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FROM THE FIELD

Trauma-Informed Care for Obstetric and Gynecologic Settings

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Abstract

Purpose Trauma is common among those seeking Ob-Gyn care and may have pervasive impact on obstetrical and gynecological health, social functioning, and healthcare engagement. While guidelines exist on the detection and treatment of perinatal mood and anxiety disorders within Ob-Gyn care, the role of Ob-gyn clinicians in identifying and addressing patients' traumatic experiences and related symptoms is less clearly delineated. This manuscript provides an overview of trauma-related symptoms in the context of Ob-Gyn care and practical guidance of clinicians aiming to improve their detection and response to trauma in their clinical practice.

Description Posttraumatic stress disorder (PTSD) describes a psychiatric illness which develops as a response to a traumatic event. Women who have experienced trauma are also at increased risk for borderline personality disorder and other psychiatric comorbidities. Postpartum PTSD has particular relevance to obstetrical care.

Assessment Screening for trauma in Ob-Gyn care can provide an opportunity to address risk and offer targeted intervention. Several brief evidence-based screening tools are available. Individuals who screen positive require assessment of immediate safety and targeted referrals. Trauma informed care describes an approach to healthcare aimed to enhance physical and emotional safety for patients and clinicians.

Conclusion Given the prevalence and the potentially devastating and enduring impact of trauma and trauma-related symptoms, there is a critical need to address trauma within Ob-Gyn care. By recognizing the signs of trauma and initiating or referring to appropriate treatments, Ob-Gyn clinicians have a unique opportunity to better understand their patients and to improve their care.

Keywords PTSD · Screening · Trauma · Trauma informed care

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Significance

Trauma is common and has pervasive effects on health, engagement in health care, and social functioning. Trauma and PTSD symptoms are largely under-reported in Ob-Gyn settings. While guidelines exist on the detection and treatment of perinatal mood and anxiety disorders within Ob-Gyn care, the role of Ob-gyn clinicians in identifying and addressing patient's traumatic experiences and symptoms is less clearly delineated. This manuscript provides a summary of the relevance of trauma-related symptoms in the context of Ob-Gyn care, an overview of trauma-informed care, as well as practical guidance for implementing screening and response protocols in Ob/Gyn practices.

Introduction

Trauma is defined as an event, series of events, or set of circumstances that are experienced by an individual as physically or emotionally harmful or threatening, and that have lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being (Abuse, 2014). Trauma comes in many forms, from circumscribed events (e.g., a natural disaster) to prolonged experiences (e.g., childhood maltreatment). While the American College of Obstetrics and Gynecology (ACOG) recommends screening for depression and anxiety using a validated tool at least once in the perinatal period, the role of Ob-Gyn clinicians in identifying and addressing patients' traumatic experiences and related symptoms is less clearly delineated, and most Ob-Gyn residents report feeling unprepared to screen for and address trauma in their practice ("ACOG Committee Opinion No. 757," 2018; Kendig et al., 2017; LaPlante et al., 2016). Recognizing and responding to trauma including adverse childhood experiences (ACEs) and intimate partner violence (IPV), is a critical component of care as it can impact one's health, social functioning, and ability to engage in healthy behaviors (Sperlich et al., 2017).

Among perinatal individuals, trauma exposure is associated with mood and anxiety disorders, low birth weight, preterm delivery, poor maternal infant bonding, reduced or early cessation of breastfeeding, and dysregulation in fetal and infant neurobiological systems (Meltzer-Brody et al., 2013; Smith et al., 2016). Individuals who have experienced a high number of ACEs are more likely to experience adolescent pregnancy, suicidal thoughts and substance use during pregnancy, and fetal death (Hillis et al., 2004; Jasthi et al., 2021). Finally, IPV is the leading cause of injury-related maternal death during pregnancy and is associated with increased risk of low birth weight, preterm delivery, placental abruption, and fetal death (Chisolm & Payne, 2016; Pastor-Moreno et al., 2020).

