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Trauma-Informed Peripartum Care

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TRAUMA-INFORMED PERIPARTUM CARE

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ROADMAP

1 **RECOGNIZING THE SIGNS**

signs and symptoms; Epidemiology

2 **ANTENATAL CARE**

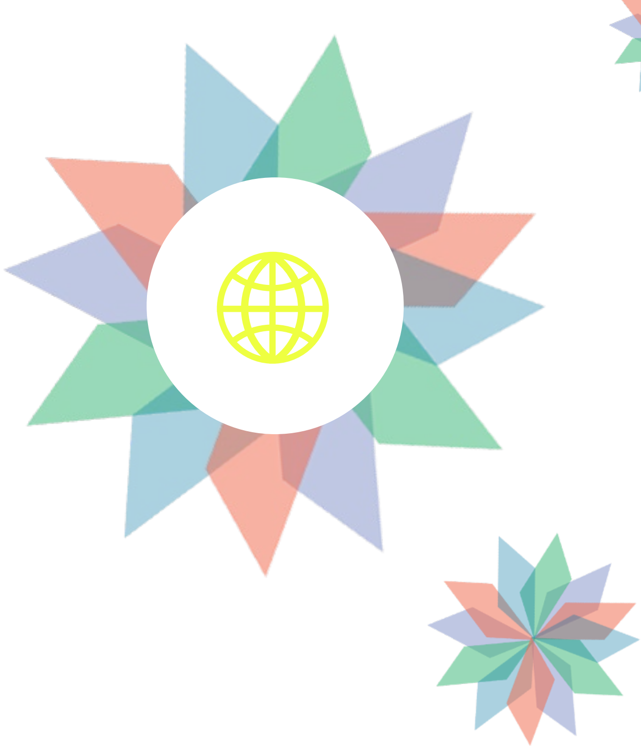
Screening, and management

3 **PERIPARTUM CARE**

Avoiding exacerbations and preventing birth trauma

4 **POSTPARTUM CARE**

Processing trauma and breastfeeding considerations



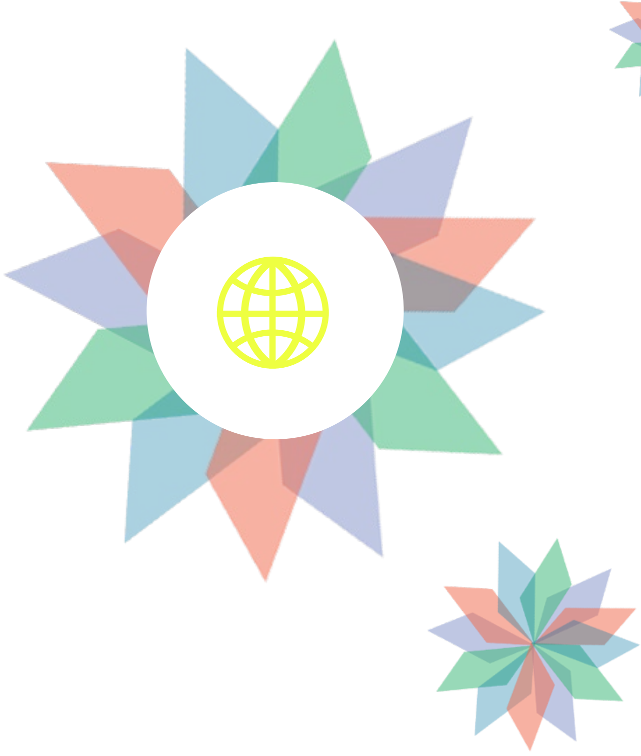
What does trauma look like from the outside?

Being aware of signs and symptoms

WHAT DOES TRAUMA LOOK LIKE FROM THE OUTSIDE?

