Providing trauma-informed care to perinatal patients

Learning objectives

- Describe ways trauma can impact patient function

- Describe strategies for integrating trauma-informed care into CoCM assessment and intervention

What is trauma?

Exposure to an incident or series of events that are emotionally disturbing or life-threatening with lasting adverse effects on an individual's functioning and mental, physical, social, emotional and/or spiritual well-being.

Trauma is an *experience*

Experiences that may be traumatic

- Physical, sexual and emotional abuse
- Childhood neglect
- Sudden, unexplained separation from a loved one
- Poverty
- Racism, discrimination and oppression
- Violence in the community, war or terrorism
- Living with a family member with mental health or substance use disorders
- Life threatening situations

Types of trauma

|	
Acute Trauma	A single traumatic event that is limited in time
Chronic Trauma	The experience of multiple traumatic events
System-induced Trauma	Traumatic removal from home, admission to a detention or residential facility or multiple placements within a short term
Complex Trauma	Both exposure to chronic trauma and the impact that this exposure has on a person
Environmental Trauma	Poverty in childhood, social inequality, early exposure to urban environments, migration and belonging to an ethnic minority

Adverse childhood experiences (ACEs)[1]
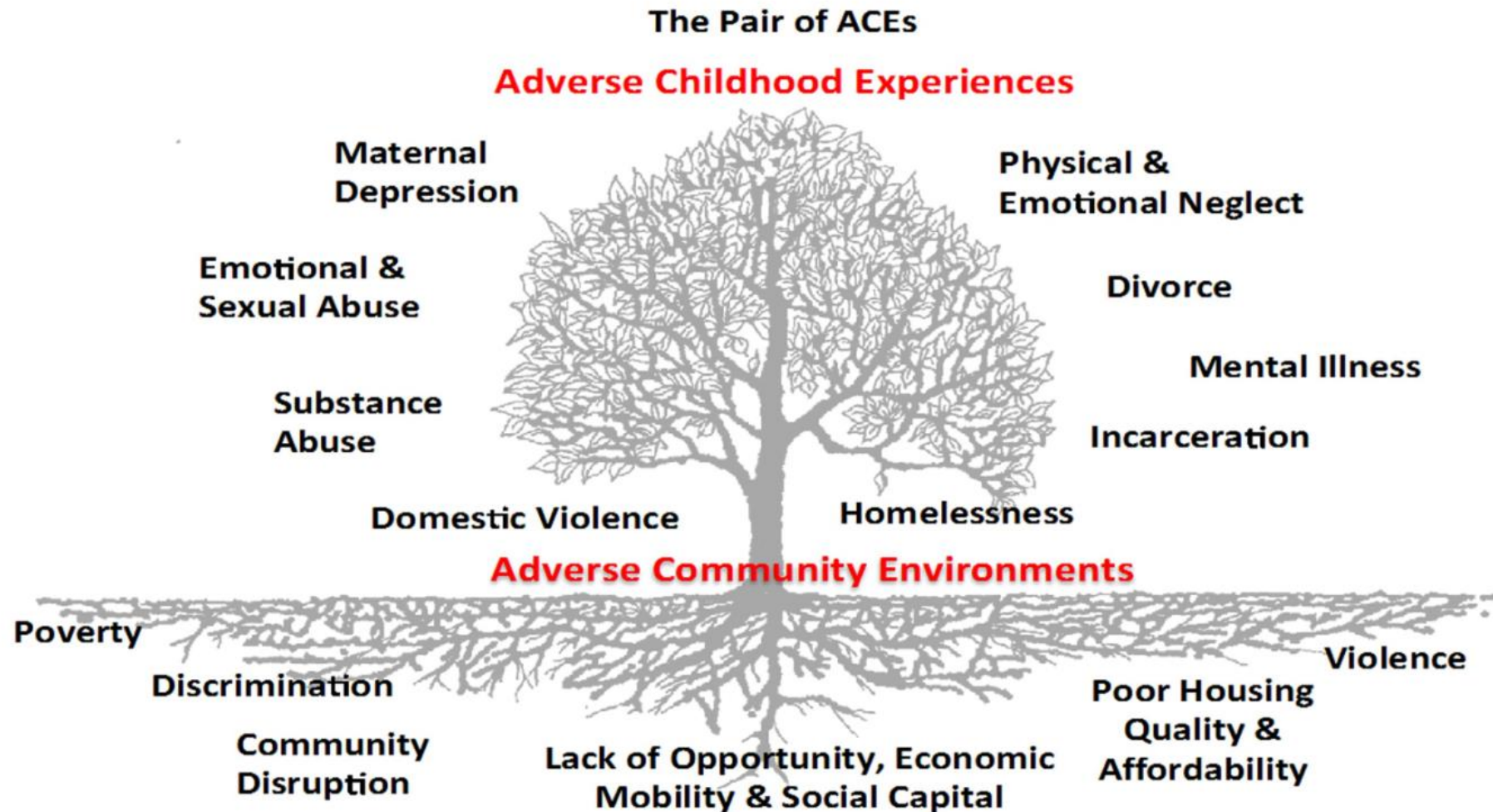
How are ACEs relevant in perinatal care?

