BEST PRACTICES FOR LIMITING RISK OF POSTTRAUMATIC STRESS RELAPSE DURING CHILDBIRTH

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ABSTRACT

Women who have a past history of sexual assault, childhood abuse, or other traumatic experiences are at high risk of developing posttraumatic stress disorder (PTSD), which can have devastating effects on the individual women, their children, and their entire families. When women with a past history of trauma go through the stressful process of childbirth, they are likely to encounter several triggers that could lead to a sudden exacerbation of PTSD symptoms, which include uncontrolled anxiety, flashbacks of prior trauma, and re-traumatization.

Current obstetrical care practices do not routinely include screening patients for PTSD or employing an individualized approach to women in labor who have a history of prior trauma. Since it is known that a woman with a trauma history may experience labor and delivery as an acute, re-traumatizing event, clinicians must begin to identify women with such a history, screen for posttraumatic stress symptoms, and facilitate mental health referral for symptom management. Yet even beyond providing referrals, the obstetrician has a unique role to play in reducing the risk of posttraumatic stress exacerbation.

Resilience, the capacity for adaptive stress coping, is a protective and potentially modifiable characteristic that enables individuals to thrive despite trauma exposure. Therapeutic interventions that build resilience have been effective in strengthening trauma survivors to cope without relapse in the setting of future stressful events. This thesis will explore the concept of
resilience-building, apply specific elements of this concept to obstetrical practice, and ultimately propose best practices for supporting women in labor who have been the victims of prior trauma. Ultimately, this thesis will outline a new three-part strategy for trauma-informed obstetrical care that calls for PTSD screening, avoiding posttraumatic stress triggers, and enhancing stress-coping resilience in order to promote the physical and mental well-being of trauma survivors during the birthing process.
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CHAPTER 1

INTRODUCTION TO POSTTRAUMATIC STRESS DISORDER

I was no longer the same person I had been before the assault, and one of the ways in which I seemed changed was that I had a different relationship with my body.  
-- Susan Brison, *Aftermath: Violence and the Remaking of a Self*

The human experience of trauma has taken many forms, affected all cultures, and marked every era in human history. Individual survivors of war, acts of torture, terrorist attacks, natural disasters, childhood abuse, sexual assault, domestic violence, and other life-altering incidents all have unique and deeply personal accounts of how their events unfolded. Despite the obvious differences between surviving a hurricane and surviving an act of interpersonal violence, what links these stories together is the common experience of similar emotional, cognitive, and physical responses to a perceived and dreaded threat. Although many people have encountered stressful life events, a traumatic event is one in which normal coping mechanisms become overwhelmed and ineffective (Herman 1997, 34). In the acute setting of unavoidable impending danger, the body’s ordinary fight or flight response gives way to an intense sense of dread, powerlessness, and extreme terror (Herman 1997, 32-35). Survivors of life-threatening events often describe a constellation of symptoms that persist long after the acute episode. Sudden surges of anxiety, heart palpitations, nightmares, intrusive memories of the incident, or difficulty sleeping may occur for weeks or months after the incident. These are some of the long term effects of trauma that can lead to a debilitating psychiatric condition known as posttraumatic stress disorder (American Psychiatric Association 2000, 309.81).

Particularly for women who have a past history of sexual assault, domestic violence, or other interpersonal traumatic experience, posttraumatic stress disorder (PTSD) can have
devastating effects on these individual women, their children, and their entire families. For that reason, it is especially important to identify PTSD, initiate psychiatric therapy, and empower survivors to prevent re-victimization or relapse in the future. The potential for relapse can be especially problematic in the setting of what is usually a tremendously stressful but overall rewarding experience for many women: childbirth.

The impact of PTSD on women preparing to give birth is a subject that warrants a careful examination of how trauma can, as philosopher and rape survivor Susan Brison explains, fundamentally change a woman’s relationship with her own body (Brison 2002, 16-17). Indeed, trauma may have drastic effects on a woman’s interpersonal relationships with others, with the outside world, and with herself that may have significant implications for her later state of mind during pregnancy, labor, and delivery. This thesis, therefore, begins with an explanation of the short and long-term consequences of PTSD, the potential for recovery, and the importance of treatment that facilitates the rebuilding of interpersonal relationships and of the self after trauma. In the end, because trauma can lead to a diminished sense of autonomy, the rebuilding of the self through a recovery process that emphasizes resilience can begin to restore autonomy in a meaningful way.

The Effects of Trauma and Posttraumatic Stress Disorder

To begin, the development of PTSD involves a specific set of physiological and psychological signs and symptoms. According to the *Diagnostic and Statistical Manual of Mental Disorders, 4th ed.*, trauma is defined as an exposure to some event or events that involve personally experiencing, watching, or anticipating “actual or threatened death or serious injury, or a threat to the physical integrity of self or others” that generates a response of “intense fear,
helplessness, or horror” (American Psychiatric Association 2000, 309.81). In other words, the stressor must be severe, and the acute reaction must be extreme. Likewise, PTSD is diagnosed only when a traumatic incident is followed by recurrent and intrusive memories of the event, the development of avoidance behaviors to block out reminders of the event, and a hypervigilant state that is evidenced by insomnia, irritability, difficulty concentrating, or a heightened startle response. In addition, for the diagnostic criteria to be met, these symptoms must persist for at least one month after the traumatic event and must cause some degree of distress or social impairment for the individual (American Psychiatric Association 2000, 309.81). Often, the changes that occur in the functions of memory, arousal, and emotions are quite distressing because they become disjointed and disorganized. For example, a trauma survivor may experience graphic flashbacks of the original event without any corresponding emotions. Alternatively, that same person may suffer from frequent, inexplicable surges of strong emotions without apparent cause (Herman 1997, 34). If a person develops the above symptoms in response to a life-changing but not life-threatening event, such as a divorce or losing one’s job, the conditions for PTSD are not met. Instead, the person may be suffering from an adjustment disorder rather than posttraumatic stress disorder. Similarly, a woman who survives a life-threatening assault while walking her dog in the park may very well have had a traumatic experience. However, if her symptoms of disruptive nightmares, avoidance of all dog-walking, jitteriness, and insomnia resolve after three weeks, she would not warrant the diagnosis of PTSD. Hence, for trauma survivors who do meet criteria for posttraumatic stress disorder, the psychological and physiological manifestations are quite profound, long-standing, and distressing.
Indeed, the combination of avoidance behavior and uncontrolled anxiety has a complex and often devastating effect on a trauma survivor’s interpersonal relationships. The development of avoidance patterns may take various forms. For some, this pattern involves purposefully blocking thoughts, emotions, or conversations that trigger a reminder of the incident in any way. Others make a concerted effort to avoid activities, places, or individuals that hold some similarity to the circumstances surrounding the traumatic event. In addition, the fear of re-opening memories may be so great that some survivors experience a form of amnesia, for they are unable to recall significant parts of the original incident. Furthermore, many who have experienced trauma speak of an overwhelming sense of alienation from the rest of the world. Psychoanalyst Robert D. Stolorow writes that in the wake of the traumatic death of his wife, he grappled with a “dreadful sense of estrangement and isolation” that he was certain none of his friends or colleagues could ever understand (Stolorow, Atwood and Orange 2002, 124). As a result, individuals like Stolorow may begin to withdraw from friends, colleagues, and social gatherings. Given the nature of these patterns of avoidance and isolation, it is possible to understand how the existing relationships of trauma survivors with family members, friends, and acquaintances may become strained.

