2021-04-08

Trauma-Informed Peripartum Care

Rebecca Gwaltney
University of Massachusetts Medical School

Let us know how access to this document benefits you.
Follow this and additional works at: https://escholarship.umassmed.edu/liberia_peer

Part of the Family Medicine Commons, Maternal and Child Health Commons, Medical Education Commons, Mental and Social Health Commons, Obstetrics and Gynecology Commons, Psychiatry and Psychology Commons, Trauma Commons, and the Women's Health Commons

Repository Citation

This material is brought to you by eScholarship@UMassChan. It has been accepted for inclusion in PEER Liberia Project by an authorized administrator of eScholarship@UMassChan. For more information, please contact Lisa.Palmer@umassmed.edu.
TRAUMA-INFORMED PERIPARTUM CARE

Rebecca Gwaltney, MD and Elizabeth Dykhouse, PhD
DEPARTMENT OF FAMILY MEDICINE & COMMUNITY HEALTH,
UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL

Content adapted with permission from presentation by Jordan Howard-Young, MD
ROADMAP

1. RECOGNIZING THE SIGNS
   signs and symptoms; Epidemiology

2. ANTENATAL CARE
   Screening, and management

3. PERIPARTUM CARE
   Avoiding exacerbations and preventing birth trauma

4. POSTPARTUM CARE
   Processing trauma and breastfeeding considerations
What does trauma look like from the outside?

Being aware of signs and symptoms
### WHAT DOES TRAUMA LOOK LIKE FROM THE OUTSIDE?

<table>
<thead>
<tr>
<th>Anxious</th>
<th>Guarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tense</td>
<td>Distrustful of authority</td>
</tr>
<tr>
<td>Avoidant</td>
<td>Hypersexual</td>
</tr>
<tr>
<td>Zoned out</td>
<td>Ashamed</td>
</tr>
<tr>
<td>Sounding scripted when recounting trauma</td>
<td>Trouble sleeping</td>
</tr>
<tr>
<td>Jumpy</td>
<td>Pain intolerant</td>
</tr>
<tr>
<td>Reckless</td>
<td>Somatic symptoms</td>
</tr>
<tr>
<td>Depressed</td>
<td>Self-harm</td>
</tr>
<tr>
<td>Irritable</td>
<td>Substance use</td>
</tr>
<tr>
<td>Angry</td>
<td>Difficult cervical exams</td>
</tr>
<tr>
<td>Suspicious</td>
<td>Distress with male providers</td>
</tr>
</tbody>
</table>
EPIDEMIOLOGY OF TRAUMA

Epidemiology, screening, and management
EPIDEMIOLOGY

- **80%**: Percentage of women who have experienced trauma in their lifetime
- **8%**: Lifetime prevalence of PTSD among women in the US
- **4%**: Prevalence of postpartum PTSD among all postpartum women
- **30%**: Percentage of women who experience subclinical postpartum symptoms
"Most western studies of war-related post-traumatic stress disorders (PTSD) have been in exiled refugees or combat veterans with only a few addressing the plight of those who stayed behind in their communities. Mollica has described considerable psychiatric disability in those massively traumatised communities who stayed behind in their countries of war - trauma, as was on the Thailand – Cambodia border and in the former Yugoslav republics. In Africa, in a study of treated war traumatised survivors, Musisi, described significant psychiatric disability in survivors of war living within their own country. In all these studies, the most common disorders were PTSD, depression, anxiety, and problems in coping with life from day to day. Various workers have described the psychiatric evaluation and treatment of massively traumatised individuals such as war-refugees or earthquake victims. Such studies are rare in Africa."