- Common

- Change world view

- Impact physical and mental health long-term

- Inadvertently cyclic

Prevalence of trauma in women

Generally

- 1 in 4 girls experience sexual abuse in childhood[2]
- 1 in 4 women have experienced completed or attempted rape in their lifetimes[3]
- 1 in 2 women experience sexual violence in their lifetime[3]
- 1/4 women experience intimate partner violence[4]

Among pregnant and parenting women

- Some studies have shown up to 45% of women report negative birthing experiences, some meeting criteria for PTSD[5]
- 4–8% of women experience intimate partner violence during pregnancy[6]
- 5% of perinatal women meet criteria for PTSD diagnosis[7]

Case study: Lina

Lina is a 19-year-old African American woman. Her mother died when she was 8 years old, and she went to live with her actively alcoholic grandmother. Lina has always felt education was important and she does well in school, but she struggles with depression and low self esteem. Her grandmother often tells her that she's "no better than the rest of them," and she'll be pregnant by 18 no matter how well she does. Her boyfriend of 2 years is her biggest cheerleader, but he also has a history of hitting her when he gets angry. Three weeks after she turns 19 years old, she learns she is 9 weeks pregnant.
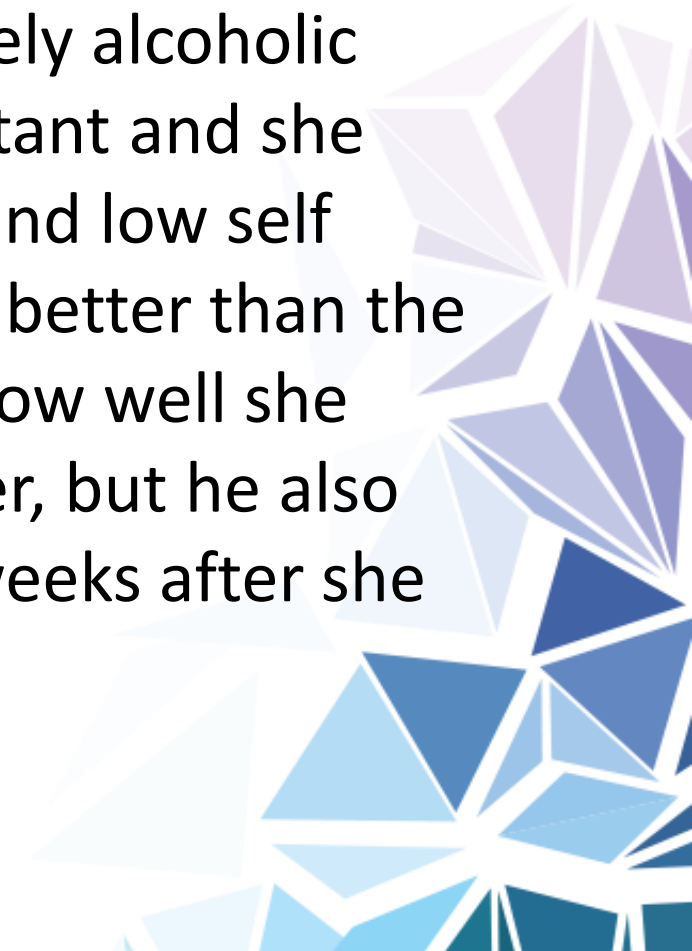
The functional impact of trauma