In addition to avoidance behaviors that can negatively affect existing interpersonal relationships, a more general shift can occur in the trauma survivor’s perception of his or her surroundings. Philosopher Susan Brison writes from her own personal experience of sexual assault and attempted murder that she suffered a kind of “emotional paralysis resulting from shattered assumptions about [her] safety in the world” (Brison 2002, 17). Most individuals develop a set of assumptions and expectations about various elements in their daily environments. Whether walking, biking, or commuting to work each morning, most people expect that the
ground upon which they travel is firm and stable enough to support the weight of their bodies, bikes, or vehicles. After living through a devastating earthquake, however, those long held assumptions are suddenly shaken as individuals learn that they can no longer trust the stability of the ground. Rather, the environment and the people within it are shockingly unstable and unpredictable. In fact, Stolorow asserts that once the “naïve realism and optimism that allows one to function in the world” is shattered, a “catastrophic loss of innocence” radically transforms one’s sense of existence in the world (Stolorow, Atwood and Orange 2002, 127). As a result, trauma may destroy previously held assumptions and expectations about the general goodness of people, the safety of one’s surrounding environment, and one’s ability to function within it.

Moreover, beyond drastic changes to interpersonal relationships and relation to the environment, the relationship with the self can be forever altered after a traumatic experience. Survivors may experience a complex web of emotions after the initial incident, including feelings of rage, sorrow, shame, guilt, fearfulness, numbness, or emptiness (Herman 1997, 45-46). Individuals may develop an inability to modulate these strong emotions or express their feelings with words. As a result, some survivors actually begin to engage in risky, self-destructive behaviors including anorexia, bulimia, drug and alcohol abuse, or high-risk sexual activity (Bryant-Davis 2005, 21-31). Such behaviors speak to a new incapacity to master one’s own emotional state, which is a vital attribute of any healthy, autonomous human person.

Trauma’s Effect on Autonomy

The effect on human autonomy is a central theme in any discussion of trauma. It is clear that several elements of the traumatic experience as well as PTSD have a significant impact on a person’s capacity to function with autonomy. In fact, according to Brison, “it is the
transformation of the self as autonomous agent that is perhaps most apparent in survivors of trauma” (Brison 2002, 27).

At a basic level, autonomy is the capacity to make free choices and to will one’s actions (Brison 2002, 27). The very nature of trauma, particularly when it involves interpersonal violence or sexual assault, robs the victim of any opportunity to exercise free choice in protecting his or her own bodily integrity. In such an assault, the victim lacks any power to assert himself or herself and to thereby stop the attack. Likewise, long after the assault, the victim may experience a loss of control over his or her own thoughts as involuntary flashbacks transport the individual psychologically back in time to a vivid reenactment of the original traumatic incident. Indeed, a trauma victim who develops PTSD may suffer from involuntary surges of emotion, uncontrollable bursts of anxiety, or intrusive memories that impair that individual’s ability to control his or her internal environment (Brison 2002, 27). Without confidence in the ability to prevent an anxiety attack or traumatic flashback at the supermarket, in the bank, or on the train, an individual may soon prefer not to leave the house at all. Others who do venture out into social settings find themselves reacting unpredictably with sudden bursts of rage in response to innocent looks or gestures from other people (Corbett 2004, 37). In essence, the physiological and psychological effects of trauma diminish a person’s capacity to voluntarily exercise self-control over certain behaviors, memories, and emotional states. In this way, autonomy necessarily diminishes as well.

In addition to directly affecting self-control, trauma often alters the survivor’s perception of his or her own body. Although there are many perspectives on what constitutes the self, one metaphysical view asserts that the self is the “bodily continuity that accounts for personal identity” (Brison 2002, 14). In other words, since persons experience life in and through the
body, those experiences of one’s body are inextricably linked to and constitute a main source of one’s personal identity. In many respects, interpersonal trauma in the case or rape or incest constitutes a destruction of the victim’s sense of bodily integrity, which is an important element of personal autonomy (Herman 1997, 54). In an attempt to re-establish some degree of control over their bodies, many women who have survived sexual trauma attempt to change their appearance with a new haircut, a new style of dress that serves to “disguise” the body, or even by means of an eating disorder (Brison 2002, 18). Individuals may even mentally dissociate from their bodies or create multiple personalities in order to psychologically escape from the inflicted violence, particularly in cases of chronic abuse or repetitive acts of trauma (Herman 1997, 102). Trauma can therefore change the survivor’s very conception of his or her own body, personal identity, and autonomy.

Furthermore, many survivors have described a death and rebuilding of the self after trauma. Brison describes her own strange perception that after surviving her sexual assault and near-death experience, she had “outlived [herself], as though [she] had stayed on a train one stop past [her] destination” (Brison 2002, 19). Similarly, numerous Holocaust survivors chose new names after World War II, allowing their former selves to remain buried at the concentration camps in which they had been tortured (Brison 2002, 19). This experience of dying and resurrecting oneself is of critical importance, for it underscores the identity of the self as a social concept.

Despite the tendency to view trauma as primarily affecting the victim’s personal sense of self, the most profound effect is on the “systems of attachment and meaning that link individual and community” (Herman 1997, 51). In other words, because the self only exists in relationship to others, any event that dehumanizes an individual has the effect of severing the invisible social
bond between that individual and the rest of humanity. For rape survivor and therapist Thema Bryant Davis, “interpersonal trauma disempowers the survivor” particularly because “the perpetrator has essentially violated the survivor’s humanity” (Bryant-Davis 2005, 4). Cathy Winkler asserts that sexual assault is a form of “social murder,” for the survivor still suffers a kind of death as the victim’s self and her relationship to society are suddenly and violently broken (Winkler 1991, 12). It is for this reason that in the aftermath of trauma, the autonomous self “can be resurrected only with great difficulty and with the help of others” (Brison 2002, 18).

Recovery after Trauma

According to psychiatrist and trauma expert Judith Herman, the three essential stages of recovery involve “establishing safety, reconstructing the trauma story, and restoring the connection between survivors and their community” (Herman 1997, 3). First, personal safety is essential for the healing process to begin. Victims who are chronically and continually exposed to trauma must first break away from that dangerous environment. Since some victims will have suffered such significant damage to their autonomy that they no longer believe themselves to be worthy of a safe environment, every effort should be made to assist them in assessing, securing, and valuing their safety. Even self-inflicted dangerous behaviors, which developed in response to trauma, are important to uncover and address. These may include suicidal thoughts or attempts, self-mutilation, excessive drug or alcohol abuse, or high-risk sexual behavior (Bryant-Davis 2005, 21). Addressing safety may therefore require a combination of interventions including possible hospitalization, rehabilitation, or cognitive-behavioral therapy to combat patterns of self-destructive behavior and distorted perceptions.
Second, once safety is established, the act of reconstructing and verbalizing the narrative of the traumatic experience is a vital step in the common pathway to recovery. Doing so enables the survivor “not only to integrate the traumatic episode into a life with a before and after, but also to gain control over the occurrence of intrusive memories” (Brison 2002, 23). It also allows survivors to rediscover their voice after having been reduced to powerlessness and silence while they were victimized. Telling one’s story therefore requires that the individual slowly and deliberately process an often jumbled collage of disjointed memories. It also requires that the individual find an understanding, receptive audience. Because post-traumatic stress involves a deep sense of isolation and alienation for the survivor, a recovering victim must truly believe that his or her listeners can somehow relate to the traumatic history that needs to be revealed but will likely prove difficult and painful to recount (Stolorow, Atwood and Orange 2002, 124-25). Here, the distinction between sympathy and empathy can be an important one, for empathy involves the capacity to truly understand what another feels and not just to lament what another feels, which is the hallmark of sympathy. Therefore, it is particularly helpful for the listeners to have had similar traumatic experiences and not simply to be encouraging and sympathetic to the plight of the victim. In this way, empathic listeners, support groups, and therapists can facilitate the renewal of the survivor’s capacity to trust others (Brison 2002, 30).