- Anxious
- Tense
- Avoidant
- Zoned out
- Sounding scripted when recounting trauma
- Jumpy
- Reckless
- Depressed
- Irritable
- Angry
- Suspicious

- Guarded
- Distrustful of authority
- Hypersexual
- Ashamed
- Trouble sleeping
- Pain intolerant
- Somatic symptoms
- Self-harm
- Substance use
- Difficult cervical exams
- Distress with male providers



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

EPIDEMIOLOGY

In West Africa

Mass trauma and mental health in Africa Seggane Musisi - Department of of Psychiatry, Makerere University Medical School & Mulago Hospital - Afr Health Sci. 2004 Aug; 4(2): 80–82.

“ 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.**

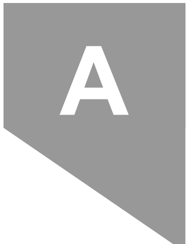
Both impact on the mental and public health African Health Sciences Vol 4 No 2 August 2004 81 of communities and the eventual socio-economic development of societies as well as to the mass psycho-social behaviour of communities e.g. **increases in domestic violence, child abuse, substance abuse** or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



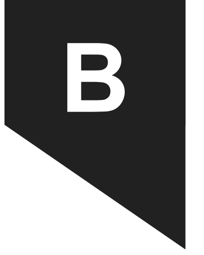
Criterion A: Trauma

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)

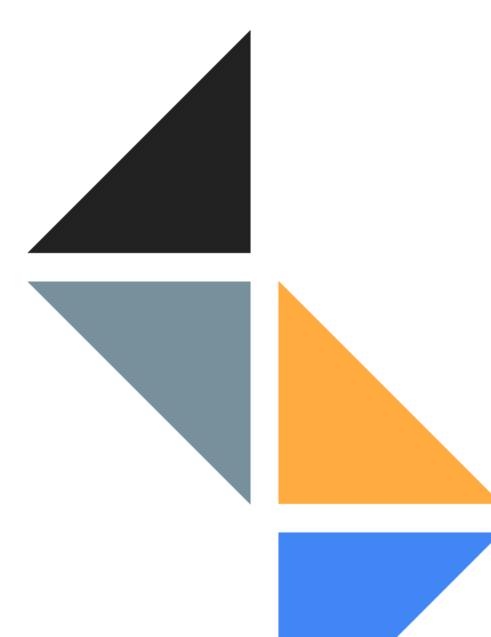
Criterion H: Exclusion

Symptoms are not better explained by medication, substance use, or another medical condition

OTHER RELEVANT DISORDERS

Acute Stress Disorder

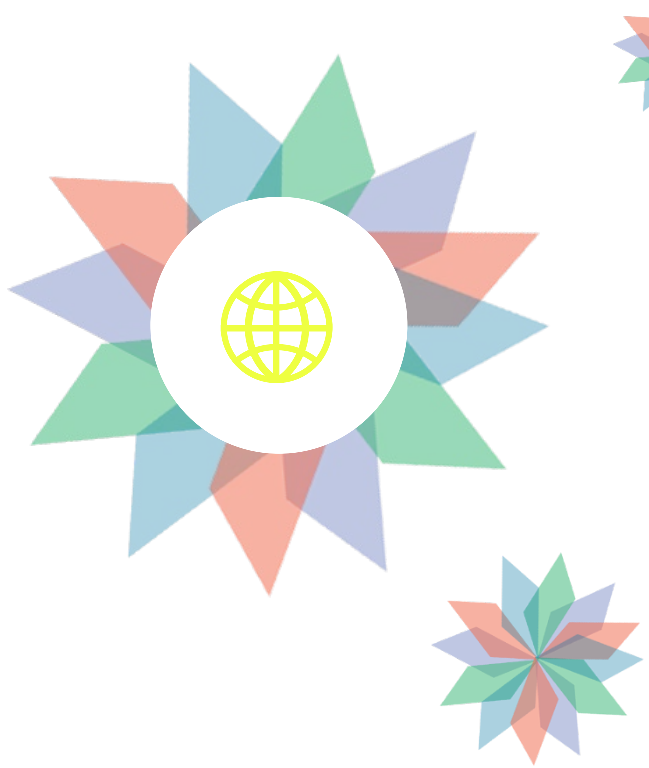
Very similar criteria to PTSD, but duration is between three days and one month



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 ❯ PROGRAMMING OF FETAL HPA AXIS

- ⇧ CRH LEVELS → STIMULATES ONSET OF LABOR, PTL
- ⇧ 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

TRAUMA-INFORMED ANTENATAL CARE

What can we do as providers?