- Behaviors are not always what they seem

- A protective brain creates protective actions

Impact on relationships

Impact on behavior

Impact on information processing
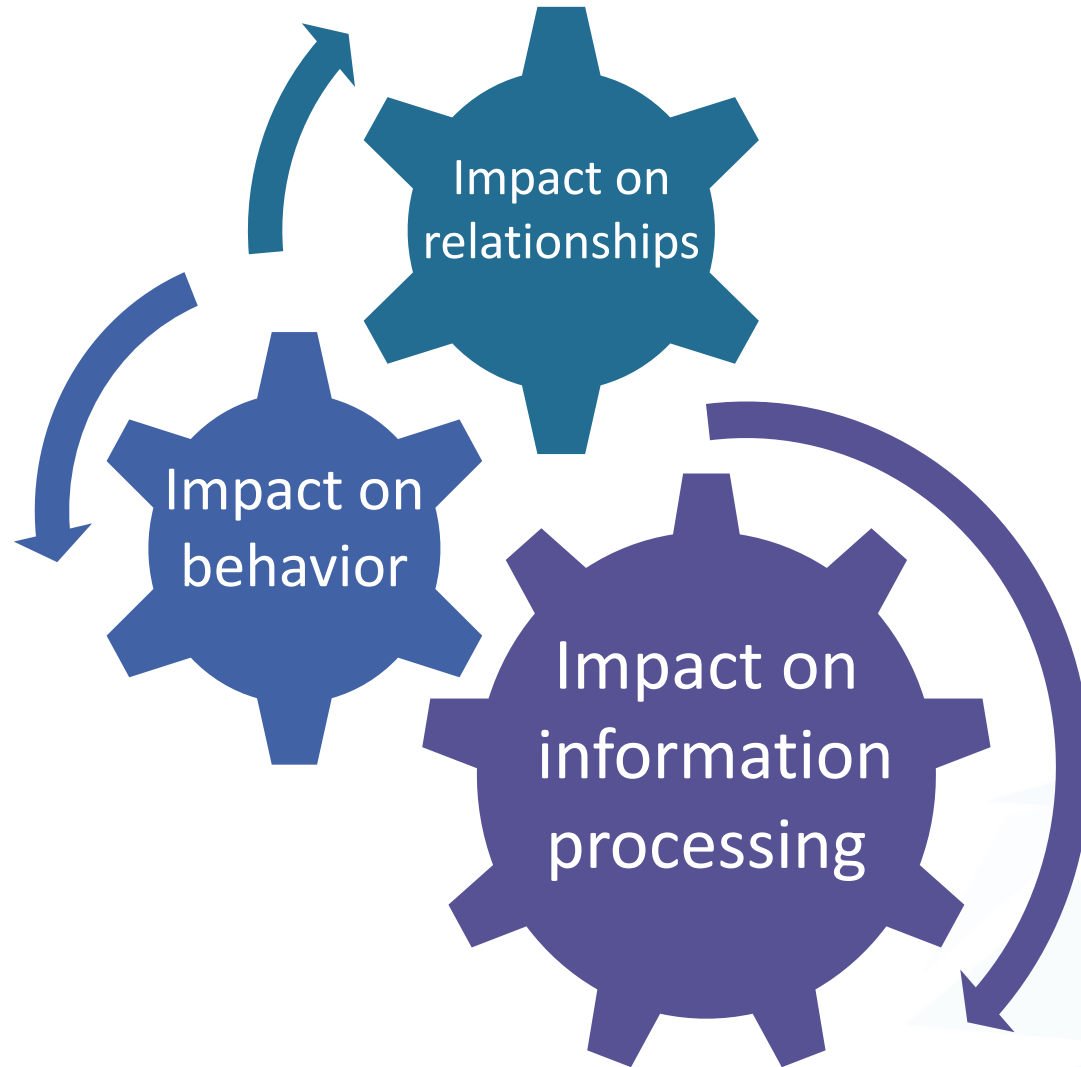
Functional impact: information processing

- Memory can be impacted

- Inability to organize information

- Difficulty focusing

- Reduced ability to utilize and understand language

- Frequently assessing their environment

Functional impact: behavior

Easily startled	• Lashes out when touched • Reaction is "bigger" than would be expected
Distracted by or reactive to triggers	• Hypervigilance can look like distractibility or inattention • Reactions can appear to "come out of the blue"
Sleeping poorly	• Lack of sleep exacerbates preexisting conditions • Can mimic depression
Seeking safety or control	• Mimics anxiety and OCD
High risk behaviors	• Substance use • Self-injury • Increase in indiscriminate behaviors

Revisiting Lina with a focus on behavior

Lina described her grandmother as "a little drunk most of the time" and said if her grandmother drank more than usual, she became abusive and unpredictable, often getting in the car and "leaving them." Lina was careful to "clean up" when she came home from school, always counting bottles as she did. She would help her younger siblings with their homework, make dinner if needed and ask her grandmother to let her practice driving whenever her grandmother wanted to go somewhere. Lina rarely slept until her grandmother fell asleep on the couch, and she woke up feeling panicked anytime she heard a door open.