Third, an essential component of thriving rather than simply surviving after trauma is the renewal of ruptured connections between the individual and his or her social network. The very nature of human autonomy reveals the extent to which healing after trauma requires a healthy dependence on others. Although autonomy is often viewed as an expression of independence, it is actually a relational concept, for it develops out of the experience of interacting with others. That sense of independence cannot be maintained if there is constant fear of intrusion and
violation of the self by another (Brison 2002, 28). In the aftermath of trauma, survivors must reestablish their autonomy not by closing themselves off from other people but through forming new relationships that reconnect them to humanity. Healing cannot take place in isolation (Herman 1997, 133). In this way, dependency on others is critical to the reestablishment of meaningful human connection, which is so necessary for autonomy to flourish after trauma.

Moreover, the most important element of a successful recovery after trauma is the “empowerment of the survivor…who must be the author and arbiter of [his or] her own recovery” (Herman 1997, 133). Any attempt to usurp control away from the recovering victim serves to undermine the process of re-establishing the capacity for self-determination, self-control, and self-empowerment. Although many well-meaning supporters and therapists can do much to assist, affirm, recommend behavioral coping strategies for, and make themselves available to the survivor, recovery requires survivor empowerment if it is to be successful (Herman 1997, 134).

The Role of Resilience

While the most important determinant of a trauma victim’s reaction and recovery is the nature of the trauma itself, it is apparent that some individuals have certain attributes that confer a level of protection from PTSD (Herman 1997, 57-60). In particular, various cross-cultural studies have shown that a number of individuals seem to naturally possess the capacity to endure tremendous danger and hostility without decompensation. This capacity for stress-resistance, termed resilience, appears to encompass three key features. Highly resilient individuals have an advanced ability to communicate with others, an active rather than passive coping style, and a strong sense of control over their own destiny, which psychologists refer to as an “internal locus of control” (Herman 1997, 58). In response to a traumatic event, individuals who freeze or
experience paralyzing numbness carry a higher long-term risk of developing PTSD than individuals who maintain some level of interaction with others and find purposeful tasks to assist themselves and others in surviving the event (Herman 1997, 58-59). For example, women with characteristics of resilience who have been faced with an attempted rapist were more likely than other women to successfully escape. Even if their attempts to prevent the assault were unsuccessful, women who “remained calm, used many active strategies, and fought to the best of their ability” were less likely to suffer severe traumatic symptoms after the attack (Herman 1997, 59). Although no amount of resilience can promise to avert extreme, life-threatening situations or reverse PTSD once it has developed, it is feasible and potentially empowering for trauma victims to cultivate resilient coping strategies in the process of their recovery.

Summary

Trauma that leads to the debilitating condition of PTSD for some individuals robs them of their bodily integrity, their ability to trust and function within their environment, and their social connectedness. Recovery from trauma requires the restoration of safety, the reconstruction and narration of the traumatic events to empathic listeners, and the reestablishment of the individual’s relationship to the community. Ultimately, treatment for PTSD in the aftermath of trauma should include therapy that helps the survivor to develop and sustain autonomy, human relationships, and resilience.
CHAPTER 2

THE ROLE OF RESILIENCE BUILDING TECHNIQUES IN COGNITIVE BEHAVIORAL THERAPY FOR POSTTRAUMATIC STRESS DISORDER

Recovery after trauma requires a multi-step, interdisciplinary approach to restoring safety, trust, a positive self-image, and effective coping strategies for the trauma survivor. Cognitive behavioral therapy (CBT) is the mainstay of treatment for acute stress symptoms, which are evident soon after the incident, as well as for the persistent symptoms of PTSD. While various approaches to CBT are helpful in the treatment of PTSD, techniques that emphasize resilience can be especially important for trauma survivors who will likely face additional stressors that can cause a resurgence of distressing symptoms. Because such techniques could have significant implications for trauma survivors facing the prospect of childbirth, a tremendously stressful event, this chapter will first explore the benefits and limitations of resilience-building techniques that have been used in other populations exposed to trauma. CBT approaches that focus on enhancing resilience after trauma have helped trauma survivors to cope without relapse when facing future stressful events.

Cognitive Behavioral Therapy and Resilience

In treating trauma-related stress, combining cognitive and behavioral therapy is superior to supportive counseling alone (Bryant, Moulds, and Nixon 2003, 489). Counseling typically offers supportive and empathic listening, general education about trauma, and problem solving skills. In contrast, CBT trains victims to restructure their cognitive processes through techniques of visualizing stressors, identifying fear-triggering beliefs, and modifying those beliefs through a series of imagery exercises that progressively expose them to similar stressors in a controlled environment. In addition to cognitive restructuring, behavioral therapy provides victims with
skills for controlling anxiety using breathing techniques, muscle relaxation, and self-coaching exercises to talk themselves through stressful situations. Trauma survivors who master the main CBT techniques have a much lower risk of developing chronic posttraumatic stress symptoms than those who do not have the benefit of this therapy (Bryant, Moulds, and Nixon 2003, 490-92). In the end, CBT leads to better outcomes for trauma survivors, especially if treatment is initiated soon after the traumatic incident.

While it is clear that effective treatment for posttraumatic stress symptoms should include some form of CBT, a paradigm shift in the approach to therapy over the past decade has led many mental health professionals to incorporate resiliency theory as part of their treatment protocol (Richardson 2002, 307). Instead of the traditional, problem-focused treatment plan to relieve symptoms of posttraumatic stress after they have occurred, resiliency theory calls for a new emphasis on strengthening the individual with preventative strategies. Resiliency theory holds that there is a “motivational force within everyone that drives them to pursue wisdom, self-actualization, and altruism and to be in harmony with a spiritual source of strength” (Richardson 2002, 309). Resilience is this very force “that drives a person to grow through adversity and disruptions” (Richardson 2002, 307). Resiliency, then, refers to the process of acquiring and fortifying resilient qualities through life’s adversities and disruptions (Richardson 2002, 308).

The body of research on resilience and resiliency theory suggests that certain character traits and responses to adverse situations help individuals to recover from difficulties, misfortunes, and hardships. Emmy Werner’s 1955 landmark study on 200 Hawaiian at-risk youth found that the resilient characteristics that enabled roughly one-third of the children to thrive included having high self-esteem, good communication skills, adaptability, tolerance, self-motivation, a desire for high achievement, a sense of social responsibility, a supportive family or
social network, and female gender (Werner 1996, 48-50). A number of subsequent studies have confirmed Werner’s original findings and named additional resilient qualities such as optimism (Lee et al. 2008, 415), pragmatism (Mancini and Bonanno 2006, 976), and the willingness to readjust one’s worldviews (Thombre, Sherman, and Simonton 2010, 15). Strong communication skills, active and purposeful coping strategies, and a confident self-possession or “internal locus of control” appear to be especially protective in the setting of extreme adversity (Herman 1997, 58).

Once researchers understood the qualities that constitute resilience, they sought to address the question of how humans generally acquire these protective qualities (Richardson 2002, 308). According to Glenn Richardson’s linear model of resiliency development, most individuals first establish an internal sense of physical, emotional, and spiritual stability within their environment, which many experience as a “comfort zone” (Richardson 2002, 311). Then, they consciously or unconsciously choose to adapt to life-changing events through a process of accessing the resilient qualities that they already possess. Each choice to adapt “resiliently . . . results in growth, knowledge, self-understanding, and increased strength of resilient qualities” (Richardson 2002, 310). On the other hand, every choice to react to life disruptions without drawing upon existing resilience leads to lost opportunities for personal growth, a delay in returning to a state of internal stability, or a dysfunctional internal reintegration after the disruption (Richardson 2002, 312). In other words, resiliency is not just bouncing back or recovering from adversity. Rather, it involves a journey of personal growth through adversity. For example, a young wife whose husband unexpectedly dies in a car accident will certainly enter a period of intense grief and face the inevitable question, “What do I do now?” In the resiliency model, this very question represents the beginning of internal reintegration after an adverse disruption. Although she can never return to her previous comfort zone in the setting of
permanent loss, she can choose to reintegrate with resiliency. Doing so might entail moving closer to her family for additional support and drawing strength from her own attributes of self-motivation and self-confidence that she had developed prior to marriage. In the process, she will become even more self-motivated and self-confident, and she may discover that she possesses a surprising degree of adaptability. If, however, she avoids the opportunity for growth and reintegrates with diminished motivation, hope, or confidence, the reintegration will be incomplete and she will remain wounded as she establishes a new, internal comfort zone. Moreover, if she turns to drugs, alcohol, or destructive behaviors in order to adapt, she is exhibiting dysfunctional reintegration (Richardson 2002, 312). Resiliency, then, is a habitual choice about how one reacts to planned or unplanned life transitions that disturb one’s comfort zone. According to this model, every life transition presents an opportunity for growth and acquisition of new resilient qualities.