- 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

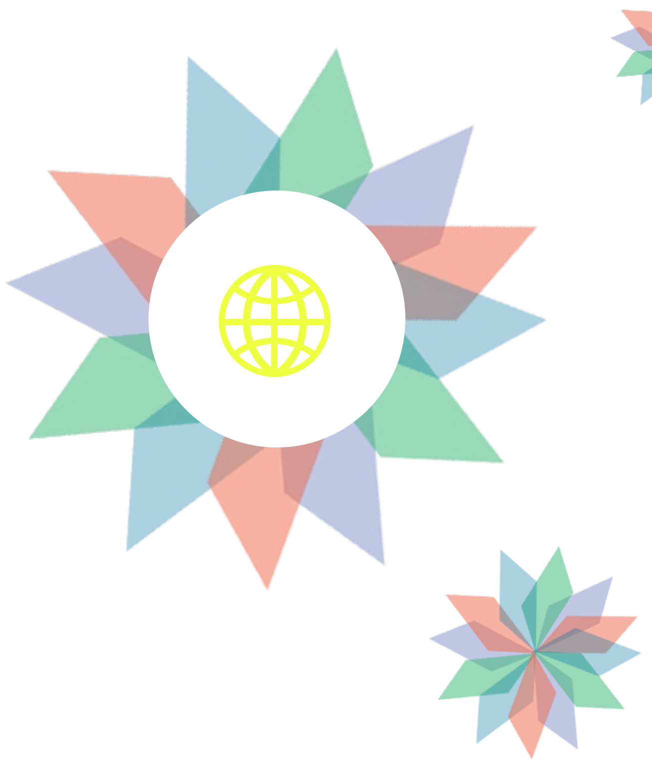
- Well established safety profiles (conflicting evidence on paroxetine)
- Best choice is whatever has worked in the past

Prazosin

- Limited evidence, but benefits will often outweigh the risks
- Highest concern is for hypotension, so low starting dose (1 mg)

Other serotonergics

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



TRAUMA + THE LABOR EXPERIENCE

Avoiding exacerbations and preventing birth trauma

EXAMPLES OF BIRTH TRAUMA

the
birth trauma
association

RISK FACTORS

Individual vulnerability

Trauma history, especially sexual.
Other psychiatric history.

1

Labor and delivery experience

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

2

3

Postpartum environment

Lack of interpersonal support.
No opportunities to process.
Feelings of responsibility.

TRAUMA-INFORMED CARE ON MATERNITY WARD

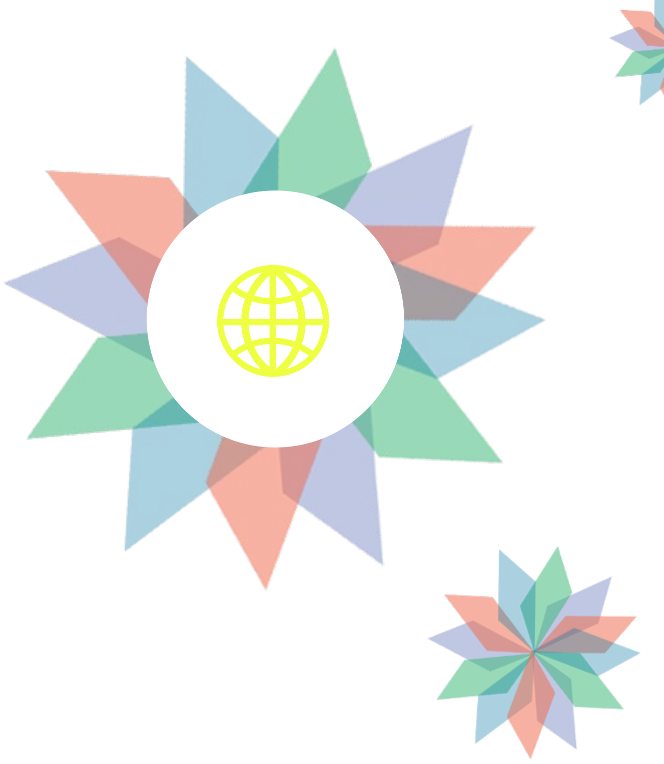
What can we do as providers?