Functional impact: relationships

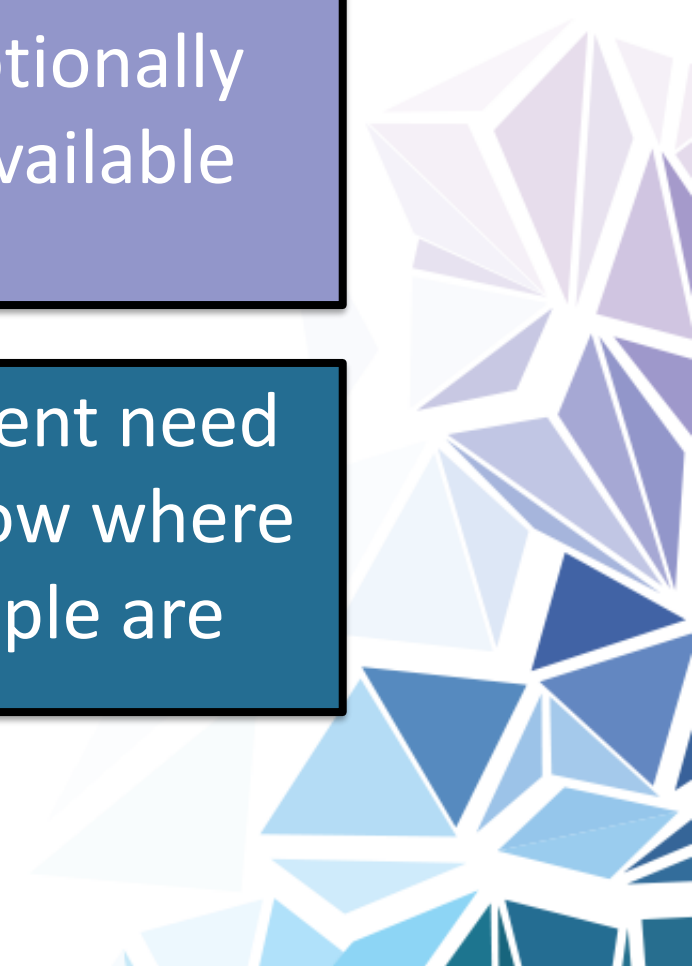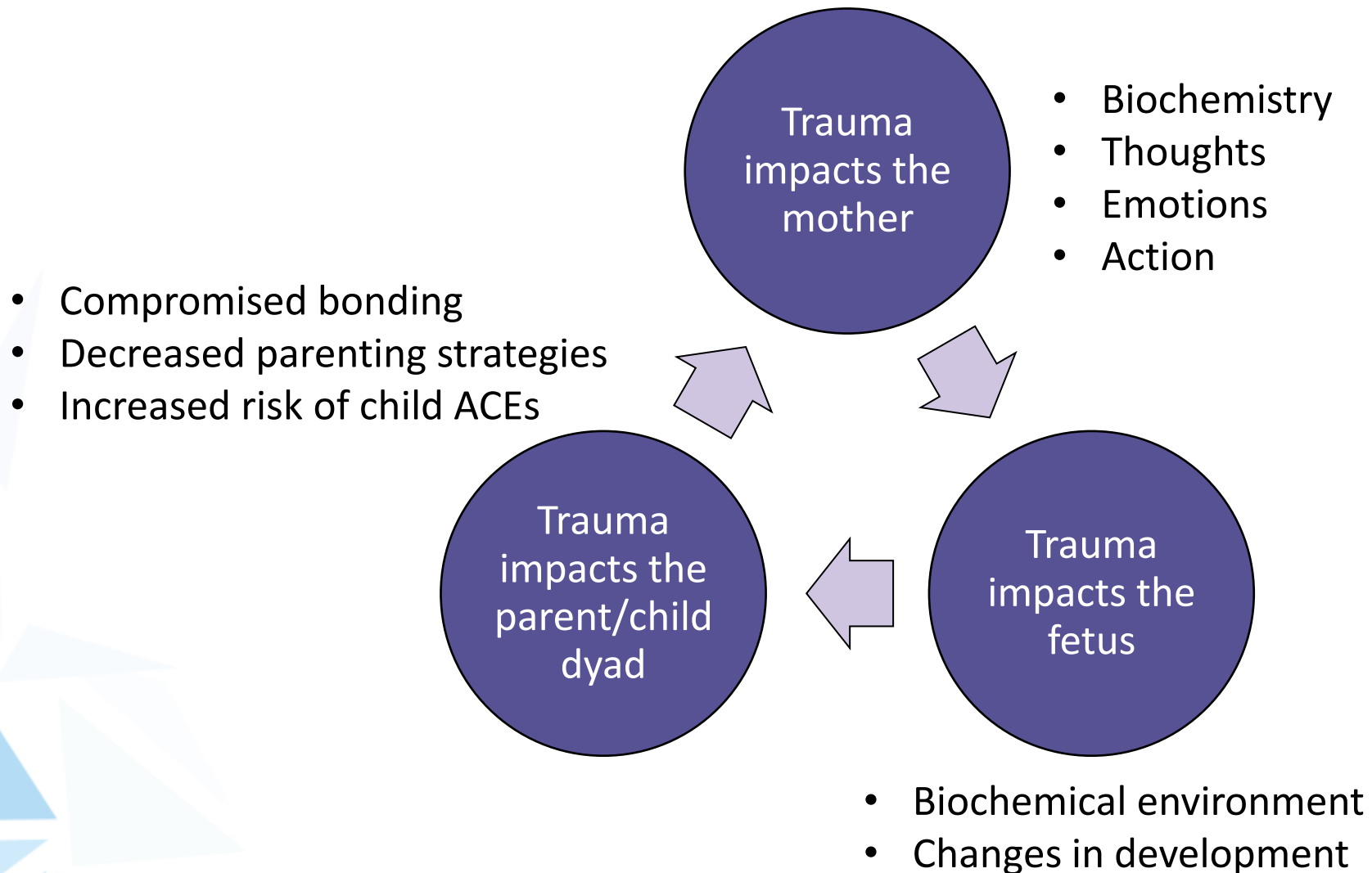|		
Withdrawn	More irritable	Emotionally unavailable
Unable to empathize	Frustratingly clingy	Insistent need to know where people are

