Trauma Informed Care in Obstetrics

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Lauren Harrington, MD
Assistant Professor, OB/GYN
Associate Division Chief, Division of Academic Specialists in OB/Gyn
Co-director of Women's Sexual Health Consultation Service
University of Colorado School of Medicine

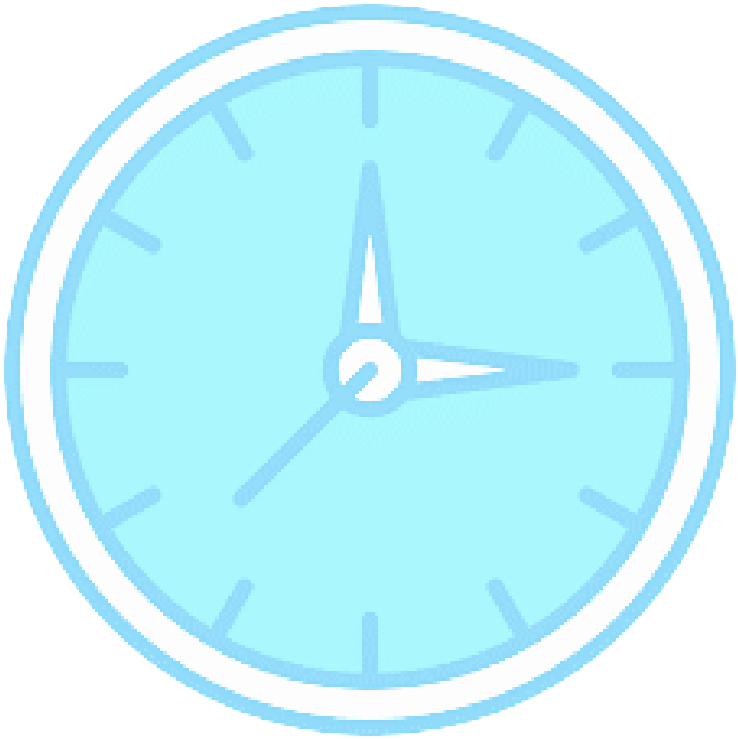
Winnie Hunter, PhD
Assistant Professor, Psychiatry
Director of Specialty Integrated Services
Co-director of Women's Sexual Health Consultation Service
University of Colorado School of Medicine