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

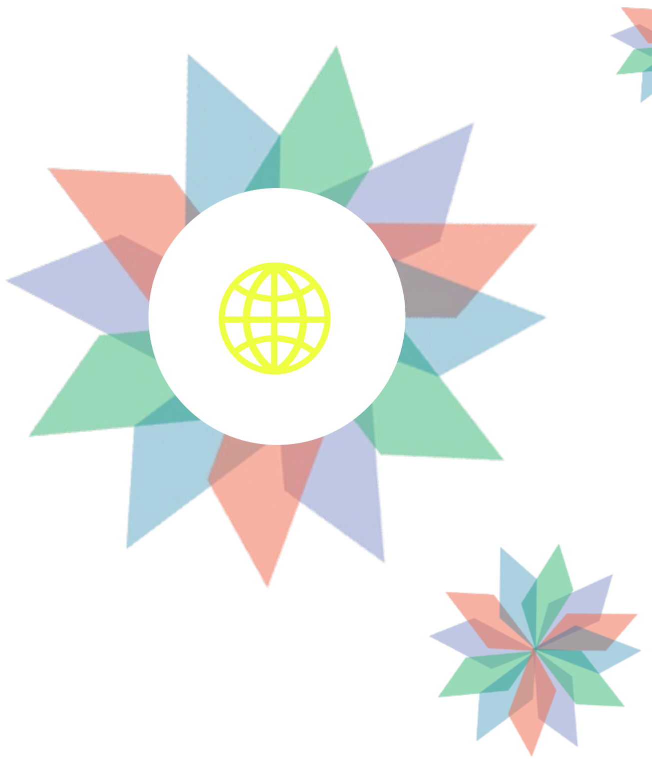
- Generally safe
- Paroxetine more likely to cause withdrawal, sedation
- Don’t switch what is working

Prazosin

- Limited data
- Use shared decision-making

Other serotonergics

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



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

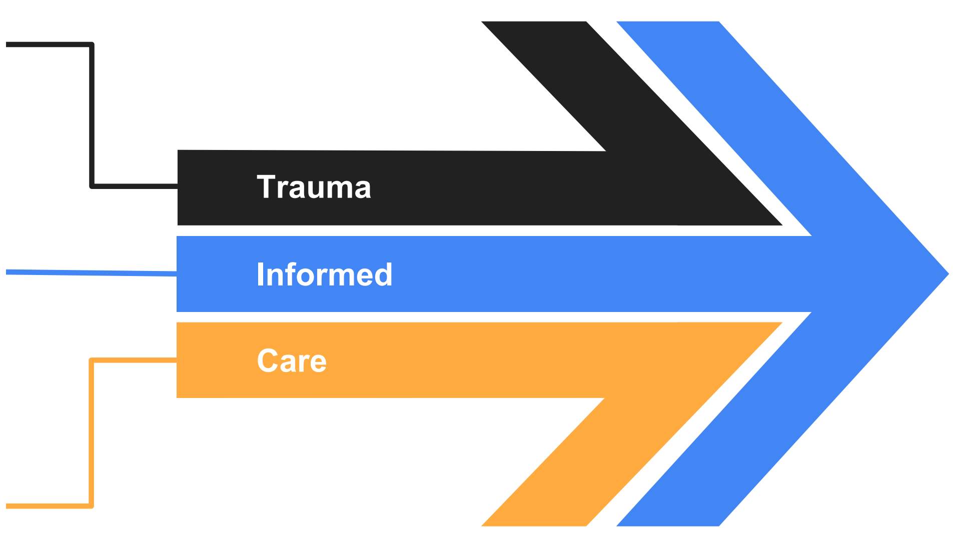
Any situation (often unintentional) that literally or symbolically resembles an individual’s trauma, triggering difficult feelings and reactions associated with the original trauma