Implications for the perinatal population

Trauma impacts the mother

- Biochemistry
- Thoughts
- Emotions
- Action

Trauma impacts the fetus

- Biochemical environment
- Changes in development

Trauma impacts the parent/child dyad

- Compromised bonding
- Decreased parenting strategies
- Increased risk of child ACEs

# The impact of trauma on the parent/child dyad[8]
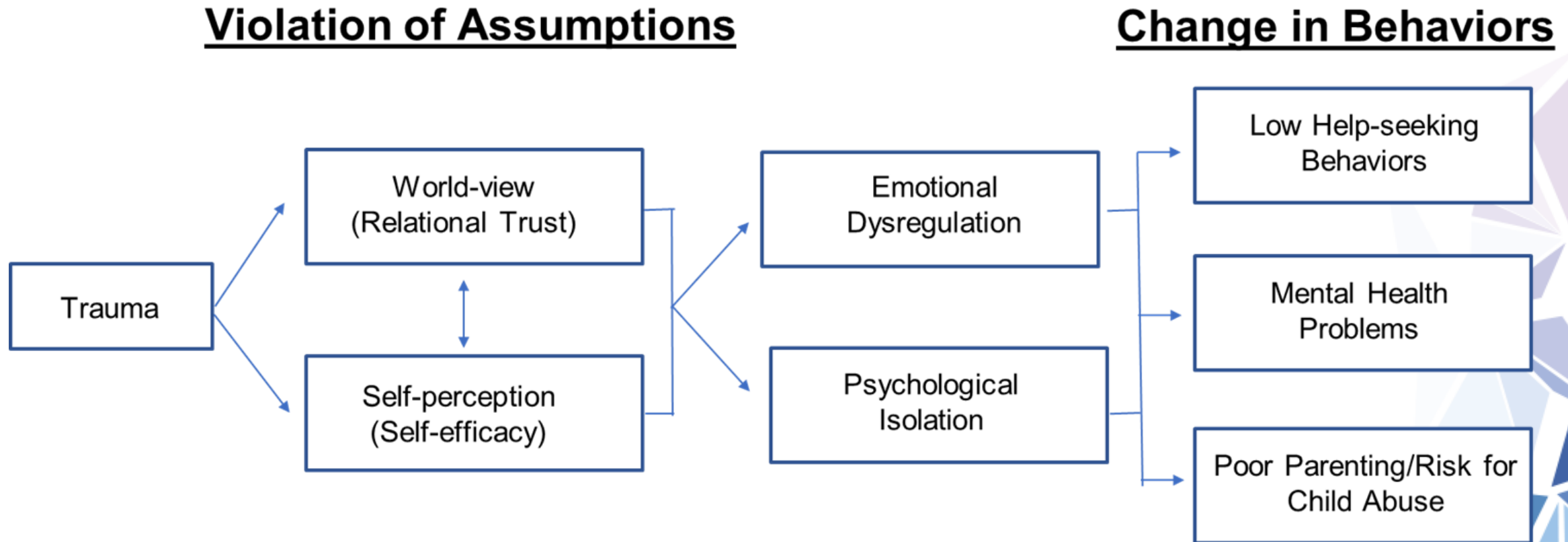
Trauma-informed care (TIC)[9]

Trauma-informed care is a "**strengths-based** approach grounded in an understanding of, and responsiveness to, the **impact of trauma**; that emphasizes physical, psychological, and emotional **safety** for both providers and survivors; that creates **opportunities** for survivors to rebuild a **sense of control and empowerment**."

The necessity of trauma-informed care for perinatal patients

- The experience of trauma is prevalent among women

- TIC is an opportunity to break the cycle and stop the negative effects for our patients and their children