Disclosures

None

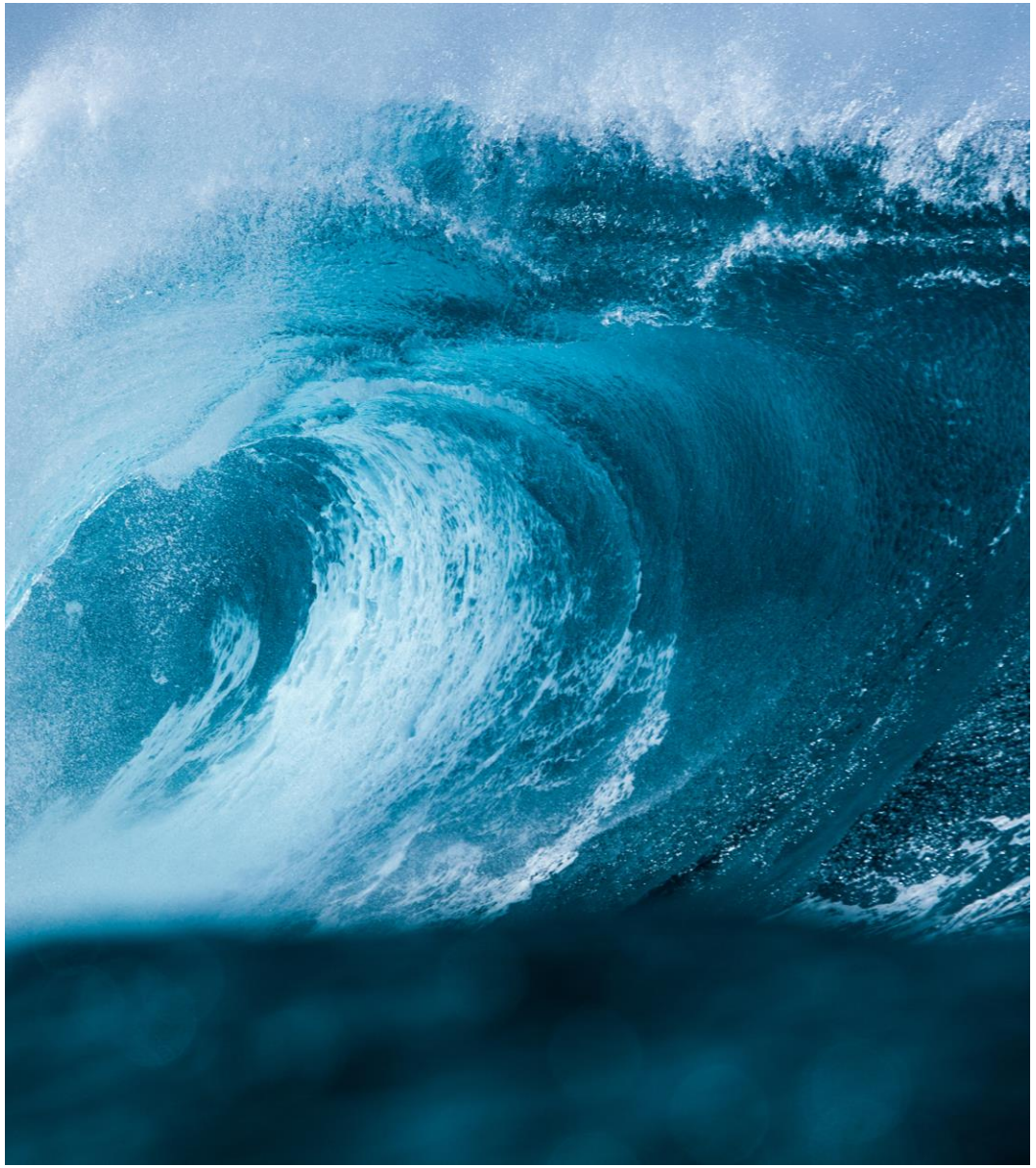
Agenda

1. Acknowledgement + self care
2. What is Trauma?
3. What is trauma informed care?
4. Historical context
5. Trauma informed care in Obstetrics
    - Patient care, exam and procedures
    - Birth trauma



Acknowledgements

- Positionality
- Speak up and take action
- Recognize systemic inequities
- Commit to allyship and solidarity
- Self care



What is trauma?

- Event, series of events, circumstances that are deeply distressing, or disturbing
- Emotional, physically harming and/or life threatening or physical pain
- Overwhelms coping mechanisms
- "Too fast, too soon, too much"


Individual
Medical
Institutional
TRAUMA
Military
Community/
Collective
Racial

Obstetrics: A Unique Intersection

Obstetrics is the intersection between one's most
private, intimate and vulnerable moments
with scenarios that could potentially
evoke **and** ***create***
significant emotional and physical trauma.

Obstetric Trauma

- Exposed, vulnerable and intimate
  - Undressed
  - Intimate exams
- High expectations, high stakes
- Dependency on others
- Unexpected outcomes
  - Emergencies
  - Neonatal complications
- Loss of autonomy and control
  - Immobile (epidural)
  - Procedures without consent
- Obstetric violence
  - Threats
  - Food restrictions
  - Forced cesarean, episiotomy
- Culture of Obstetrics, L&D

They told me that if they do not break my water, my baby may not survive.

You haven't had sex since you had your baby 2 years ago? Wow, how is your husband dealing with that?

My doctor told me that because I am a petite, Asian woman my labor experience will be even more painful than for other people

I know this is uncomfortable but let's just try to breathe and get through it and it will be over very fast.

Yeah, I had vaginal tearing but no one told me how bad it was.

When I was 5 years old, I remember that my mom and the doctor had to hold me down to check my vagina. It was scary. My mom never told me why that happened. I hate pelvic exams.

