-income mothers of young children. Thirty of the 31 mothers reported a history of trauma and were included in the analysis. The subjects ranged in age from 20 to 39 (Table 3). Fourteen participants were black, 8 were white, and 8 were Hispanic/Latino. Twenty-five had less than a college degree, and 18 reported that they were the only adult in the home.

Each of the 30 mothers who reported a history of trauma had experienced multiple traumatic events in her lifetime. The most common traumatic exposures (not mutually exclusive) included physical assault (18 participants), the violent death of a close contact (18), emotional abuse (17), rape (14), other sexual assault (12), and child physical abuse (13) (Table 4). The mean ages of the first exposure to each type of trauma ranged from 8 years old for child physical abuse to 22 years old for physical assault.

Themes

Four major themes emerged.

Theme 1: Repetitive child behaviors are the most stressful.

Mothers reported that they found it most stressful when their children engaged in repetitive frustrating behaviors as opposed to unexpected behaviors. In this context, mothers specifically reported frustration that their children were not listening to them and tended not to link this frustration with traumatic episodes in their lives.

> *"If you're telling somebody 'sit down, sit down,' it gets tiring after awhile. You have to keep repeating yourself and repeating yourself and repeating yourself. It just gets so tiring sometimes"* (20-year-old mother, 22-month-old child).

Mothers reported feeling particularly stressed by repetitive child behaviors when they perceived themselves as ineffective, such as when they were unable to control their child's behavior. Feeling ineffective amplified the level of stress the mothers reported feeling during these frustrating episodes.

> *"Lately, he's doing this little hitting thing. Not hard, lightly or whatever and he laughs, but when you tell him no he just continuously does it and does it and does it"* (28-year-old mother, 2 children including 20-month-old child).

Table 2. Primary Questions About Trauma Included in the Stressful Life Events Screening Questionnaire[a]

1. Have you ever had a life-threatening illness?
2. Were you ever in a life-threatening accident?
3. Was physical force or a weapon ever used against you in a robbery or mugging?
4. Has an immediate family member, romantic partner, or very close friend died because of accident, homicide or suicide?
5. At any time has anyone (parent, other family member, romantic partner, stranger, or someone else) ever physically forced you to have intercourse, or to have oral or anal sex against your wishes or when you were helpless, such as being asleep or intoxicated?
6. Other than experiences mentioned in earlier questions, has anyone ever touched private parts of your body, made you touch their body, or tried to make you to have sex against your wishes?
7. When you were a child, did a parent, caregiver, or other person ever slap you repeatedly, beat you, or otherwise attack or harm you?
8. As an adult, have you ever been kicked, beaten, slapped around, or otherwise physically harmed by a romantic partner, date, family member, stranger, or someone else?
9. Has a parent, romantic partner, or family member repeatedly ridiculed you, put you down, ignored you, or told you you were no good?
10. Other than the experiences already covered, has anyone ever threatened you with a weapon like a knife or a gun?
11. Have you ever been present when another person was killed? Seriously injured? Sexually or physically assaulted?
12. Have you ever been in any other situation where you were seriously injured or your life was in danger (e.g., involved in military combat or living in a war zone)?
13. Have you ever been in any other situation that was extremely frightening or horrifying or one in which you felt extremely helpless, that you haven't reported?

[a]Affirmative answers are followed up by questions about respondent's age at the time of the traumatic exposure, how many times the trauma occurred and over what time period, and the relationship—if any—to the perpetrator.

Table 3. Maternal Demographic Characteristics (N = 30)

Maternal Characteristics	
Age, mean (range), yr	28.7 (20–39)
Race, n	
White	8
Black	14
Asian	1
Other	7
Ethnicity, n	
Hispanic/Latino	8
Highest education level, n	
Less than high school degree	9
GED or high school degree	7
Vocational or trade school	3
Some college	6
Associates degree/2-yr degree	2
Bachelor's degree	2
Graduate or professional school	1
Other adults who live in the home (not mutually exclusive), n	
Spouse/partner	6
Mother or mother-in-law	5
Father or father-in-law	3
Brothers or sisters	1
Mother is the only adult in the home, n	18

GED, General Education Development certificate.