- The American College of Obstetricians and Gynecologists (ACOG) committee opinion states that all providers of OBGYN care should adopt a trauma-informed approach[10]
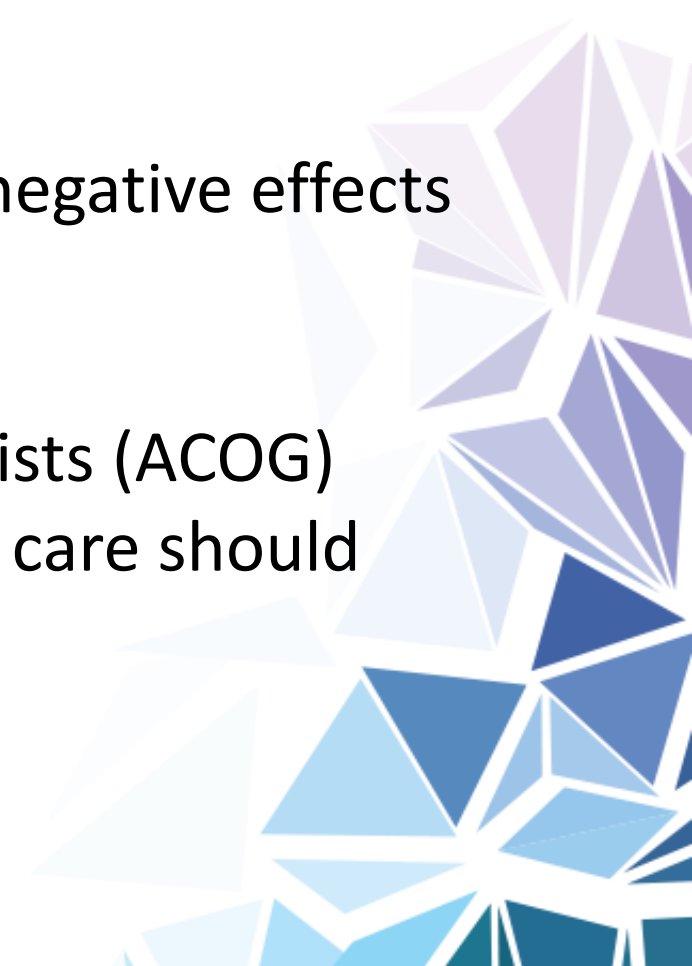
Incorporating trauma-informed care into CoCM perinatal practice
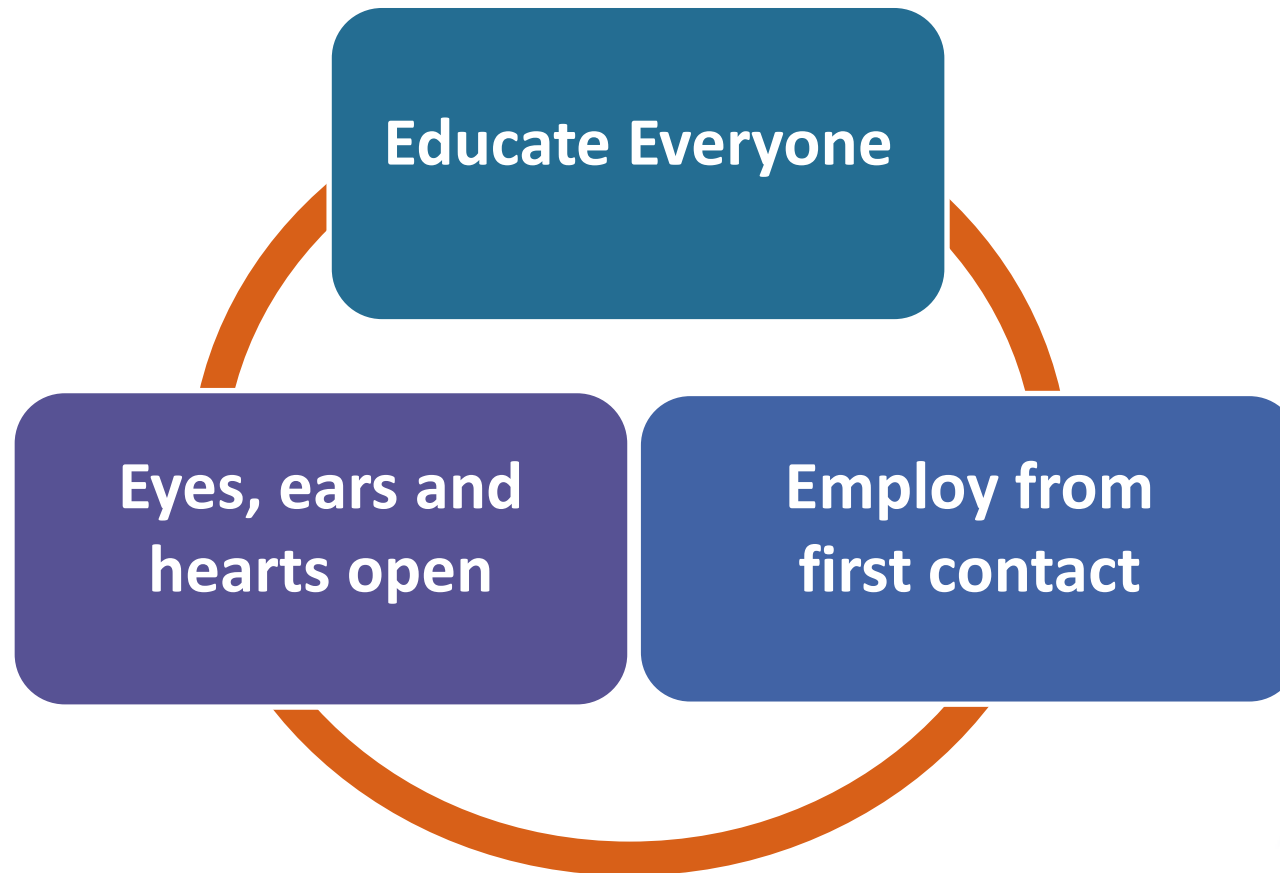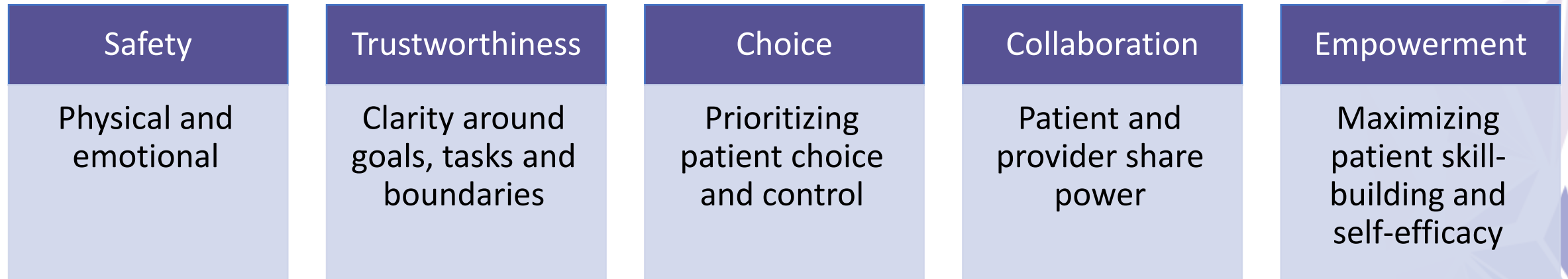
Perinatal TIC the patient experience