Resiliency theory proposes several observations about the human experience that help to identify those individuals who could benefit from resilience-enhancing therapy. First, the process of growth actually requires the introduction of life stressors that test the individual’s capacity to adapt to new circumstances (Richardson 2002, 312). Resilience is a common phenomenon that many people exhibit after suffering loss, grief, or trauma (Mancini and Bonanno 2006, 972). The resiliency process may happen quickly, in cases of minor stressors, or over a period of several years in cases of severe trauma. However, when there is an initial failure to utilize resilient qualities, incomplete reintegration tends to have a compound effect as additional adverse events lead to continued incomplete or dysfunctional reintegration (Richardson 2002, 311). In the absence of resilient coping mechanisms, a particular life disruption causes chronic stress instead of personal growth. Fortunately, therapy can help to complete the process of reintegration and train the individual to aim for growth in the setting of adversity instead of mere recovery. In fact, Richardson suggests that the primary “value in therapy and education is that clients can visually
recognize that they have choices to grow, recover, or lose in the face of disruptions” (Richardson 2002, 312).

Resilience-building in High-risk Populations

While unpredictable life disruptions can be especially disconcerting for someone lacking resilience, anticipated stressors present an opportunity to prepare for the process of disruption and reintegration with a fortified attitude of resilience. Civilians in wartime and childhood cancer survivors experience high levels of recurrent stress that can lead to acute stress reactions or PTSD. For this reason, resilience therapy can be particularly important in such high risk populations.

Community Resilience Program for Civilians in Wartime

Psychiatrists have utilized resilience-building techniques for entire communities at high risk for developing widespread PTSD. One such intervention took place in the Israeli city of Sderot after adult and child civilians at a local preschool were killed in a 2004 rocket attack between Israeli and Palestinian military forces. Given the longstanding political unrest and increasing number of violent conflicts affecting the entire population living near the Gaza Strip, various mental health experts united their efforts to address the widespread impact of trauma on the Israeli civilian community. Based on their assessment that at least 30 percent of the Sderot population was suffering from acute trauma with 10 to 20 percent showing evidence of chronic posttraumatic stress symptoms, the Jewish Federation of North America funded a community intervention program similar to prior large-scale PTSD interventions in Haiti, Ethiopia, and Indonesia after terror attacks or violent conflicts in those countries. However, what distinguished this public health intervention from previous ones was the goal not only to treat affected
individuals but also to prevent the development of chronic stress reactions among seemingly unaffected individuals through resilience-focused techniques. Hence, this program proposed an innovative approach to PTSD as a potentially preventable condition to be inoculated against in advance rather than treated in retrospect (Friedman-Peleg and Goodman 2010, 422-23).

The city’s “community resilience” program aimed to “build a resilient community and empower Sderot by providing immediate aid in order to manage the intense reactions of the residents to the situation and strengthen their coping skills” (Friedman-Peleg and Goodman 2010, 422). In addition, for civilians without intense reactions, mental health professionals designed “psychosocial interventions for the purpose of strengthening their personal and family resilience” (Friedman-Peleg and Goodman 2010, 423). The program placed a particular emphasis on empowering children, who were considered the most vulnerable members of the community at highest risk of mental health deterioration. Resilience coaching took place in workshops held at various elementary schools in the city. These workshops included training exercises showing participants how to recognize, verbally describe, and manage various emotions such as intense fear or anger. Imagery exercises taught workshop participants to mentally envision themselves in safe, pleasant environments despite being in a setting of intense danger and fear. Likewise, certain workshops helped Sderot civilians to cultivate positive thinking, hopefulness rather than pessimism, and personal strengths instead of deficiencies.

Furthermore, these sessions encouraged civilians to strengthen both their religious faith and their social bonds. Experts postulated that fostering deep spirituality and community ties would compel these individuals to seek meaning and purpose in a future traumatic event and to maintain a sense of connection to the community after such an event. In this way, entire groups were taught to embrace an attitude of confidence, self-determination, control, and social
connectedness in order to protect themselves from the insecurity, paralysis, and isolation that so often characterize posttraumatic stress (Friedman-Peleg and Goodman 2010, 431).

As a consequence of the resilience program in Sderot, new questions arose about the optimal population demographics, political climates, and implementation strategies for an effective approach to building community resilience. While many senior Israeli psychologists deemed the interventions a success, many others voiced concerns that too many financial and social resources had been devoted to healthy individuals without even a pathologic diagnosis. Even stronger criticisms highlighted the oversight of program directors who neglected to provide language interpreters for numerous immigrants living in the region, oversimplified the effects of underlying social iniquities among Sderot residents that impeded real community bonding, and disregarded the urgent need for more safe havens to protect civilians in physical danger (Friedman-Peleg and Goodman 2010, 436-37).

Despite the controversy surrounding the actual implementation of the Sderot program, the lessons learned in the international mental health community underscored the necessity of strengthening individuals and entire populations exposed to repetitive traumatic events. While the Sderot program demonstrated the possibility of resiliency training to prevent PTSD in an at-risk population, most resilience-focused interventions are directed towards individuals who have already been diagnosed with PTSD and can benefit from therapy to acquire coping skills.

**Resilience-building Interventions for Cancer Survivors**

A compelling example of resilience-building after trauma comes from the experience of young cancer survivors and their families. Psychiatrist Dawn Flosnik recounts the case of an eighteen year-old woman who had been diagnosed with brain cancer at the age of six. Despite
successfully completing surgery, chemotherapy, and radiation that led to her remission from cancer, her parents remained hypervigilant, overprotective, and chronically anxious about the ever-present risk of cancer relapse in their daughter. As a result, every headache or minor symptom triggered posttraumatic stress responses in her parents that, over time, impeded the development of a healthy parent-child interaction. While the daughter looked forward to becoming an independent adult, her parents suffered even more anxiety, and their family relationships became severely strained (Flosnik and Griffith 2011, 447-48).

As this example demonstrates, families of child cancer survivors are a population at high risk for developing posttraumatic stress symptoms. In fact, while up to 21 percent of the children develop PTSD, their parents have even higher rates with up to 25 percent meeting criteria for the diagnosis of PTSD (Flosnik and Griffith 2011, 448). Parents of affected children often have difficulty evaluating and guiding their children through normal developmental milestones for years after the initial diagnosis. Due to the long-term implications and recurrent stressors of a cancer diagnosis, it is essential that family members choose to respond to these stressors resiliently.

To address this need, Flosnik and colleagues employed a brief family intervention that combined traditional cognitive-behavioral therapy and resilience-building techniques. They specifically utilized the Surviving Cancer Competently Intervention Program (SCCIP), which is a one-day family workshop that has been tested in a randomized trial and validated as an effective tool for cognitive, behavioral, and resiliency therapy to reduce family anxiety (Kazak et al. 1999, 175-76). The workshop is comprised of four sessions that encompass education about the symptoms and consequences of PTSD, coping strategies, a video about constructive family development in the setting of cancer, and a final session to help families make concrete plans to
incorporate their new skills and perspectives in the immediate and long-term future (Kazak et al. 1999, 180-82). Family members who attended the day-long SCCIP program did, in fact, show a reduction in anxiety and posttraumatic stress symptoms six months after therapy.

