The Need for a Trauma-Informed Model of Maternity Care

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There's an elephant in the labor room. It brings with it sadness, pain, anger and shame. It will impact most of our lives in some way and yet we often ignore the devastation it causes. The elephant is trauma. In America, up to 1 in 3 women describe their birth as "traumatic" and up to 1/3 of those will go on to have diagnosable Post Traumatic Stress Disorder (PTSD) after childbirth.[i] Birth trauma can occur when there is an actual or threatened serious injury or death, or when a woman feels stripped of her personal dignity, experiences intense fear, helplessness, loss of control, or horror.[i]

How could such a large number of women have this type of experience? Cheryl Beck, an expert in traumatic birth, points out "in international studies the most frequently reported risk factors for PTSD due to childbirth have been high levels of obstetric interventions (i.e. inductions, forceps), lack of caring and support by labor and delivery staff, cesarean birth, prenatal depression, a history of prior counseling, history of prior trauma, and feelings of loss of control during labor."[ii]

Additionally, studies show a significant number of women in the U.S. have a history of trauma; up to 40% are survivors of childhood sexual abuse, around 1 in 4 have been sexually assaulted [iii] and an equal number have experienced intimate partner violence [iv]. Therefore, it is imperative for providers to fully realize how previous trauma can impact the experience for those giving birth as well as those supporting the birth.

To illustrate, consider Jane's story. As an abused child, she grew up hungry and was punished when she wanted more food. Sometimes she was tied up, not allowed to move around without permission from those who were supposed to protect and care for her. She was sexually violated, touched by multiple people and ignored when she said "No." They said if she would just relax, it wouldn't hurt so much. She was told that she was "bad" for questioning her abusers. *She believed* that she deserved whatever happened to her, that she couldn't do anything about it, and even if she told, who would believe her?

Now imagine how easily that past abuse could be triggered during labor as she experiences some routine maternity care policies. She is "not allowed" to eat during labor and told that it's for her own good (which is not based on the best evidence[v]). She is "not allowed" to move about freely during labor, forced to stay bed tied to an electronic fetal monitor for continuous monitoring (which, for low-risk women, is not based on the best evidence[vi]). Multiple people insert their fingers inside of her vagina to check her cervix, often not bothering to ask permission (which, in addition to being totally unacceptable, is also not based on best evidence[vii],[viii],[ix]). When she becomes upset she is told if she would just relax, it wouldn't hurt so much. None of these routine practices have been shown to improve outcomes for moms or babies yet *she believes* she must accept them because only a "bad" mother questions the experts, the providers are the ones who decide what treatment happens, and if she complains, who will care?

The reality is that many routine maternity care policies promote violating a person's bodily autonomy and dignity to the point where it has become accepted as normal, even justified. This is the status quo that must to be challenged and changed.

Dehumanizing maternity care is a global epidemic so commonplace that the World Health Organization felt compelled to address it, decrying the widespread "disrespectful, abusive or neglectful treatment during childbirth in facilities." They report on the use of humiliation, physical abuse, verbal abuse, threats, coercion, and refusal of pain medication or anesthesia—actions which "can amount to a violation of a woman's fundamental human rights."[x]

It is important to realize that it doesn't take an extreme example of abuse to cause damage. The incredibly intimate nature of birth must be respected, and it should be recognized that even seemingly benign routine procedures have the potential to cause trauma or bring up memories of abuse. Most women give birth in hospitals that provide the "Medical Model" of care which tends to look at the process rather than the person, often treating all birthing women as high-risk when most are at low-risk for complications, thus exposing them to medically unnecessary interventions (all of which have potential risks of their own).[xi] In this model, tests and interventions are presented as standard or even mandatory, emphasizing the provider as the ultimate authority in decision-making.[xii] Hospital policy, liability concerns, and personal convenience are frequently prioritized above the pregnant person's wishes, informed consent, and even sometimes despite their explicit refusal.[xiii] The idea of "shared decision-making" sounds collaborative, yet when one person is an expert holding a position of authority there is an unequal balance of power. In reality, the pregnant person is the most invested in her baby and the outcome of her birth, and has to live with the lifelong consequences of treatment, therefore she is the undisputed decision maker for her care.