Environment

- Patient spaces
- Forms
- Staff presentation

Interactions

- Make trauma screening routine
- Focus on building a relationship
- Communicate well and often
- Be consistent and reliable
- Check-in regularly regarding preferences and comfort

Principles of trauma informed care

Safety	Trustworthiness	Choice	Collaboration	Empowerment
Physical and emotional	Clarity around goals, tasks and boundaries	Prioritizing patient choice and control	Patient and provider share power	Maximizing patient skill-building and self-efficacy

Defining TIC strategies

TIC Principle	Defined
Safety	The experience of physical and emotional safety
Trustworthiness	Clear, consistent communication and action surrounding goals, tasks, and boundaries
Choice	Taking actions that prioritize a patient's choice and control
Collaboration	Sharing of power with the patient
Empowerment	Maximizing patient skill-building and self-efficacy

Putting TIC strategies into action

TIC Principle	Defined	Related Action
Safety	The experience of physical and emotional safety	• Waiting areas and exam space is clean, uncluttered, has clear sight lines and an opportunity for "back to wall" • Seek permission to touch patients • Ask patients if they have concerns about this visit and what can be done to help them feel safe before you begin (option to defer)
Trustworthiness	Clear, consistent communication and action surrounding goals, tasks and boundaries	• Saying what you'll do and doing what you say • Explaining communication pathways • Collaboratively defining goals and boundaries • Being consistent and responsive to a patient's needs
Choice	Prioritizing a patient's choice and control	• "Now that we've discussed the plan, where would you like to begin?" • "Which of these approaches would you like to try?"
Collaboration	Sharing of power with the patient	• Seeking patient input • Options are explained and discussed • Patients are involved and respected in their decisions
Empowerment	Maximizing patient skill-building and self-efficacy	• Encouraging skill-building and self-efficacy • Bringing attention to positive outcomes

Important reminders in TIC

- **Safety** precedes learning
- **Fear** overrides the ability to think clearly
- **Behaviors** communicate feelings
- **Environment and activities** can calm
- **Relationships** can heal
- **Non-verbal communication** is powerful
- **Teamwork** and shared responsibility are vital
- **Connections** across the system are protective

Perinatal TIC screening recommendations

When

- First contact
- Midway through pregnancy
- End of pregnancy
- 1-2 weeks postpartum
- 6-8 weeks postpartum
- Baby at 3, 6, 9, 12 months of age

By whom

- Coordinating care:
  - PCP
  - OBGYN
  - Pediatrician

- Major impact for workflow

With what

- PHQ-9
- GAD-7
- EPDS
- ACES
- PC-PTSD
- TSQ
- PPQ

Systemic bias can impact all of these

Perinatal TIC impact on assessment process

Comfort

Control

Open Space

Containment

- Physical comfort

- Offer patient control over situation and environment

- Uncluttered
- Open sight lines
- Access to exit

- Introduce and explain question sets
- Don't ask for detailed accounts
- Ask specific questions about impact
- Normalize reactions
- Highlight resilience and survival

Perinatal TIC intervention planning

Education

- Ask permission to share information with them
- Include information about options for modalities, contact frequencies and contact initiation

Co-construct the intervention plan

- "What do you need to feel safe in this process?"
- "What do you think will work best for you?"
- "What are you ready to try?"