Trauma also plays a prominent role in gynecologic care. Patients who have experienced trauma are more likely to experience chronic pelvic pain or sexual dysfunction (Basson & Gilks, 2018; Meltzer-Brody & Leserman, 2011). Additionally, adult survivors of childhood sexual abuse are more likely to engage in high-risk sexual behaviors, contract a sexually transmitted infection and present with non-specific vaginitis (Obstetricians & Gynecologists, 2011). Individuals with a higher trauma load are less likely to have regular cervical cancer screening or engage in other routine Ob-Gyn care (Meltzer-Brody & Leserman, 2011; Obstetricians & Gynecologists, 2011).

Patients who have experienced traumatic events are vulnerable to re-traumatization during health care encounters. Trauma survivors may experience distress during what are routine medical procedures or by the power imbalance inherent in the patient-clinician relationship. The patient's expression of trauma symptomatology may lead to a breakdown in the care relationship or present a barrier to care altogether. The nature of Ob-Gyn care, which may include repeated pelvic exams and restriction of movement by fetal monitoring equipment, may be especially distressing for trauma survivors. Clinician-patient communication problems, such as a patient feeling that her preferences or needs are disregarded, can prompt feelings of helplessness and re-traumatization even during routine clinical care (Reed et al., 2017). This manuscript provides a summary of trauma-specific and -related symptoms in the context of Ob-Gyn care, an overview of trauma-informed care (TIC) as it relates to Ob-Gyn settings, as well as practical guidance for clinicians who aim to implement screening and response protocols in their clinical practice.

Description

Diagnoses Related to Trauma

Posttraumatic stress disorder (PTSD) is a psychiatric illness characterized by symptoms across multiple domains that persist more than 1 month after exposure to one or more traumatic events (American Psychiatric Association, 2013). The clinical symptoms of PTSD vary and can be categorized into intrusive symptoms, avoidance, and negative changes in thought or mood. Depressive, anxiety, and substance use disorders are highly comorbid with PTSD. When screening for these disorders within Ob-Gyn care, it is important to consider underlying trauma or trauma-related symptoms among screen-positive patients (Kendig et al., 2017).

While approximately half of women will be exposed to at least one traumatic event in their lifetime, a minority will develop PTSD (Gopalan et al., 2022). After a traumatic event, most will endorse transient PTSD symtpoms which will resolve quickly and without specific treatment. Risk factors for the progression to PTSD include a history of childhood abuse, exposure to interpersonal violence (IPV) or sexual assault, exposure to three or more traumatic events, and having a premorbid psychiatric diagnosis (Gopalan et al., 2022). Being female is also a risk factor. Women are twice as likely to meet criteria for PTSD than men across their lifetime (12% of women vs. 6% or men) (Kessler, 1995).

While borderline personality disorder does not include trauma as a diagnostic criteria, this diagnosis has a strong association with developmental trauma and has a high degree of co-morbidity with PTSD (Golier et al., 2003). Both PTSD and borderline personality disorder include specific symptoms which may overlap with, and thus be confused with symptoms of Bipolar Disorder, such as intense mood states, difficulty regulating anger, impulsive behaviors, and relationship dysfunction (American Psychiatric Association, 2013). Thus, patients who present with trauma-related symptoms will benefit from a referral to a psychiatric clinician who can thoroughly and contextually evaluate the patient's course of illness and provide diagnostic clarification.

Postpartum Posttraumatic Stress Disorder

Postpartum posttraumatic stress disorder (PP-PTSD) refers to PTSD which develops from the childbirth experience. It is important to note that childbirth may be experienced as traumatic by a patient, regardless of whether the birth was physically traumatic or obstetrically complex. The US prevalence of PP-PTSD is approximately 4–6%, and the strongest risk factor is a personal history of PTSD. Other risk factors include low social support, poor coping, perception of low support during labor, threatened death, actual or threatened injury to the baby, and dissociation during childbirth (Hollander et al., 2017; Seng, 2015). In clinical practice, PP-PTSD may present as difficulty with pelvic exams or fear of childbirth in future pregnancies. An individual with PP-PTSD may also report nightmares or flashbacks of the birth, emotional numbing in the relationship with the infant, avoiding reminders of the birth (e.g., the hospital), or avoiding the baby altogether. Ob-Gyn professionals can mitigate the risk of PP-PTSD by recognizing a patient who may be at risk, providing clear communication during situations that require intervention, and incorporating principles of trauma-informed care as described below. In a recent survey of women who reported a traumatic childbirth experience, most identified that their caregiver could have done something differently to prevent the traumatic experience, including listening more to their concerns, better communicating about what was happening and explaining why decisions were made (Hollander et al., 2017). The Council of Patient Safety in Women's Healthcare offers a helpful "Support after a Severe Maternal Event" bundle with helpful tools [Table 4] (Council on Patient Safety in Women's Health Care, 2015).