Since thriving after cancer requires not only the management of anxiety but also a resilient approach to adversity, several key elements of SCCIP are geared towards resilience-building. As part of the coping session, family members practice the cognitive skill of “reframing beliefs,” which enables a distressed individual to accept circumstances that are outside of his or her control, refocus attention on conditions that are within the scope of control, and use positive thinking as well as personal strengths to accomplish change (Kazak et al. 1999, 180). In essence, this reframing skill helps family members develop and maintain an “inner locus of control,” which is a key characteristic of resilient individuals (Herman 1997, 58). In addition, all four sessions endow parents with the resilient perspective that they will need in order to help their children cope with the stresses of their cancer diagnosis. Therapists reassure families that their emotional and behavioral reactions to the traumatic diagnosis are normal. This message helps to diminish the sense of isolation, facilitate social connectedness to similar cancer-affected families, and thereby help to cultivate a resilient outlook. The program also increasingly highlights resilient family strengths by emphasizing that both the parents and children are “competent, able to adapt to adverse circumstances, and [able] to continue growing and developing as a family” in the very setting of their child’s disease (Kazak et al. 2005, 648). Given the successful outcomes for families enrolled early in SCCIP, Flosnik lamented that in the case of her 18 year-old patient with a history of brain cancer, earlier intervention with SCCIP or a similar program combining CBT and resilience therapy “could have reduced the subsequent family stress from anxious hypervigilance and its secondary effects on the mother-daughter relationship” (Flosnik and Griffith 2011, 448).
Summary

An emphasis on the prevention of posttraumatic stress in the setting of anticipated exposure to trauma shows promise when resilience is cultivated in a population at high risk for the development of new-onset or worsening PTSD. Resilience therapy can fortify individuals, families, and entire communities that have survived traumatic life events. While cognitive-behavioral therapy is essential for treating trauma survivors who already exhibit symptoms of posttraumatic stress, the added benefit of resilience-building interventions as part of that therapy can empower these individuals to achieve personal growth in the setting of adversity in order to thrive and not just survive future life disturbances. For this reason, a resilience-focused approach to therapy may be especially helpful for the population of female trauma survivors who choose to go through the life-changing and potentially traumatic experience of childbirth.
CHAPTER 3

STRESSORS OF NORMAL LABOR

The unique experience of delivering a baby is physically, mentally, and emotionally stressful for the majority of women. To understand the additional challenges facing women with a history of past trauma, it is first necessary to examine some common stressors of childbirth. The very concept of “normal” or uncomplicated childbirth is an oversimplification of a highly complex cascade of events. Even if a birth is deemed medically uncomplicated, the experience of delivering a baby is often fraught with severe physical discomfort, psychological stressors, and a loss of control over internal and external events for women from diverse cultures, social backgrounds, and prior birth experiences.

Pain as a Stressor in Childbirth

The most obvious physical stressor for women in labor who have a natural vaginal delivery is pain. Unlike almost every other category of pain, which stems from tissue damage or a pathologic disease process, labor pain is unique in its association with a non-pathologic process (Lowe 2002, S16). Although medical research still has not identified the exact physiologic trigger that initiates the process of labor, science has uncovered the important hormonal and biochemical changes that lead to uterine contractions and their associated labor pains (Gabbe 2012, 268-270).

In most cases, the onset of labor is marked by uterine muscle contractions that occur rhythmically and increase in both frequency and intensity. These contractions are coupled with the gradual softening, dilation, and thinning of the cervix. Oxytocin, which is released from the pituitary gland in the brain, is the primary hormone responsible for generating the involuntary,
rhythmic contractions in uterine smooth muscle that will eventually create enough pressure to propel a fetus down and out of the uterus. At the same time, the body releases certain naturally-occurring inflammatory substances termed prostaglandins that soften and prepare the cervix to accommodate the passage of a fetus from the intrauterine environment, through the birth canal, and into the outside world (Gabbe 2012, 268-270).

The actual discomfort that many women experience during a typical 60 to 90 second contraction is related to the complex of nerves that innervate the uterus, cervix, and vagina. In the first stage of labor, uterine contractions and cervical dilation activate nerve fibers that travel through the thoracic region of the spinal cord to the brain, where they are interpreted as painful stimuli. As labor progresses, the gradual descent of the fetus from the relatively spacious uterus into the mother’s smaller, bony pelvis causes the sensation of tremendous pressure in her lower abdomen, lower back, pelvic floor, and buttocks. Finally, the actual expulsion of a fetus requires a remarkable degree of painful stretching and often tearing of the tissue inside and around the vaginal opening (Gabbe 2012, 362-365). All of these physiologic factors cause escalating and often distressing discomfort that lasts for hours and sometimes days. One mother reminisced:

Right before the baby is born, when his head is pushing up against the perineal tissue, it burns like fire. And really, there’s no getting away from it, or not feeling it. You just have to go straight through it, and push him through. It’s really hard and you can’t see that the pain will be over . . . . (Clark Callister et al. 2003, 148)

The significance of pain and its effects in labor are profound. It is now understood that the sensation of pain triggers a biochemically-mediated stress response that has direct and indirect effects on the mother’s physiology, her mental state, the course of labor, and even the fetus. Animal studies on several mammals have demonstrated that painful stimuli cause a release of the adrenal stress hormone cortisol, the catecholamines epinephrine and norepinephrine, and other
biochemical factors that increase the heart rate, elevate blood pressure, and prepare the animal for fight or flight (Gabbe 2012, 363-364). That same stress response, however, causes a decrease in blood flow to the uterus. In humans, this can sometimes lead to a dysfunctional labor pattern, a heightened level of discomfort with each contraction, maternal hyperventilation, and an insufficient delivery of oxygen to the fetus (Gabbe 2012, 363-364). Reducing the severity and impact of pain during labor often involves the use of relaxation techniques, narcotic administration, or epidural anesthesia.

Women who undergo a planned, uncomplicated cesarean section also may experience pain as a significant stressor. Although spinal or epidural anesthesia is routinely administered before surgery in order to block the sensation of sharp pain during the procedure, mothers often have post-operative discomfort from the skin incision and from uterine cramps that normally take place in the weeks following cesarean or vaginal delivery (Gabbe 2012, 362-363).

While much is known about the physiology of pain, assessing a woman’s degree of suffering is much more difficult. Various emotional, social, and cultural factors contribute to an individual woman’s perception of pain and suffering in childbirth. In a qualitative study of pain perception using validated pain scoring instruments including the McGill Pain Questionnaire, the Visual Analogue Scale, and the Present Pain Intensity scale, women commonly described their early labor pains as “tiring, exhausting, intense, and troublesome” (Brown, Campbell, and Kurtz 1989, 293). After five centimeters of cervical dilation, which marks the transition from early to active labor, a majority rated pain as “distressing, horrible, and excruciating” (Brown, Campbell, and Kurtz 1989, 293). However, a portion of women who indicated their pain numerically at the “horrible or excruciating” level avoided using the corresponding descriptive words because the terms “horrible” or “excruciating” carried a negative connotation that conflicted with their overall
positive perception of childbirth (Melzack 1981, 359). Cultures that celebrate natural birth without pain medication generally prepare women to anticipate pain as an integral and necessary component of labor. These mothers are generally satisfied with their natural birth experiences despite pain scores that are essentially equivalent to those from laboring women from different cultures that tend to vilify pain and embrace pharmacologic intervention (Lowe 2002, S20). Across various studies, consistent predictors of higher pain scores include severe menstrual cramps prior to pregnancy (Melzack and Belanger 1989, 227; Harrison 1991, 471) and high anxiety related to the fear of pain (Lang et al. 2006, 267; Harrison 1991, 469). Conversely, women with the most positive pain perceptions appear to be those with the greatest confidence in their ability to cope with the pain that they expect to encounter in labor (Clark Callister et al. 2003, 146-147; Lowe 1989, 240). Cultural and personal expectations thus play an important role in mediating women’s perceptions of pain and suffering in childbirth.