The OB team kept asking "where is dad"? My wife and co-parent was right there and we told them multiple times.

The resident and attending checked my cervix repeatedly and then talked about me instead of to me about what they were observing/feeling.

Historical context

- Profoundly troubling history
  - Exclusion from medical education and research
  - Forced medical experimentation and sterilization
  - Racial bias in diagnosis and treatment
  - Inequities in access to reproductive health
  - Surgical instrumentation
  - Perceptions of pain tolerance
  - Insidious language

History Informs Now

- Implicit bias is an attitude, of which one is not consciously aware, against/for a specific social group.
  - Automatic and unintentional which affects judgments, decisions, and behaviors.
- Activated in stressful working conditions such as in L + D and OB/GYN settings.
  - Impact communication and quality of care with patients.
- Studies indicate:
  - Implicit bias correlated with lower quality care for patients
  - BIPOC patients are more likely to report lower satisfaction with health care providers interactions decreased attendance to prenatal visits
  - Recommending different treatment options for patients based on assumptions about treatment adherence "capabilities" or presumed health conditions
  - Interpretations of pain
  - Lower rates of epidural analgesic management offered to birthing people of color, fewer referrals for pain management
  - Medical students – across races tend to perceive that BIPOC patients have higher pain thresholds
  - Implicit bias is conveyed in EMR/Charting - open charting

Reflexivity

- Patient is expert of experience Aim to connect with patients instead of assuming expertise on the patient's race, culture, or ethnicity and how those relate to the patient's health
- Build our own practice of curiosity,
  - A personal **lifelong commitment to self-evaluation and self-critique**
  - Examine one's own beliefs and cultural identities
- Recognition of power dynamics and imbalances, a desire to **fix those power imbalances and to develop partnerships with people and groups who advocate for others**
- **Institutional accountability***

Reflexivity

- Mindfulness practices are correlated with decreased expression of implicit bias
  - Empathic curiosity
    - Example: Barriers to attending appointments.
    - What was it like getting here today? What might facilitate getting here at the start of our visit?
    - How is our clinic supporting you? What can I do better for you?
    - When you think about your L + D experiences, what words come to mind?
  - Notice strong emotions
    - Support persons
    - Acknowledge strong emotions
  - Documenting patient preferences
      - "patient refused" vs. "patient educated on options","strongly encouraged to".. Patient shared decision-making related to declining procedure, intervention, vaccination