Assessment

Screening and Identification

Screening for trauma as part of routine Ob-Gyn care can provide an opportunity to proactively address risk, offer targeted interventions, cultivate a trusting clinician-patient relationship, and improve long-term outcomes. Despite the importance of trauma to overall health, traumatic experiences and PTSD symptoms are largely under-recognized in Ob-Gyn settings (Smith et al., 2004). Patients are often reluctant to reveal trauma due to feelings of helplessness, potential retaliation of a partner, and fear of child protective services involvement. For Ob-Gyn clinicians, insufficient training, lack of time, or a perceived dearth of resources for those who screen positive all pose deterrents to inquiring about trauma (Byatt et al., 2012). Universal screening for traumatic events and PTSD symptoms within Ob-Gyn care can be a feasible and acceptable approach to increase detection of trauma when appropriate referral resources are in place (Flanagan et al., 2018; Smith et al., 2004). Several brief screening tools are available to assess for specific types of traumatic experiences, such as the Adverse Childhood Events Scale (ACES), the Primary Care PTSD Screen (PC-PTSD-5), and the Woman Abuse Screening Tool (WAST). Implementing screening for trauma within Ob-Gyn settings can also strengthen the patient-clinician relationship, reduce stigma, and increase insight into patient behaviors that may otherwise be interpreted as "difficult" such as hostility or distrust. ACOG and other relevant professional society recommendations are described in (Table 1) along with corresponding evidence-based screening tools.

Routine screening increases detection, yet itself does not lead to symptom improvement. Thus, screening for traumatic experiences and PTSD symptoms should be a critical first step followed by further evaluation. As disclosing traumatic experiences and PTSD symptoms often requires considerable courage, it is important to acknowledge the patient's strengths at disclosure, to express hope, and to communicate knowledge of available resources for safety and for treatment. Further recommended implementation

Table 1 Screening Guidelines and Tools for Traumatic Experiences and Symptoms

Trauma Domain	Existing professional society recommendations about screening	Evidence-based screening tools
Childhood Traumatic Experiences	ACOG CO #498 acknowledges the pervasive and complex long-term effects of childhood sexual abuse and recommends Ob-Gyns screen all patients for such experiences.	**Adverse Childhood Experiences (ACEs) Questionnaire**: 10 item self-report scale, extensive literature shows association between higher ACEs and poor mental and physical health outcomes
PTSD	ACOG CO #547 recommends that Ob-Gyns screen for PTSD, especially in veterans, and offer appropriate referrals to screen-positive patients.	**Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)** 5 item screen designed for use in primary care
Interpersonal Violence	ACOG CO #518 recommends Ob-Gyns screen universally for IPV at first prenatal visit, at least once per trimester and at the postpartum visit. ACOG CO #777 recommends Ob-Gyns screen all patients for a history of sexual assault and incorporate a trauma informed care framework.	**Humiliation, Afraid, Rape, Kick (HARK)**: 4 questions that assess emotional and physical IPV in the past one year **Hurt/Insult/Threaten/Scream (HITS)**: 4 items that assess the frequency of IPV **Woman Abuse Screening Tool (WAST)**: 8 items that assess physical and emotional IPV

Table 2 Screening Implementation Strategies

Strategies for successful implementation of trauma screening into Ob-Gyn practice
1. Provide education to Ob-Gyn professionals around the importance of trauma on health outcomes prior to implementation of screening protocols.
2. Coach all members of the team on how to sensitively respond to screening results. Role-play conversations in responding to patients disclosing trauma to build skills and comfort.
3. Pair screening measures with specific visit intervals or with perinatal depression or other screening protocols.
4. Consider the logistics: when and how the screening will be administered, who will be responsible for providing and responding to screening and which resources are available for patients who disclose trauma?
5. Screening measures must be appropriate for the literacy level of the clinic's patient population.
6. Protect privacy by offering the patient a private space in which to complete the screening tool or provide a cover sheet for paper screeners.
7. Follow-up positive screens with an evaluation to assess safety, determine need for referral to other services or evaluations, and learn a patient's treatment preferences.
8. Cultivate referral relationships with trauma-focused community clinicians.
9. For patients struggling with psychiatric conditions including substance use disorders, immediate referral with a warm handoff to an onsite mental health professional is ideal.

strategies for screening within an Ob-Gyn setting are detailed in (Table 2).