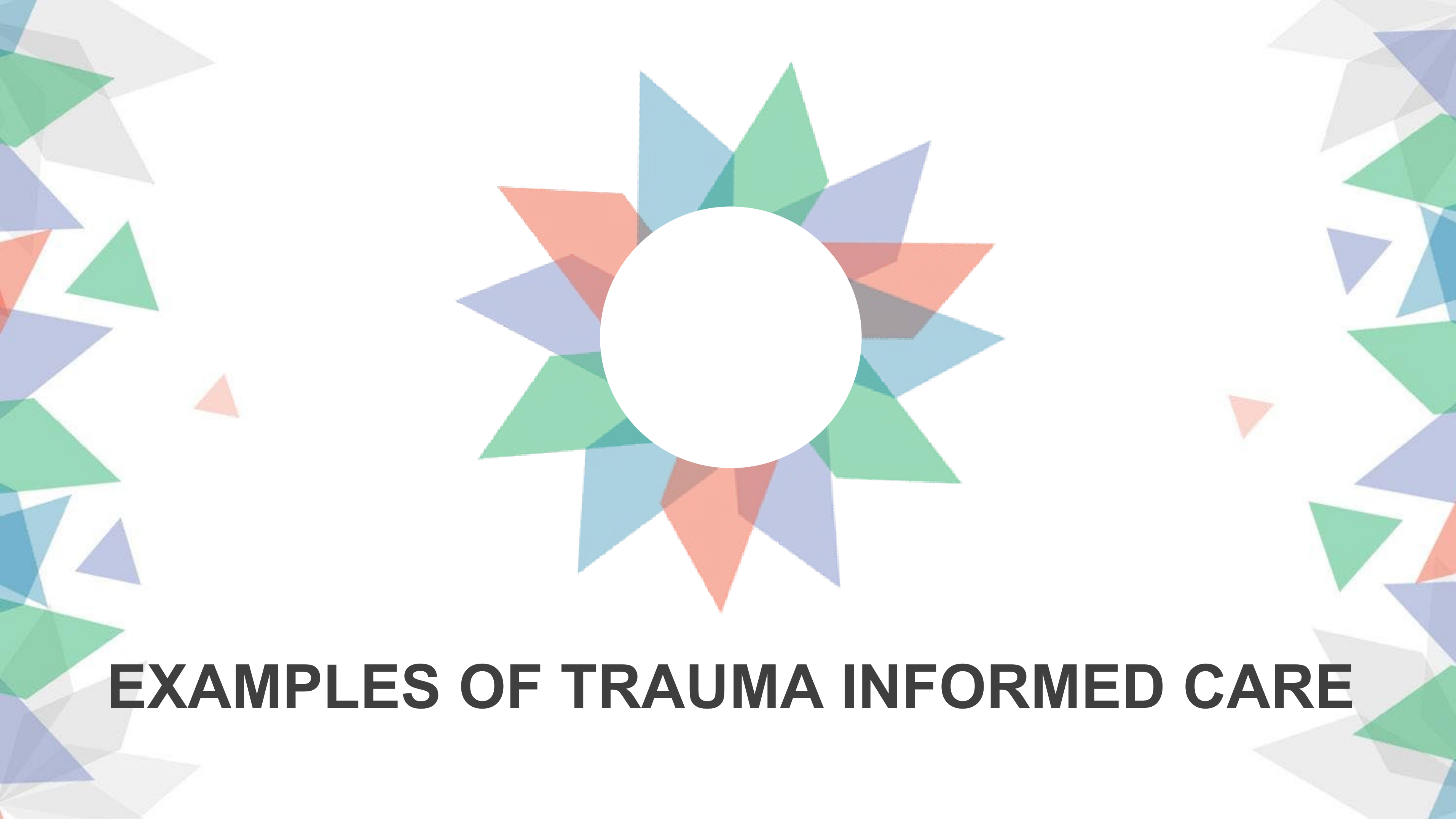
Historical, intergenerational, or cultural trauma may also be present

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

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