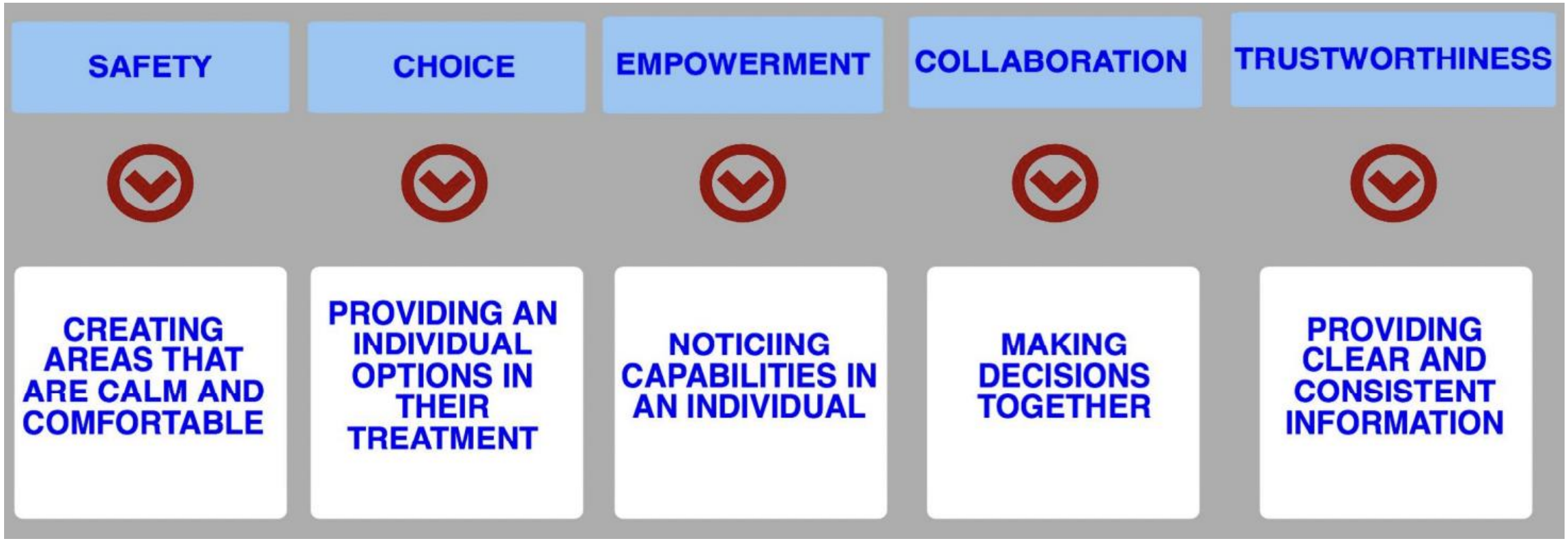
What is Trauma Informed Care

- Paradigm of clinical practice
- Applied universally
- Understand the social and health effects of trauma
- Acknowledge the potential to create new trauma
- Avoid re-traumatization
- Transfer power
- Build trust and transparency
- Promote healing and recovery

Why Does TIC Matter?

- High prevalence
- High incidence of trauma (new or reactivation) in OB care
- Obstetric trauma is a risk factor for depression, PTSD
- Attachment and bonding
  - Prematurity
  - Low birth weight
  - Delayed or impaired bonding with baby
- Long term health consequences
- Reduces burnout

5 Principles of TIC



https://socialwork.buffalo.edu/content/dam/socialwork/social-research/ITTIC/trauma-informed-care-infographic.pdf

SAMHSA's 4 R's

https://resilientnortheastgeorgia.org/trauma-resources/

Providing TIC: Labor & Delivery

- Universal precautions
- Respect and resilience (not pathology).

  "What happened to you?", instead of *"What's wrong with you?"*
- Cede control, stop anytime
- Ask permission
- Describe and communicate
- Limit exposure

Trauma-Informed Model of Care in Obstetrics. American College of Obstetricians and Gynecologists. Adapted from ACOG Committee Opinion No. 825, 4/2021.

TIC on L&D: Intake

- Create the space, normalize the conversation

  "Traumatic events are very common and can have a direct impact on physical and mental health. For these reasons, I ask all of my patients if there are any prior difficult experiences or traumas they'd like to share with me."

- Assess medical knowledge and awareness – opportunity to educate
- Hx of medical trauma, medical naivete
- Support persons
- Preferred terms