Harsh discipline was seen by many of our informants as a means to regain control or as an effort to feel like a more effective parent. In this context, mothers specifically viewed more gentle parenting approaches (i.e., those not involving hitting or yelling) as weak.

> *"It's not that you want to strike your child. That's not what a parent wants to do, but you just want your child to stop. You just want your child to know, I say no and, again, no means no"* (20-year-old mother, 22-month-old child).

> *"I let her off the hook easily. She'll come to kiss me and I'll be like no, no, and then I'll give in. I feel like I'm weak in a way, and that's why I'm afraid. I feel like it has to do with me not having that control"* (33-year-old mother, 4 children including 28-month-old child).

While discussing these repetitive frustrating behaviors, mothers reported feeling that their children were misbehaving purposefully and even, at times, maliciously.

> *"Yeah, I think he does it on purpose, everybody does. I'm like, you need to stop doing that, little man! You can't do that!"* (24-year-old mother, 14-month-old child).

> *"They just say no to me like they don't understand. They understand, but they just rebelling against me"* (24-year-old mother, 3 children including 30-month-old child).

Table 4. Characteristics of Maternal Trauma Exposure (N = 30)[a]

	Serious Illness	Accident	Mugging	Violent Death Close Contact	Rape	Other Sexual Assault	Child Physical Abuse	Physical Assault	Emotional Abuse	Threatened by Weapon	Witnessed Violent Crime
No. reporting exposure, n	9	6	7	18	14	12	13	18	17	8	11
Mean age of the first exposure, yrs	21.3	19.7	19.5	20.3	14.2	9.6	8.2	21.7	19.5	20.8	14.4

[a]Trauma exposures are not mutually exclusive.

Theme 2: Coping by taking time away.

Mothers reported that they had a number of strategies that they used when they felt stressed with their children, most often trying to remove themselves from the situation to keep from reacting harshly in the moment.

> *"When I start to feel like I'm at the boiling point, okay, it's time to remove myself or remove you. Sometimes I'll step out on the porch for some fresh air, sometimes I'll go in my room and sit on the bed for 5 or 10 minutes. You know, but sometimes you just have to remove yourself. If I feel like I'm going to explode or start screaming at her, I'll just move. Yeah, and then sometimes you just feel like 'boy, this was the right thing to do before I hurt one of my children'"* (33-year-old mother, 3 children including 14-month-old child).

In some cases, however, mothers reported leaving their children unsupervised for much longer periods of time. This was described by some mothers as a necessary period to further calm down before reengaging with their children.

> *"I have to go lay down, take a nap, something. I have to get out of the situation or the issue, just, you know, so I can kind of calm down and take a breather. When my anxiety kicks up, I start sweating and I start seeing fuzzy dots—it's bad. So laying down, closing my eyes, it's like a "woo-saw" (relaxing) moment—it's the best. Then when I wake up, I'll be like 'okay, let's deal with the issue at hand.' I'm more calm"* (24-year-old mother, 30-month-old child).

Alternatively, other mothers described leaving their children for prolonged periods as a punishment, not to calm themselves down.

> *"I threw him on time out for at least 30 minutes, and he stayed there. He cried and he cried. I walked up to him and I told him why he's in time out, and he continued to yell so I just left him there. I put him on time out again and I left him there. I just left him there and he cried and cried and he fell asleep and I put him to sleep, and that's that."* (20-year-old mother, 22-month-old child).

Theme 3: Harsh punishment is a purposeful solution to ensure appropriate long-term child behaviors.

Mothers were commonly concerned with their children's long-term well-being and future behavior, and they primarily worried about how to best discipline their children in this context.