Psychological Stressors in Childbirth

In addition to physical pain, psychological factors can also independently trigger the stress response. Animal studies have demonstrated that inducing psychological stress with bright lights or other anxiety-provoking trigger sets off the same cascade of hormones that govern the fight-or-flight response to physical stressors (Gabbe 2012, 364). While women typically experience a wide range of shifting emotions during the course of labor, anxiety can contribute significantly to the level of psychological stress generated during the labor process.

A certain level of anxiety is normal and expected during labor, particularly for women who have not experienced a prior delivery. For first-time mothers, childbirth fears often arise from an uneasy anticipation of the unknown, disturbing pregnancy and childbirth information
from various sources, or negative stories from other women. Multiparous women, who have delivered a baby in the past, more often report anxiety related to prior negative birth experiences (Melender 2002, 109). Studies in Western countries including the United States, Italy, and Sweden have found that women who express a fear of labor often have underlying concerns about fetal well-being and the prospect of losing aspects of control over their environment and over their bodies (Lowe 2000, 222; Saisto and Halmesmaki 2003, 204). A closer look at some of these issues illustrates how understandable such worries can be for expectant mothers.

Fetal Well-being

Concern for fetal well-being appears to preoccupy a large number of women from various cultures as pregnancy progresses. Studies of expectant mothers in their third trimester of pregnancy revealed that over 25 percent of Swedish, Italian, German, and Hungarian women expressed some anticipatory fear of fetal injury or fetal death on pre-delivery questionnaires or interviews (Saisto and Halmesmaki 2003, 204). In a study of 280 nulliparous women in the United States, 52 percent expressed a fear of labor. A substantial number cited “something being wrong with the baby” as a reason for their anxiety (Lowe 2000, 222).

Fears related to fetal injury or death may stem from obstetric provider precautions during prenatal care, prior pregnancy losses, knowledge of obstetrical emergencies, narratives of friends or family members who have experienced fetal complications, or from written and televised materials that have highlighted cases of labor complications resulting in fetal injury (Melender 2002, 106). During the third trimester of pregnancy, for example, obstetric providers routinely encourage expectant mothers to assess the presence of fetal movement at various times throughout the day as a reassuring sign of fetal well-being (Froen 2004, 13). Obstetricians
generally stress that the sudden decrease or absence of typical fetal movements should prompt an urgent visit to the hospital for a clinical assessment of fetal status. While it is common for providers to emphasize this precaution in prenatal care, it may also become a source of patient anxiety. Some decreases in fetal movement are expected during a normal fetal sleep cycle or when the fetus has grown to occupy enough intrauterine space that there is little room to kick vigorously. For women who have experienced a previous miscarriage or a late fetal loss in a prior pregnancy, the uneasy anticipation and the sensation of transient decreases in fetal movement can generate significant alarm that may persist even when ultrasound and fetal heart rate monitoring evaluations are reassuring (Eller, Branch, and Byrne 2006, 446). In this way, routine prenatal care instructions can sometimes contribute to a sense of fear.

Other apprehensions about fetal well-being may be linked to a general public awareness that obstetrical emergencies can and do occur. With stillbirths in developed nations averaging 5 out of 1000 births, poor outcomes involving unexpected fetal death are relatively rare in the practice of modern obstetrics (McClure, Goldenberg, and Bann 2007, 141). Individual cases, however, may result in high profile litigation or media attention that tends to heighten the public’s perception of fetal risk during normal labor. In an attempt to reduce this risk, many hospital labor and delivery wards employ continuous electronic fetal monitoring, which traces the heart rate of the fetus during the entire course of labor in order to alert the medical team about any sudden change in fetal status that might warrant an operative delivery. Physicians, nurses, residents, and medical students typically enter each room on the labor and delivery unit at routine intervals to review the fetal heart tracings for reassuring signs of fetal well-being. As a result, some women understandably become preoccupied with the constant tracking of the fetal monitor, for they worry that every fluctuation of the fetal heart rate may signal a potential problem. Despite the
fact that electronic fetal monitoring has had a negligible impact on reducing rates of fetal morbidity since its introduction in 1970, it remains the mainstay of fetal surveillance during labor (Lyerly 2009, 37). Hence, even technology designed to reduce the risk of fetal death or injury may contribute to a mother’s level of anxiety during labor.

The Hospital Environment

Multiple environmental factors can also influence a laboring woman’s level of psychological stress in a hospital setting. First-time mothers opting to deliver at a hospital facility are often unfamiliar with the disorienting and often surreal nature of the hospital environment. Environmental psychology studies have identified multiple stress-inducing hospital features including noise disturbances, strange odors (Dijkstra, Pieters, and Pruyn 2006, 175), glaring lights, limited privacy, and windowless walls with minimal visual stimulation (Ulrich 1992, 23-4). Labor and delivery units vary in their design across private and public hospitals from beautifully-decorated, private labor suites to dreary, colorless, and hectic labor wards with multiple beds per room that are divided by curtains (Janssen et al. 2000, 236). A disconcerting lack of privacy, an absence of comfortable features, and the overall drab appearance of some hospital facilities are external factors that may add to the inherent stressfulness of hospital admission (Sosa et al. 1980, 600).

On the hospital labor and delivery unit, additional structural, procedural, and personnel-related elements can add to the apprehension of a new patient. Labor and delivery units function in many hospitals as specialized emergency rooms, with monitors placed along the walls, frequent alarms beeping, and periods of quiet busy work punctuated by sudden bursts of frenetic urgency when obstetrical emergencies occur (Simkin and Klaus 2004, 61). A new patient may
arrive in labor when the unit appears calm or in the midst of an emergency code, when she is almost certain to become alarmed at the sight of a swarm of nurses, physicians, and technicians hurrying to the operating room with a woman on a stretcher.

Even the appearance, interaction, and apparent hierarchy of members of the medical team can create confusion and some anxiety for patients. First, many women whose obstetricians belong to large group practices will encounter unfamiliar physicians and nurses at the time of delivery who did not provide their prenatal care (Simkin and Klaus 2004, 61; Sperlich and Seng 2008, 90). The various medical personnel on duty at the time of admission may comprise a team of attending physicians, medical residents in training, medical students, nurses, certified midwives, physician assistants, technicians, and other ancillary staff (Collins-Fulea 2009, 288-89). Understandably, the various uniform colors and lengths that were designed to distinguish these individuals according to their titles and experience can easily confuse someone who was previously unaware of the distinct roles of an attending, a resident, and a student. At each change of shift, an entirely new team may be assigned to assume patient care. Hence, the challenges of interacting with her shifting care teams can add an additional level of stress.

Environmental factors may influence even the ability to cope with pain. A study in Denmark comparing women who chose to deliver in birth centers to those who delivered in a hospital setting revealed that in the hospital, women utilized pain medication at four times the rate of those in birth centers (Skibsted and Lange 1992, 184). Interestingly, among women who had planned to deliver at a birth center but were forced to deliver in a hospital due to a lack of birth center rooms, the rate of pain medicine administration equaled that of women who had planned a hospital birth (Skibsted and Lange 1992, 184). This suggests that the hospital environment itself may introduce peculiar elements such as restricted movement during labor and caregiver practices.
that affect a woman’s stress level and coping mechanisms (Skibsted and Lange 1992, 186; Lowe 2002, S21). All of these environmental factors are potential sources of anxiety for the laboring woman.

**Loss of Control and the Role of Autonomy**

Given the very nature of childbirth as an involuntary and spontaneous event, mothers inevitably lose a certain degree of control over their bodily functions once labor begins. One Swedish mother describes her labor pains as a “giant wave that’s coming ashore and you are forced to follow the wave, and if you fight against it . . . you can’t . . . it just turns worse so [you] have to follow” (Lowe 2002, S22). While some women adjust to these waves without necessarily experiencing distress, others may find the process disconcerting and frightening. Issues of bodily control, therefore, arise throughout the course of labor.