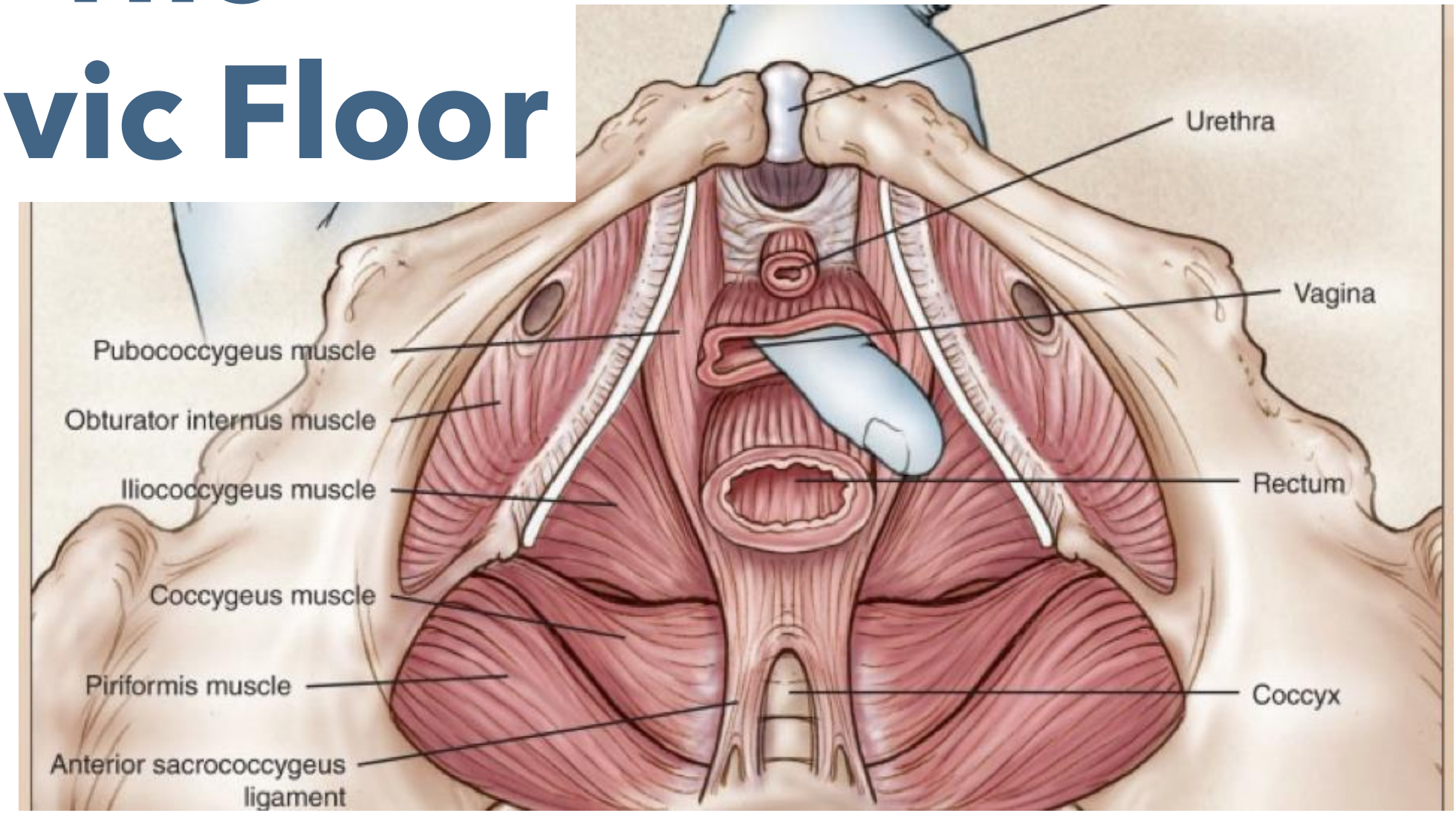
TIC on L&D: Intake

- Expectations & anticipatory guidance
  - Physical changes and body response to labor, delivery, early postpartum period
  - Analgesia options and side effects
  - Sleep, mood changes
- Patient-centered conversations, shared decision-making
  - Pain management
  - Feeding baby
  - Body autonomy, movement
- Management of dissociative responses

TIC on L&D: Exam

- Ask permission.
- Explain **what** you'll do and **why**.
- Establish that the patient is in control.
- Support persons present.
- Deliberate language: what body parts to move, how to release pelvic floor tension.
    - High tone pelvic floor myalgia
    - Pain-avoidance cycle