Individuals who screen positive or otherwise disclose trauma to their Ob-Gyn clinician warrant a safety evaluation with attention to immediate risk as well as an assessment of suicidal or homicidal thoughts. When relevant, the assessment must be inclusive of safety of the children of the individual who has disclosed the trauma. Healthcare professionals are mandated reporters of suspected child abuse and neglect and should be familiar with reporting laws in their own states. If a report to a child welfare agency is indicated, principles of trauma-informed care guide clinicians to inform the patient of the report directly and compassionately. It may be useful to highlight the role of child protective services in providing resources and support.

While universal screening and evaluation of patients for traumatic experiences has numerous advantages, the successful implementation of screening protocols within larger practice settings requires substantial support from practice administrators, clinicians, and support staff. When this is not feasible, individual clinicians may be mindful that indicators of trauma are varied and include unexplained somatic symptoms, sexual dysfunction, mental health disorders, high risk sexual behaviors, substance use disorders, or eating disorders. For example, individuals who frequently miss appointments, are non-adherent to treatment recommendations, or display inappropriate anger during appointments may have underlying trauma symptomatology.

Trauma Informed Care in the Ob-Gyn Setting

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), trauma-informed care (TIC) includes: (1) realization of the widespread impact of trauma and understanding of potential paths for recovery; (2) recognition of signs and symptoms of trauma; (3) response that integrates knowledge about trauma into policies, procedures, and practices; and (4) prevention of re-traumatization (Abuse, 2014). TIC shifts the question from "What is wrong with you?" to "What happened to you?" A trauma-informed approach does not assume universal trauma; it anticipates this possibility and cultivates treatment framework aimed to identify trauma symptoms and enhance physical and emotional safety for both patients and clinicians. Emerging

Table 3 National Center for Trauma-Informed Care Core Principles of TIC in Ob-Gyn Practice

NCTIC Core Principles	Example within an Ob-Gyn practice
Safety	• Materials displaying trauma-specific resources are visible to patient • Patient seating always faces the door in the exam room
Trustworthiness and transparency	• Clinician explains every step of exam and obtains permission before touching patient • Healthcare team members clearly state their title and role on the team.
Peer support	• Collaboration with a peer support group appropriate for the individual patient's needs (i.e. group for women struggling with perinatal depression or pelvic pain, parenting support group)
Collaboration and mutuality	• Care planning is completed with patient and incorporates her preferences • A patient is provided with screening results and given a choice among available referral options
Empowerment, voice and choice	• Clinician asks patient for permission to begin exam • Patient is proactively informed that she is in charge and is encouraged to let clinician know immediately if she becomes uncomfortable
Cultural, historical and gender identity	• Clinician uses professional language interpreters • Clinician asks patient about preferred pronouns • Cultural differences in childbirth traditions are respected

evidence suggests that trauma informed care may not only increase safety and engagement in care among patients but reduce burnout and compassion fatigue among clinicians (Kuehn, 2020; Marsac et al., 2016).

Ob-Gyn care is often experienced as invasive and can be particularly challenging for trauma survivors. Undressing, pelvic and breast exams, and feeling out of control of one's body while in pain during labor, may be especially challenging with potential to cause re-traumatization (Montgomery, 2013). Ob-Gyn clinicians have a meaningful opportunity to implement TIC that can positively impact the care of their patients. TIC can allow a survivor of trauma to begin the process of healing within the context of a safe relationship with members of the treatment team and reduce the likelihood that care is experienced as traumatic.