Perinatal TIC intervention goals

Support

- Who is on their support team?
- Who can they turn to when?

Relief

- Self-care activities
- Behavioral activation
- Problem solving treatment
- Brief Trauma Interventions
- Medication

Resilience

- What worked? What is in their control?
- When something didn't work, how did they adjust?
- Normalize the process of success and set-backs

Perinatal TIC when and how to refer

- Referring out
  - CoCM and community-based care are not mutually exclusive
  - Allow patient to have control over as many factors as possible
  - Have a well-curated resource base for relevant, accessible care

- Supporting the referral process
  - BHCM or another embedded MH provider in the practice
  - Finding a trauma-trained provider
  - Connecting with that provider

Trauma informed care takeaways

- Traumatic experiences are **common**

- Trauma **impacts long-term health** of mom and baby

- Trauma history **does not exclude** patients from CoCM

- Trauma informed care is **imperative**

Resources

- [Trauma-Informed Care in Behavioral Health Services](#)

- [MC3 Approach to Trauma](#)

- [Trauma Survivors Network Questions for the Patient to ask Himself or Herself](#)

References (1 of 3)

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10. American College of Obstetricians and Gynecologists. (2021, April). Caring for patients who have experienced trauma. Committee on Health Care for Underserved Women. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/04/caring-for-patients-who-have-experienced-trauma#:~:text=Obstetrician%E2%80%93gynecologists%20should%20become%20familiar,avoiding%20stigmatization%20and%20prioritizing%20resilience.

Additional support from PRISM

Advanced training

- https://micmt-cares.org/upcoming-trainings
  - Implementing Collaborative Care with Perinatal Patients
  - Implementing Collaborative Care with Adolescent and Pediatric Patients
  - Treating Substance Use in Collaborative Care Settings

Upcoming webinars

- https://micmt-cares.org/events?type%5B4639%5D=4639

BHCM monthly discussion group

- 3rd Thursday of the month from 12:00pm–1:00pm ET

Ongoing implementation support

- Discuss scheduling with your Implementation Specialist

CE reminders

- **Following the course completion**, you will receive an e-mail from the Michigan Institute for Care Management and Transformation

- Please allow up to 24 hours to receive the e-mail. If you do not receive within 24 hours, please submit an inquiry via the [MICMT contact form](#).

- Please follow the link to complete the evaluation within (5) business days for each session you attend to earn credit.
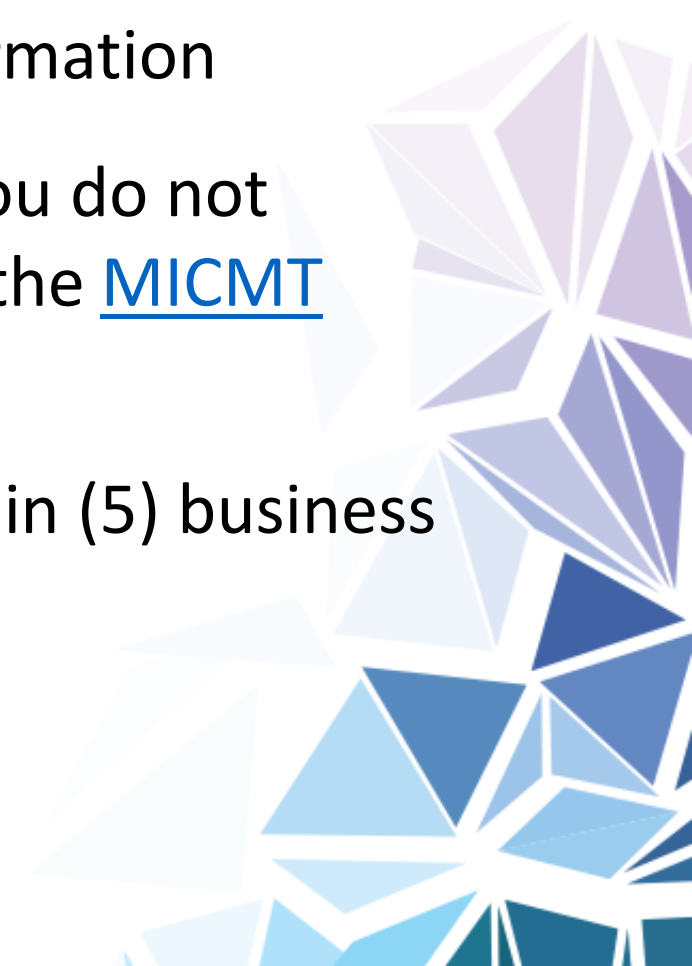
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