A "trauma-informed" model of maternity care is desperately needed to address those parts of the current model which are not only unhelpful but damaging, specifically the rights violations and lack of respect given to birthing women. A trauma-informed system of care is one where staff at all levels of an organization understand trauma—how common it is, how it affects brain development and behavior, and how to recognize a trauma response and provide support. They are not necessarily trained in trauma-specific treatment methods, however they do learn how to minimize the potential for re-triggering a person's trauma. Being trauma-informed means knowing about the past or current trauma in a person's life and providing compassionate care and wraparound support in areas of need. Another aspect of this philosophy is the importance of self-care for providers and staff. The core values that form the foundation of this model are: Safety, Trust, Choice, Collaboration and Empowerment.

Trauma-informed care stems from the Sanctuary Model which was created to address the trauma history of adults on an inpatient psychiatric unit [xiv]. Care was offered in such a way that respected their right to informed consent, was less punitive and less likely to retrigger past trauma. Trauma-informed care has become the new standard of care in substance abuse and behavioral health systems.[xv]

In accordance with the core values of trauma-informed care, this model is founded on the belief that the pregnant person is the best one to make choices for her own care, and that of her baby. She is provided with accurate information about high quality evidence-based options and informed of the benefits, risks, and alternatives. Her informed decisions are supported by her providers because it is understood that the role of the care team is to provide accurate information but the final choice to accept or decline the care offered always resides with the woman. This is in alignment with the human right to accept or refuse medical care as described by Human Rights in Childbirth [xvi], as well as ACOG's statement "In the obstetric setting, recognize that a competent pregnant woman is the appropriate decision maker for the fetus that she is carrying."[xvii]

A trauma-informed model of maternity care treats each person as an individual, tailoring care to their specific needs and goals, respecting their history and situation, and supporting their informed choices; all things that bode well for a healthier postpartum adjustment. It is based on the understanding that a person's emotional, psychological and spiritual health are equally as important as physical health.

Trauma-informed maternity care also promotes collaboration with other care providers to offer wraparound support in order to improve outcomes as well as address immediate safety needs, (such as resources for housing, domestic violence, or mental health care). By using a universal screening tool (see the resources listed below), providers can determine history of trauma and areas of need, thus informing the care plan.

Components of a Trauma-Informed Model of Maternity Care

Safety—*Care options are based on high-quality evidence showing the best outcomes for moms and babies. A universal screening tool is used to assess current situation and history of trauma, and connect with appropriate support services or providers. The care environment is safe, confidential, free from bullying, coercion, physical/emotional/verbal abuse. Providers knock on doors, ask permission to enter, introduce themselves, make eye contact, explain what they'd like to do and why, then obtain (and respect) informed consent or refusal and always ask permission to touch.*

Trust— *Providers are consistent, supportive, and deliver high-quality, evidence-based care in a respectful manner. They do not "bait and switch" or give false impressions of the care they provide. Current and accurate information on all options is provided so people can be fully informed when asked for consent prior to any procedure or intervention. Preferably, one primary provider commits to attend the labor and birth, rather than meeting several providers and not knowing who will be at the birth. Building a trusting relationship with providers over time is an important part of safety as well as trust.*

Choice—*It is understood that the pregnant person has the right to give informed consent as well as informed refusal, as it is recognized that pregnancy is not a justification to deny a person's right to bodily autonomy. Additionally, all people must have access to the spectrum of quality, evidence-based options for maternity care providers, birth places, etc without limitations from insurance carriers.*

Collaboration— *The pregnant woman is the undisputed leader of the care team. She alone determines who is on the team, such as a partner, doctor, midwife, doula, specialists, childbirth educator, or social worker. Everyone understands her birth preferences and they support her informed choices. Based on her wishes, members might collaborate with other service providers for wraparound support both before and after the birth. Care is individually tailored to her specific situation, needs, goals and desires.*

Empowerment—*When a person receives respectful care, accurate information to make informed decisions, and support in their choices, it is likely to be an empowering experience. A satisfying birth improves the likelihood of a smoother postpartum adjustment which is not merely a luxury, but in the best interest of baby as well. [xviii]*

It is my sincere hope that everyone working with childbearing women be trained in trauma-informed care because it is vital that they realize the things they say and do matter tremendously. *It must be understood that these are our bodies!* We remember our births. We remember what was said to us and how we were touched. We remember if we were respected, given eye contact and explanations, asked for consent, supported, and encouraged. And we sure as hell remember if we weren't. The simple act of being treated with kindness and respect, especially during such an intense experience, can make all the difference. In fact, even when unexpected complications arise, the way a woman is treated can be the difference between having a good birth and having a traumatic one.[xxxviii]