“Some workers have cautioned against the “medicalisation” of what they see as normative human response to extreme adversity as happens in war. However, most studies of mass trauma point to a core set of mental health symptoms in traumatised individuals but which symptoms may lend themselves to varied expressions in different cultural settings. These symptoms centre on the concept of the diagnostic categories of PTSD, depression and anxiety disorders including panic anxiety and phobias.”
Recent evidence points to demonstrable neurobiological changes in the brains of individuals with PTSD such as hippocampal atrophy, amygdaloidal hypersensitivity or Hypothalamic – Pituitary – Adrenal Axis dysfunction thus giving neuro-biological correlation to the effects of psycho-traumatisation. **Co morbidity is common and often, there are other associated psychological problems such as substance abuse, personality changes and general psychosocial dysfunction in the life after trauma of affected individuals.**

Both impact on the mental and public health African Health Sciences Vol 4 No 2 August 2004 81 of communities and the eventual socio-economic development of societies as well as to the mass psycho-social behaviour of communities e.g. **increases in domestic violence, child abuse, substance abuse** or the tendency to use militarism resolve all forms of conflict even at interpersonal level.

However, for the presently traumatised populations, efforts at decentralised mental health care through an integrated Primary Health Care approach is deemed most practical, appropriate, affordable and achievable. This calls for **appropriate training of primary mental health counsellors, and all health care providers in the awareness, recognition and management of problems of mass trauma and their associations.** These treatment approaches would involve culturally, gender and age sensitive psychotherapeutic approaches, social support and affordable medications where indicated.

It behoves all African scholars, and health workers in particular, to research and publicise the causes, effects and sequels of mass trauma on our peoples and to find appropriate solutions both for prevention and treatment.
POSTTRAUMATIC STRESS DISORDER
DIAGNOSTIC CRITERIA IN DSM 5

Criterion A: Trauma
Exposed to actual or threatened death, actual or threatened serious injury, or actual or threatened sexual violence by:

1. Personal experience
2. Witnessed in person
3. Learned of a relative or close friend’s trauma
4. Detailed or repeated indirect exposure, usually in the context of professional responsibilities
POSTTRAUMATIC STRESS DISORDER

DIAGNOSTIC CRITERIA IN DSM 5

**Criterion B: Intrusion (1/5)**
Recurrent, involuntary, and intrusive recollections; traumatic nightmares; dissociations (e.g., flashbacks); intense or prolonged distress to triggers; marked physiological reactivity to stimuli

**Criterion C: Avoidance (1/2)**
Persistent effortful avoidance of: trauma-related thoughts or feelings; external reminders (e.g., people, places, conversations, activities, objects, or situations)

**Criterion D: Cognition, Mood (2/7)**
Negative alterations that began or worsened after trauma: inability to recall key details; negative beliefs about self; blame of self or others; negative emotions; anhedonia; alienation; constricted affect

**Criterion E: Arousal, Reactivity (2/6)**
Alterations that began or worsened after trauma: irritable or aggressive; self-destructive or reckless behavior; hypervigilant; easy to startle; trouble concentrating; sleep disturbances
POSTTRAUMATIC STRESS DISORDER
DIAGNOSTIC CRITERIA IN DSM 5

**Criterion F: Duration**
Symptoms last for more than one month

**Criterion G: Function**
Symptoms create distress or functional impairment (e.g., social, occupational)

**Criterion H: Exclusion**
Symptoms are not better explained by medication, substance use, or another medical condition
**Acute Stress Disorder**

Very similar criteria to PTSD, but duration is between three days and one month.

**Adjustment Disorders**

Emotional or behavioral symptoms in response to an identifiable stressor within three months of its onset.

1. Depressed mood
2. Anxiety
3. Mixed anxiety and depressed mood
4. Disturbance of conduct
5. Mixed disturbance of emotions and conduct
6. Unspecified
ANTENATAL CARE
Management
FETAL IMPACT OF MATERNAL STRESS