One factor that appears to contribute greatly to a mother’s overall satisfaction with her birthing experience is the level of control that she is able to exercise over some aspects of her own labor (Lowe 2002, S22; Goodman, Mackey, and Abbas 2004, 212). Narrative analyses of in-depth interviews before and after delivery identified “self-determination, respect, personal security, attachment, and knowledge” as the five most important domains that influence women’s perceptions of a “good” birth (Namey and Lyerly 2010, 771). All of these factors involve distinct aspects of control. For some women, exercising control as self-determination meant making choices and “directing, ordering, or taking charge of events” as the primary agent of the delivery process (Namey and Lyerly 2010, 772). Women valued the notion of respect in terms of their own capacity for self-control, as in the ability to refrain from screaming, as well as the expectation that they could best maintain self-control in the presence of caregivers who would
treat them with honor and dignity (Namey and Lyerly 2010, 773). A desire for the sense of control over the surrounding environment and for the appearance of order rather than chaos led other women to define control as personal security (Namey and Lyerly 2010, 773). Attachment was an important element of control when women were able to have familiar, supportive friends and family around them during labor. Finally, knowledge about the common physical and psychological changes that they could expect in childbirth allowed some women to anticipate and understand their experiences, which enabled them to preserve mental control despite the loss of bodily control (Namey and Lyerly 2010, 774). These various definitions of control underscore its complexity and significance for many laboring women.

In a broader context, these expressions of control also represent important aspects of autonomy in labor. Among the various conceptualizations of autonomy that biomedical ethicists have put forth to describe this principle, Beauchamp and Childress define personal autonomy as the capacity to act as an independent agent who is able to make choices deliberately, with a high degree of understanding, and without undue influences (Beauchamp and Childress 2009, 100-101). Feminist theory has further illuminated the significance of certain relational components of autonomy, which emphasize the influence of communal relationships on an individual agent’s exercise of choice in light of his or her interdependence on others (Donchin 2001, 377-78) (Friedman 2000, 40-41). These notions of autonomy echo the themes of self-determination, attachment, and knowledge that comprise the domains of control, which are central to laboring women’s birth perceptions. Without the sense of being actively engaged in decision-making about certain aspects of her delivery, the birthing environment, the presence of family members, access to information, and her choice of coping strategies in labor, a woman can feel helpless due
to a diminished sense of control. In this way, the exercise of control signifies the ability to act autonomously.

Even in uncomplicated labor, a mother may experience a limitation of her autonomous control and a considerable source of stress. A woman who hopes to eat and drink lightly during labor, for example, may be dismayed to encounter individual clinicians or hospital policies that advise against eating in the active phase of labor. Although an obstetrician might discourage eating for a sound reason, the risk of aspirating stomach contents in the event of an urgent cesarean section requiring general anesthesia, the probability is low that this will occur for a woman with an uncomplicated pregnancy (Singata, Tranmer, and Gyte 2010, under Abstract). In cases like this, when a laboring woman’s wishes conflict with the recommendations of the medical team, she may feel strongly that her control has been unjustifiably limited in the medical decision-making process.

At other times, a woman’s sense of autonomous control over her labor process dissipates in the setting of unanticipated emergent circumstances in which medical decisions must be made quickly without the luxury of lengthy deliberation. When the fetal heart tracing suddenly shows prolonged or repetitive decelerations, the obstetrical team is trained to respond immediately with maneuvers to improve blood flow and oxygen delivery to the fetus (Macones et al. 2008, 664). If the tracing remains concerning, the obstetrician will often have a brief counseling discussion and recommend a cesarean delivery with a tone of urgency. For a mother who strongly desired a normal vaginal delivery, the rapid change of events and the time-pressured consent that she must give in order to proceed with surgery can seem overwhelming and frightening. Although consenting to the procedure is a manner of exercising personal autonomy, this mother is unlikely to view the consent process as empowering in this emergent setting. As one mother recalled, “It
was a frightening experience, so I guess whenever you are in a frightening experience you don’t feel in control . . . like you normally do” (Namey and Lyerly 2010, 773). Hence, the particular circumstances of a mother’s labor course can determine the degree of control that is possible during labor and delivery. At times, such limitations can become a significant source of stress for women in labor.

**Achieving a Positive Birth Experience**

Certain elements of a woman’s birth experience can help to reduce childbirth-related stress and promote positive birth perceptions. Studies have demonstrated that one important predictor of a positive-birth experience is the presence of support during labor (Sosa et al. 1980, 598; McGrath and Kennell 2008, 92). Family members, friends, or coaches attending the laboring mother’s delivery often provide meaningful comfort that mitigates anxiety. These individuals can encourage and reassure the mother through her entire range of emotions, which might include anticipation, frustration, fear, disappointment, exhilaration, and relief at various points during the labor process. The presence of support appears to be so important that mothers with a doula, a trained labor coach, have a lower risk of cesarean delivery, a reduced need for epidural analgesia, and generally high satisfaction with their birth experiences (McGrath and Kennell 2008, 92).

Perhaps an even stronger predictor of effective stress management is a woman’s sense of self-efficacy for labor (Manning and Wright 1983, 421; Lowe 2000, 223). Women who are confident in their ability to cope with the anticipated stressors appear motivated to utilize numerous coping strategies like breathing techniques, relaxation strategies, and other stress-coping mechanisms in the early and active phases of labor (Lowe 2002, S21; Larsen et al. 2001,
Since self-efficacy is a quality of resilient individuals (Karademas 2006, 1288), a woman’s degree of resilience appears to be an integral component of effective stress coping in labor and, consequently, a positive birth experience.

Finally, the ability to exercise control over certain elements of the delivery process shapes many women’s perceptions of a satisfying birth (Namey and Lyerly 2010, 775; Goodman, Mackey, and Abbas 2004, 212). When a mother maintains a reasonable degree of control over the process of her childbirth experience, she may acknowledge and even master the intense pain of labor without perceiving it as intense suffering (Lowe 2002, S22). For some women, a satisfying birth may depend on their ability to make informed choices about whether and when to request an epidural for pain management, whether to accept oxytocin augmentation to increase the strength and frequency of contractions when labor has stalled, and whether or not to proceed with a cesarean section when labor is no longer progressing. For others, it may involve the achievement of bodily self-control and the ability to focus during the most difficult phases of labor (Namey and Lyerly 2010, 772). While the nature of desired control is multi-faceted and unique for each woman, the clinician’s willingness to respect important aspects of autonomy can greatly contribute to a woman’s positive experience of labor and delivery.

Summary

Childbirth is an unusually stressful event for many women. The physical and psychological stressors of pain, anxiety, and diminished control all lead to the activation of a common stress response that has effects on the mother’s physiology, her mental state, the course of labor, and the fetus. In addition to the involuntary, escalating frequency and intensity of uterine contractions, many women have reasonable concerns about fetal well-being, unfamiliar
features of the hospital environment, and their ability to maintain control. Each of these factors can contribute to surges of anxiety at various times during the normal course of labor.

Although the stressors of childbirth are intense and memorable, they do not cause lasting distress for most women. For those with a history of PTSD, however, the common features of childbirth and maternity care can have amplified psychological and physiological effects that add to a laboring woman’s experience of stress. As the next chapter will explore, these additional trauma-related factors are often compounded with the normal stressors of labor to have a potentially negative effect on a woman’s experience of childbirth.
CHAPTER 4

MAJOR AND MICRO-TRIGGERS FOR POSTTRAUMATIC STRESS RELAPSE IN CURRENT OBSTETRICAL PRACTICE

The previous chapter explored ways in which the normal course of labor and delivery may cause a considerable degree of stress for women. In the special case of a woman with a prior history of PTSD, the childbirth experience may also trigger emotional and physical memories that lead to a resurgence of acute stress symptoms. While the delivery process in its entirety can be considered a major trigger for symptom relapse in some trauma survivors, there are many less obvious points along the continuum of prenatal, intrapartum, and postpartum care that can also trigger the exacerbation of posttraumatic stress symptoms. A closer look at these more subtle triggers, which clinicians might view as *micro-triggers*, reveals that even minor, standard clinical practices can generate significant posttraumatic stress reactions with important health consequences. Identifying these micro-triggers is critical, for it opens up the possibility of reconsidering certain practices and tailoring them to better support and empower this unique population of women.