The Pelvic Floor

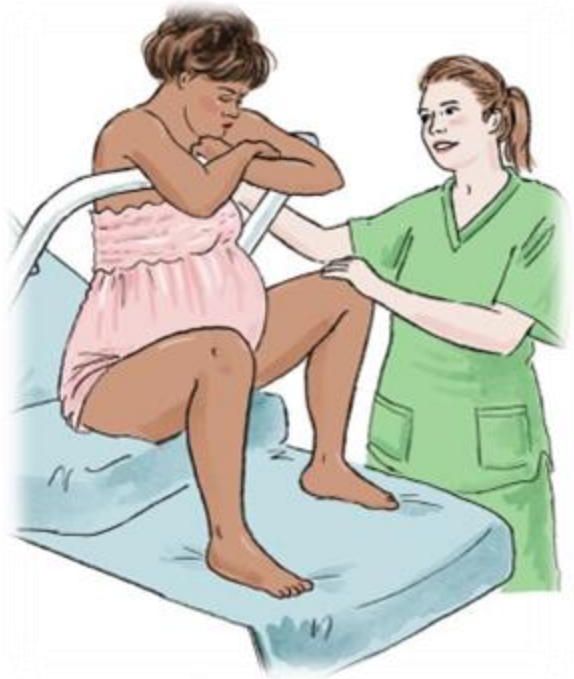


TIC on L&D: Exam

- Performing the exam:
  - Covered
  - "When you're ready, can you please move your knees until you touch my hands?"
  - Ask permission, again. Keep checking in.
  - Slow, but not prolonged
  - Feedback on results of the exam
- Avoid triggering language
  - *"Just relax."*
  - *"You're making this harder by clenching."*

TIC on L&D: Delivery

- Choices and control
  - Body autonomy related to dressing/undressing/exposure; Mirror
- Environment
  - Music
  - Familiar clothing (no gown; fuzzy socks)
- Anticipatory guidance & planning:
  - Involuntary reactions – "the shakes", bloody show, defecation
  - Medication outcomes – diarrhea, nausea, somnolence, immobility
  - Other teams in the room
  - Interventions immediately after delivery
  - Cut cord? See placenta?



TIC in the OR

- Dehumanization
  - Touching without permission (holding O2 mask, placing stickers, trimming hair)
- The patient maintains control
- Environment
  - Quiet, lights dimmed, music
- Explain medications
  - Indication, side effects, alternatives

TIC: Emergencies

- Communicate and explain
- Set the tone
- Debrief
- Behavioral health consult

Behavioral Health

- Behavioral health across the obstetric journey
  - Prenatal visits
  - Preparation for birth
  - Labor and delivery
  - Early postpartum
  - Later postpartum
- Providing support between provider and patient

Additional

- Beyond the routine perinatal mental health evaluation
- History of pelvic trauma
  - Childhood pelvic injuries
  - Unwanted touch
  - Medical trauma
- History of pain/discomfort with pelvic/vaginal touch
  - Use of tampons or menstrual cups
  - Pain with insertion/intercourse – digital, dilator, in context of sexual encounter
- Intergenerational obstetric history
  - Values/beliefs
- Dismantling assumptions
- Opportunity to identify preferences/hopes

Birth Trauma

- Frightening or upsetting experience during birth – self-defined and subjective.

- ⅓ of people find some aspect of their birth traumatic; only 3% will meet criteria for post-traumatic stress disorder

- Negativecare interactions with medical providers = **strongest predictor** for developing birth related trauma reactions

Risk Factors

- Perinatal depression
- Hx of post-traumatic stress disorder
- Past history of medical interventions/traumas/surgeries
- History of an anxiety disorder
- Tokophobia – extreme fear of giving birth
- Medical professionals – less likely to self-advocate, fear of being pushy, hiding medical knowledge
- First pregnancy with limited knowledge, exposure, and insight into potential
- L + D outcomes and experiences
- Challenges related to self-advocacy, adaptability
- Perception of accessible support

Birth Trauma

- Listen to patient language used to describe post L + D
  - "Scary, violent, confusing"
  - "Not what I expected"
- Dissociative – not interacting with baby, affect flat
- Advocacy and decision-making – no longer engaging, "do whatever"
- Avoiding language "you're all safe that is what matters"
- Recognize change of birth plan
- Communication with family and boundary setting e.g. how to communicate about birth experience, L + D course, challenging beliefs about "failed" delivery, anatomical explanations of arrest of descent
- Validation and avoidance of minimization of experience

Provider Role

- Opportunities to answer questions, review with patients
- Facilitate continued care across disciplines
- Avoidance worsens the birth trauma

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