Implementation of TIC within Ob-Gyn care settings can be pursued using the National Center for Trauma Informed Care's (NCTIC) six principles of TIC: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment and choice, and cultural and gender identity (Sperlich et al., 2017). For example, a clinician may respond to a patient's hesitancy about a pelvic examination by listening to and validating her concerns, asking her how the exam might be done most comfortably (i.e. the patient can insert the speculum herself) and providing transparency about which aspects of the exam cannot be modified (principles of safety, transparency, empowerment/choice). For a patient who is experiencing stalled labor and declines augmentation with oxytocin due to fears the intervention might harm her baby, the clinician may validate the patient's desire to keep the baby as safe as possible and provide her the opportunity to weigh the risks of medication vs. the risks of stalled labor well ahead of the time a Cesarean section is urgently needed (principles of safety and collaboration/mutuality). Collaboration with peer support groups for perinatal mood disorders integrates the principle of peer support. Finally, gender neutral restrooms, educational materials in multiple languages, and curiosity about and respect for cultural traditions in childbirth are important ways to incorporate cultural and gender identity into practice. (Table 3) summarizes these principles and provides further examples of implementation within Ob-Gyn care.

Treatment and Referral Considerations

While TIC principles provide a guide for a universal approach for healthcare teams, many individual patients will need and want pharmacologic treatment, psychotherapy, or other psychosocial treatments. Trauma-informed care considers that patients have different levels of treatment need and promotes collaboration with local organizations and clinicians offering trauma-specific interventions (Sperlich et al., 2017). Furthermore, the TIC principle of collaboration and mutuality guides clinicians to provide patients with information about a range of treatment options and develop a plan of care based on their preferences.

Psychotherapy

Evidence based treatments for PTSD in adults include cognitive processing therapy (CPT), eye movement desensitization and reprocessing therapy (EMDR) and prolonged exposure (PE) (NICE, 2018). Dialectical Behavioral Therapy, Metallization-Based Treatment and Transference-Focused Psychotherapy are widely regarded as evidence-based psychotherapy models for personality disorders rooted in trauma (Youngner et al., 2014). Multiple national resources exist for locating trauma-focused therapists on a local level. (Table 4) provides an expanded list of mental health and trauma resources relevant to Ob-Gyn patients.

Table 4 Resources for the Ob-Gyn Professional

Emergency Resources		
Crisis Text Line	https://www.crisistextline.org/texting-in	Text HOME to 741 741
National Suicide Prevention Lifeline	https://suicidepreventionlifeline.org	1-800-273-TALK
SAMHSA National Helpline	www.samhsa.gov/find-help/national-helpline	1-800-662-HELP
Mental Health Provider Organizations and Directories		
International Society for Traumatic Stress	https://istss.org ("find a clinician" tool)	
EMDR International Association	https://www.emdria.org (searchable database of trained therapists)	
Postpartum Support International	https://www.postpartum.net	1-800-994-4773 Text 503-894-9453
American Psychological Association	https://locator.apa.org	
Intimate Partner Violence and Sexual Assault		
National Domestic Violence Hotline	https://thehotline.org	1-800-799-SAFE
Love is Respect (for teens)	www.loveisrepsect.org	Text LOVEIS to 22522 1-866-331-9474
Rape, Abuse & Incest National Network	https://www.rainn.org	1-800-656-HOPE
Provider Toolkit		
Council of Patient Safety in Women's Health Care Support after a Severe Maternal Event Bundle	https://safehealthcareforeverywoman.org/patient-safety-bundles/support-after-a-severe-maternal-event-supported-by-aim	

Pharmacotherapy

Serotonergic antidepressant medications (SSRIs and SNRIs) are an evidence-based treatment for PTSD and are indicated for patients with moderate to severe symptoms, when patients decline or do not fully respond to psychotherapy, or for those who cannot access psychotherapy for geographic, financial, or other reasons. Comorbid depression or anxiety may present additional indications for treatment with an antidepressant. While sertraline and paroxetine are the only selective serotonin reuptake inhibitors (SSRIs) with a US Food and Drug Administration (FDA) indication for PTSD, most guidelines support the use of any SSRI or the serotonin-norepinephrine reuptake inhibitor (SNRI) venlafaxine as an initial treatment consideration. Adjunctive medications such as a second generation antipsychotic or prazosin (an alpha-blocker) can be used to target specific symptoms such as nightmares, anger, or impulsivity. Benzodiazepine medications should be avoided due to associated risks such as potential for tolerance or dependence, sedation, increased risk of fall in elderly patients and their potential to interfere with engagement in other long-term treatment strategies (Youngner et al., 2014).