> *"You know, as they get older, it's hard. Sometimes I sit there and I think, you know, what's going to happen to my son when he gets older? Like, if he's*

going to take the right step in life or he's going to stray away and do stuff that he's not supposed to. That really worries me. I try so hard to discipline him when he's being bad, because sometimes it's really hard. It's really hard, and I'm trying my best" (25-year-old mother, 2 children including 28-month-old child).

"I worry that if I don't discipline him now, he'll grow up thinking that these behaviors are ok. I don't want to be too harsh, but I don't want to be too lenient. It's really just finding the middle ground I guess" (24-year-old mother, 33-month-old child).

Mothers described their children's current misbehavior as a sign of future trouble and spoke of the need to intervene early before behaviors got out of hand. Mothers who used harsh discipline described deliberately choosing this approach in an effort to keep children from exhibiting more concerning behaviors later on.

"You think, is there something wrong with my child? Why is every other one-year-old acting different and he's acting this way? How is he going to behave when he gets older? Is there going to be a conflict where he gets suspended? Am I going to have to go out in the streets looking for him? Your mind tends to wonder. And stress like that, when you think about your child, you think, oh, if I don't start being stricter with him, he's not going to do this, he's not going to do that" (20-year-old mother, 22-month-old child).

"I have to start it now. If I don't, like, put my foot down now, she'll just—you know what? This is what I really feel like she's going to think: If I don't start telling her no and being serious with her, she'll just look at me and when I'm like 'no, no sweetie,' she'll just like roll her eyes and think 'Pssht, what is she going to do?' Like, I think that's what she's thinking in her head—she might be. Like 'she's just going to tell me no, nothing's going to happen, that's it and I'll do whatever I want'" (30-year-old mother, 2 children including 20-month-old child).

In this context, mothers felt they were more likely to be mocked or ignored by their children if they used a more gentle approach.

Theme 4: Mothers' traumatic experiences influence their parenting fears and goals.

Mothers commonly related their children's negative behaviors to their own past experiences. Those who had experienced domestic violence with their children's fathers specifically expressed fear that their children's behavior was an indication of future violent tendencies.

"A lot of times people say when you have children they tend to come out like you. The way my family and my siblings are, the children tend to grow up a certain way, then they turn to a direction where they're all getting in trouble, they're in court, or they're troubled teenagers. It's very rare that you find a child in our family who is doing good" (33-year-old mother, 28-month-old child).

"His father, I've had a lot of problems with him. He's got a lot of rage and that's what I worry about with my son, that it's not going to be something he grows out of. I'm worried that this is, like, a warning sign of future things to come. His father's mother has told me that this is how his father used to act when he was younger. That's what worries me the most. I don't want him to be a violent person, or, I don't know. It's just scary to me" (24-year-old mother, 33-month-old child).

DISCUSSION

Our findings suggest that for low-income mothers with a history of trauma, the most stressful parent-child interactions appear to involve repetitive child behaviors that make parents feel ineffective and frustrated. Mothers use a variety of coping strategies in the heat of the moment, including removing themselves from stressful situations to calm down. In many cases in our sample, however, mothers report leaving young children alone for prolonged periods. Some mothers use this time as a means of further coping with parenting stress, whereas others employ this approach as a punishment for the child. Mothers worry about the long-term well-being of their children and commonly interpret their children's behavior as a sign of significant trouble to come, often based on their own traumatic experiences. Mothers who use harsh discipline report using it deliberately to both regain a sense of control and to prevent future behavior problems.

We see our study as a first step in a process to develop specific intervention models to promote positive parenting and prevent child maltreatment in families where mothers have suffered significant trauma. We identified several ways in which maternal trauma exposure appears to influence discipline approach, which have implications for intervention development.