MATERNAL STRESS OR DEPRESSION → HPA AXIS DYSREGULATION → ↑ CRH LEVELS → ↑ CORTISOL LEVELS → ↓ PLACENTAL BLOOD FLOW, LBW → PROGRAMMING OF FETAL HPA AXIS → DYSREGULATION OF FETAL HPA AXIS → ↑ REACTIVITY TO STRESS → ↑ VULNERABILITY TO MOOD AND ANXIETY D/O’S
Screen for PTSD in pregnant patients
Treat when indicated
Discuss the delivery experience with every patient
  Anticipate and document potential challenges
  Encourage birth plans that empower women and promote a sense of safety
    Pain management
    Environmental controls (music, lighting, mirrors, etc.)
    Interpersonal support
    Agency over physical exams
    Helpful coaching (volume, number of coaches, tone, etc.)
PTSD MANAGEMENT IN PREGNANCY

**Psychotherapy**
- Cognitive Behavioral Therapy (CBT)
- Eye Movement Desensitization and Reprocessing (EMDR)

**SSRIs**
- Well established safety profiles (conflicting evidence on paroxetine)
- Best choice is whatever has worked in the past
- Limited evidence, but benefits will often outweigh the risks
- Highest concern is for hypotension, so low starting dose (1 mg)

**Prazosin**
- SNRIs may increase risk of HTN, PPH, ?PTL
- Mirtazapine may increase risk of SAb, ?PTL

**Other serotonergics**
TRAUMA + THE LABOR EXPERIENCE
Avoiding exacerbations and preventing birth trauma
EXAMPLES OF BIRTH TRAUMA
RISK FACTORS

Individual vulnerability
Trauma history, especially sexual.
Other psychiatric history.

Labor and delivery experience
Perceptions of event, level of fear.
Lack of control, felt overwhelmed.
Emergency CS, assisted deliveries.
Bleeding, pain, prolonged labor.

Postpartum environment
Lack of interpersonal support.
No opportunities to process.
Feelings of responsibility.
TRAUMA-INFORMED CARE ON MATERNITY WARD

What can we do as providers?

---

**Regardless of history of trauma:**
- Understand that trauma may be shared selectively
- Listen to concerns
- Explain what happens and why
- Ask for consent and wait for a response
- Reduce feelings of vulnerability
- Offer what you can to limit stress, including:
  - Control over the situation
  - Medications
  - Environmental changes
  - Bystanders/Support

**Known history of trauma:**
- Do whatever you can to avoid inflicting further trauma
- If you cannot accommodate, be apologetic and compassionate rather than dismissive and authoritarian
- Discreetly share trauma history with triage, charge, and labor nurses
- Make sure signout is updated with details other providers need to know
POSTPARTUM CARE
Processing trauma
TRAUMA-INFORMED POSTPARTUM CARE

What can we do as providers?

- Process the birth experience with all patients
- Normalize experiences
- Avoid becoming defensive
- Link to treatment when indicated
PTSD MANAGEMENT + BREASTFEEDING

**Psychotherapy**
- Cognitive Behavioral Therapy (CBT)
- Eye Movement Desensitization and Reprocessing (EMDR)

**SSRIs**
- Generally safe
- Paroxetine more likely to cause withdrawal, sedation
- Don’t switch what is working
- Limited data
- Use shared decision-making

**Prazosin**
- SNRIs appear to be safe, particularly venlafaxine
- Mirtazapine not well studied

**Other serotonergics**
TRAUMA INFORMED CARE
A New Approach to Clinical Practice
Recognizes that trauma is pervasive

We should assume that an individual is more likely than not to have a history of trauma

We should consider that behaviors and personality traits we find difficult may be (mal)adaptive or protective

We should shift our paradigm from, “What is wrong with this person?” to “What has happened to this person?”

Avoids re-traumatization

Any situation (often unintentional) that literally or symbolically resembles an individual’s trauma, triggering difficult feelings and reactions associated with the original trauma

Historical, intergenerational, or cultural trauma may also be present

Promotes empowerment and healing

Trauma affects an individual’s sense of self, their sense of others, and their beliefs about the world around them

Having a degree of control over uncertain situations becomes very important
EXAMPLES OF TRAUMA INFORMED CARE
Thank you

Questions and comments welcome


Howard-Young, J. M. (October , 2018). Personal notes from Women’s Health Panel Discussion at MGH Psychopharmacology Conference 2018.