Parent-infant dyad-focused Interventions

Parents who have experienced trauma may face challenges in becoming a caretaker. For example, they may struggle with emotional engagement and bonding, consistency in parenting, and managing emotions and their children's emotions (Seng, 2015). While most parents with histories of abuse do not go on to abuse their own children, as a group they do have increased risk for perpetrating abuse or neglect (Van Ijzendoorn, 1992). A trauma-informed Ob-Gyn clinician proactively recommends trauma-informed parenting interventions as a component of obstetrical care. A dyadic focus can begin even in the antepartum period. For example, a therapist can focus on a pregnant individual's own developmental experiences, as well as emerging ideas about the fetus. While the availability of such interventions will vary considerably throughout different geographic regions, many evidence-based programs around the country integrate dyadic treatment into broader home visiting programs, provide group-based parenting education and therapeutic interventions, and offer intensive interventions designed for individual high-risk mother-infant dyads (Seng, 2015; Sperlich et al., 2017).

Intimate Partner Violence

When intimate partner violence (IPV) is disclosed during a patient visit, it is important to acknowledge the courageousness of the disclosure and maintain collaboration while discussing quick access to available resources. An immediate safety evaluation is warranted. Factors that indicate higher risk for IPV homicide include abuse during pregnancy, use of weapons, threat to life, strangulation, and access to a firearm (Matias et al., 2020). Each obstetric practice should develop an easily accessed protocol for IPV safety planning, including a resource list (e.g., crisis text-line or hotline, rape crisis services, shelters, and legal aid). Printed take-home information with emergency numbers can be coupled with educational posters about IPV in private spaces such as bathrooms to reach patients who are not able to disclose the abuse. Providing a safe space for a patient to call a specific resource can be an important intervention.

TIC principles of collaboration and mutuality are important for Ob-Gyn professionals to know when patients disclose IPV, and in response to their choices regarding referral options. Clinicians should avoid trying to force a patient to leave a relationship or "sneaking" information into belongings as a partner may discover the material and respond with violence. Most states do not mandate IPV reporting outside of the context of child abuse, elder abuse, or abuse of a vulnerable adult (e.g., individuals with disabilities). Accurate documentation in the medical record of clinical interactions and/or physical signs can be important legal evidence in the future. National resources for addressing intimate partner violence can be found in (Table 4).

Conclusion

Given the prevalence and the potentially devastating and enduring impact of trauma and trauma-related symptoms, there is a critical need to address trauma within Ob-Gyn care. By recognizing the signs of trauma and initiating or referring to appropriate treatments, Ob-Gyn clinicians have a unique opportunity to better understand their patients and to improve their care. When healthcare professionals recognize the impact of trauma, respond with compassion, and respect, and then provide trauma informed care, they have the power to have a transgenerational impact and improve the health of individuals and their children for decades to come.

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Data Availability n/a.

Code Availability n/a.

Declarations

Conflict of Interest The authors Drs. Sarah Nagle-Yang, Jyoti Sachdeva, Lulu Zhao, Neeta Shenai, Nicole Shirvani, Linda Worley, Priya Gopalan, Elizabeth Albertini and Meredith Spada have no conflicts of interest. Dr. Leena Mittal served as a consultant for Sage Therapeutics in February 2019. Dr. Moore Simas is the Medical Director of Lifeline for Moms. She is the co-chair of the ACOG Maternal Mental Health Expert Work Group. Dr. Nancy Byatt is also the statewide Medical Director of MCPAP for Moms and the Executive Director of Lifeline for Families. She has served on the Medscape Steering Committee on Clinical Advances in Postpartum Depression. She has received honoraria from Global Learning Collaborative, Medscape, Miller Medical Communications and Mathematica. She has served on Advisory Boards for Sage Therapeutics. She has also served as a consultant for The Kinetix Group.

Ethical Statement This manuscript includes a short analysis of a topic relevant to Ob-Gyn care. As it does not entail human subject research, include original data or protected health information, Institutional Review Board approval was not obtained.

Ethics Approval n/a.

Consent to Participate n/a.

Consent for Publication n/a.

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