Resources For Trauma-Informed Care

"What is Psychological Trauma" by Esther Giller:
Sidran.org>Resources for Survivors and Loved Ones>What is Psychological Trauma

Screening form to assess past trauma, as well as tips for trauma-informed care, can be found through the SAMHSA-HRSA Center for Integrated Health Solutions: www.integration.samsha.gov>Clinical Practice>Screening Tools>Trauma Screening Tools

Improving Birth's Trauma Toolkit, including resources and support for parents and providers: improvingbirth.org/trauma-toolkit/

Solace for Mothers: solaceformothers.org

Postpartum Support Internal: www.postpartum.net

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[i] "Traumatic Childbirth" by Cheryl Tatano Beck, Jeanne Watson Driscoll & Sue Watson, Routledge, 2013.[ii] Karraa, Walker. "Book Review: Traumatic Childbirth and an Interview with the Author – Cheryl Beck." *Science and Sensibility*. January 9 2014. www.scienceandsensibility.org/?s=cheryl+beck
[iii] "Sexual Violence Statistics." *WOAR*. www.woar.org/resources/sexual-assault-statistics.php
[iv] "Get the Facts and Figures." *The National Domestic Violence Hotline*. www.thehotline.org/resources/statistics/
[v] "Optimal Care in Childbirth; The Case for a Physiologic Approach" by Henci Goer & Amy Romano, Classic Day Publishing, 2012.
[vi] Dekker, Rebecca. "Evidence Based Fetal Monitoring". *Evidence Based Birth*. July 17 2012. evidencebasedbirth.com/evidence-based-fetal-monitoring
[vii] Downe S1, Gyte GM, Dahlen HG, Singata M.Routine vaginal examinations for assessing progress of labour to improve outcomes for women and babies at term.Cochrane Database Syst Rev. 2013 Jul 15. PMID:23857468
[viii] Dekker, Rebecca. "What is the Evidence for Inducing Labor if Your Water Breaks at Term?" *Evidence Based Birth.* November 20 2014. evidencebasedbirth.com/evidence-inducing-labor-water-breaks-term/
[ix]Seaward PG1, Hannah ME, Myhr TL, Farine D, Ohlsson A, Wang EE, Haque K, Weston JA, Hewson SA, Ohel G, Hodnett ED. International Multicentre Term Prelabor Rupture of Membranes Study: evaluation of predictors of clinical chorioamnionitis and postpartum fever in patients with prelabor rupture of membranes at term. Am J Obstet Gynecol. 1997 Nov;177(5):1024-9. PMID:9396886
[x] World Health Organization statement on Prevention and elimination of disrespect and abuse during childbirth. www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth/en/
[xi] Overuse of Cesarean Section and Other Interventions Puts Women and Babies at Risk, Increases Costs. Childbirth Connection. 8 Oct 2008. www.childbirthconnection.org/pdfs/ebmc-press-release.pdf
[xii] Declercq ER, Sakala C, Corry MP, Applebaum S, Herrlich A. Listening to MothersSM III: Pregnancy and Birth. New York: Childbirth Connection, May 2013.
[xiii] Top 10 pregnancy procedures to reject. ConsumerReports.org. March 2015. www.consumerreports.org/cro/2012/05/what-to-reject-when-you-re-expecting/index.htm
[xiv] The Sanctuary Model by Dr. Sandra L. Bloom. www.sanctuaryweb.com
[xv] Acharya, *Bharati. "*Trauma-Informed Behavioral Health Care". National Council for Behavioral Health. www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare
[xvi]: "Right to Refuse Medical Treatment". Human Rights in Childbirth. www.humanrightsinchildbirth.org/right-refuse-medical-treatment
[xvii] "Ethical Decision Making in Obstetrics and Gynecology" Update of "Ethical Decision Making in Obstetrics and Gynecology in *Ethics in Obstetrics and Gynecology,* Second Edition, 2004. Reaffirmed 2013. www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Ethical-Decision-Making-in-Obstetrics-and-Gynecology
[xviii] "Frequently Asked Questions". Center for Postpartum Adjustment. www.postpartumsupport.com/faq.htm

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