First, in our sample, mothers appear most stressed by interactions with their children that are challenging but predictable. Many of the child behaviors described by our participants include developmentally normal attention-seeking, limit-testing, or oppositional behaviors that were interpreted by their mothers as being volitional or malicious and made them feel that they were ineffective parents. This feeling, for some, prompted the use of harsh discipline as a means of exerting control. Although participants tended not to link their frustration with traumatic episodes in their lives, there is a well-described association between trauma exposure and low perceived self-efficacy.[21,22] Mothers who have previously experienced trauma may therefore be particularly vulnerable to

feeling ineffective as parents and attempting to exert control through the use of harsh discipline. Although it would be unrealistic to expect any discipline approach to completely eliminate difficult toddler behavior, mothers who can anticipate and prepare for challenging moments, and interpret them in the context of normal toddler development, may feel less overwhelmed, more empowered, and better able to engage with their children in a positive way without resorting to the use of hash discipline.

Second, many parent handouts and professional recommendations on discipline, from sources including the American Academy of Pediatrics and the Centers for Disease Control, include information on how parents can keep calm in the moment with their child.[23–25] Mothers in our study commonly remove themselves briefly from stressful interactions, which is a widely recommended approach.[23–25] Some mothers, however, take this approach to an extreme, leaving their children alone for much longer periods of time either as a coping mechanism for themselves or as a form of punishment for their children. This prolonged time away may actually lead children to act out more in an attempt to reengage their parents.[26–28] Therefore, the use, duration, and intention behind leaving a child alone as part of a coping or discipline strategy should be explored explicitly and alternative approaches should be considered.

The mothers in our study were principally concerned with discipline in the context of their children's long-term well-being, which is not explicitly addressed by the AAP or Centers for Disease Control parent materials.[23–25] Although previous studies have suggested that emotional dysregulation is the pathway by which maternal trauma exposure leads to the use of harsh discipline,[8–10,29,30] the participants in our study who reported yelling or spanking overwhelmingly described it as a rational, proactive decision that they felt would best establish their authority in the relationship and avoid delinquent behavior down the road. In this context, some mothers explicitly viewed less harsh parenting approaches as weak and worried they would exacerbate their children's bad behavior. Ironically, studies show that in the long-term, harsh discipline does not effectively improve child behavior and can even lead to increased problematic behaviors such as hitting and fighting,[5–7] which are among the behaviors that mothers in our study report they are most interested in eliminating.

Finally, the mothers in our study report that they have significant fears about their children's future behavior, often based on their own traumatic experiences. Further education in normal child development, a common component of parenting interventions,[11,12,23,25] may be insufficient in the face of previous trauma to allay mothers' fears about their children's trajectories. Eliciting parents' specific goals and fears about their children's future behavior, acknowledging their dedication to promoting their children's overall well-being, and sharing what is known about the long-term impact of harsh discipline in this context, is therefore an important step in forming an alliance with the family and promoting behavior change around discipline practices.

This study has several limitations. First, the participants contacted the study team themselves after reading about the study on fliers. Although the experiences of this group may therefore not reflect the experiences of all low-income mothers who have experienced trauma, we do feel that they are representative of mothers who would be more likely to participate in a parenting intervention in the future. Second, by the nature of our study, all measures, including trauma exposure, were based on self-report. To maximize reliability and validity, we used a well-established instrument to measure trauma exposure. Finally, our observations are limited to what was discussed in the interviews. Even though we continued to interview participants until we reached thematic saturation, it is possible that there are additional important themes that were never discussed. In addition, we cannot conclude that the themes we identified are unique to low-income mothers who have experienced trauma and are not experienced as well by low-income mothers with no history of trauma. Despite these limitations, the findings from this study highlight important themes that may increase the effectiveness and relevance of interventions to promote positive discipline and prevent child maltreatment with high-risk families.

CONCLUSIONS

Trauma-informed interventions to promote positive discipline in high-risk families should acknowledge the potential impact of maternal trauma on parenting practices and should help mothers predict and plan for stressful parent-child interactions; identify supports that will allow mothers to cope with stress without resorting to harsh discipline or leaving their children unsupervised for prolonged periods; and explicitly address parents' long-term goals for their children and the impact of different discipline approaches.

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