Prenatal Care Micro-triggers

From the perspective of many trauma survivors, the initial prenatal care visit with a new obstetrician often determines their level of confidence in the clinician’s competency to provide trauma-informed care. Patients who have undergone previous psychotherapy for a history of past abuse, for example, are often aware of their own symptom triggers and may be empowered enough to select physicians who appear to understand their needs and who are sensitive to those triggers (Seng et al. 2002, 365). One such survivor reflected that early in her pregnancy she
worried that she “wasn’t sure if all the exams and all that stuff was gonna trigger a lot of things. . .” so she switched from one unaccommodating prenatal care provider to another who was “very receptive, and things progressed actually really well” (Seng et al. 2002, 365).

Other survivors who have not had prior psychotherapy may have more limited knowledge about the connection between their own symptoms and triggering events that might occur during the course of their pregnancies or in face-to-face consultation with their prenatal care providers. Trauma survivors interviewed in a study of patient perspectives on maternity care practices revealed that some women were not ready to confront disturbing memories of childhood abuse that they had managed to compartmentalize away from daily adult life (Seng et al. 2002, 365). As one woman explained, “I kind of knew in some way it was affecting me, but I just couldn’t connect the dots ever . . . but when I got pregnant it all just came out, came clear, and it was hard . . .” (Seng et al. 2002, 365). Such patients may not be able to anticipate certain triggers or advocate effectively for themselves when selecting a prenatal care provider. It is therefore important for obstetricians to consider some ways in which obtaining a new obstetrical patient’s medical history, performing a comprehensive physical exam at the initial prenatal care visit, and establishing rapport in the doctor-patient relationship might cause micro-trigger exacerbations for pregnant trauma survivors.

**Cursory Trauma Screening as a Micro-trigger**

Identifying pregnant women with risk factors for physical and mental health complications begins early in prenatal care. At the first or second prenatal visit, obstetricians often inquire about a mother’s prior history of depression, anxiety, domestic abuse, alcohol, tobacco, or illicit drug use, and past trauma. Recommended guidelines for perinatal care
suggested by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) provide a structured framework for eliciting a complete medical, surgical, social, and family history in an efficient and organized way. These guidelines include sample checklists of screening questions that health care providers may utilize at various points during the course of prenatal and postpartum care (AAP and ACOG 2012, 463 Appendix A). Any positive answers to screening questions prompt the physician to flag these issues as problems that may warrant additional attention if they impact the pregnancy, delivery, or the overall wellbeing of the woman. Depending on the available time for the office visit and the urgency of the newly discovered problem, the obstetrician may seek additional information at the initial visit or over the course of the next several appointments.

The screening for prior trauma that is suggested in the standard ACOG prenatal care flow sheet is non-specific and open to the health care provider’s interpretation. It consists of a checkbox marked “trauma/violence,” two corresponding boxes to record a positive or negative response, and additional space in the margin to write important comments (AAP and ACOG 2012, 463 Appendix A). With no given definition of trauma provided and little medical school or residency training specifically addressing trauma in this population, obstetricians address this checkbox in a variety of ways. The physician may choose to elicit a trauma history in a cursory fashion by inquiring, “Have you ever been in a traumatic or violent situation?” Depending on the woman’s socioeconomic background, education level, experience with the mental health system, and familiarity with the significance of the word “traumatic,” she may respond with varying degrees of confusion or denial of any such history. Instead of formulating a generic screening question, the obstetrician could opt for a more direct approach such as, “Have you ever been the victim of a sexual or physical assault, military or civilian war-related violence, or a natural
disaster?” Phrasing the question with this level of specificity will likely clarify the concept of “trauma” for the patient. Obtaining a more detailed and pertinent history in this way may also present greater challenges for the physician that require more training, sensitivity, and time commitment than is possible in a typical fifteen minute prenatal care visit. In either case of general or directed initial history-taking for prior trauma, the physician has little to guide him or her in formulating the most effective screening approach.

In the event that a woman does have a history of prior trauma, the very nature of screening makes it a possible micro-trigger for uncovering posttraumatic stress symptoms. Anxiety, suspicion about the significance of such personal questions, and even indecisiveness over whether to reveal or deny this history to a new doctor at the initial prenatal care visit may reasonably preoccupy the patient. Skepticism and distrust may be significant factors, particularly for women from low-income, ethnic minority groups with a historically low rate of accessing mental health services. Focus group interviews conducted with pregnant women from urban populations with low socioeconomic backgrounds found that women overwhelmingly valued confidentiality when discussing personal issues concerning mental health (Leis et al. 2011, 314). Some expressed a general apprehension about revealing information about their emotional or mental state that might prompt a Child Protective Services investigation or that might interfere with their ability to qualify for a job (Leis et al. 2011, 316-317). Obstetricians who are unfamiliar with the PSTD characteristics of heightened arousal, intrusive memories, and avoidance behaviors may never recognize these signs and symptoms if a patient decides not to disclose them at the initial screening visit.

Equally alarming is the potential for a physician to elicit and possibly intensify chronic posttraumatic stress symptoms through the very act of screening without a concrete plan to
address the problem. Once a patient answers “yes” to an initial screening question about prior trauma, few health care providers are fully prepared to respond with additional longer prenatal visits, a validated formal screening questionnaire for PTSD, referral to mental health services, and patient education about the nature of PTSD and its impact on pregnancy, labor, and the postpartum period. It is therefore concerning that the cursory method of screening in many obstetric practices is vague, inconsistent, incomplete, and problematic for both patients and physicians.

Physical Exam Micro-triggers

A new patient visit usually involves a thorough physical exam after completion of the comprehensive patient history. In addition to a standard examination of the woman’s head, neck, heart, lungs, and abdomen, a breast exam and pelvic exam are routinely performed. For some trauma survivors, this exam is anything but routine. Both the breast and the pelvic portions of the physical exam can generate intense anxiety, flashbacks of prior fondling or penetration, and even dissociation as a means of mentally escaping from the experience of the exam (Weitlauf et al. 2010, 1272; Ackerson 2012, 683). Over 40 percent of childhood sexual abuse survivors in a western European study reported re-experiencing memories of earlier abuse during a gynecologic evaluation (Leeners et al. 2007, 389). Similarly, sexual trauma survivors with PTSD from a cohort of female military veterans in the United States recounted high levels of embarrassment, distress, and fear associated with pelvic examination (Weitlauf et al. 2010, 1275). In the prenatal care office setting, some women may not be aware that their initial visit will include a pelvic examination. Without time for mental preparation, the experience may trigger distress, shame, and sometimes panic at the prospect of lying powerless on an exam table with legs spread apart,
covered only by a thin drape, with the examining doctor leaning over her and urging her to “relax.”

In addition to the triggering effect of the exam itself, a physician’s response to a survivor’s expressions of fear can also be perceived as re-traumatizing. Touching her genitals without asking permission first, insisting on completion of the exam, or forcing the patient’s legs apart are all responses that most clinicians would label as inappropriate. However, attempting to reassure her by suggesting that “this won’t hurt” is also a micro-trigger for some women as evidenced by interviews with trauma survivors (Leeners et al. 2007, 389). It is often very challenging for a clinician to encounter a patient who needs 20 or 30 minutes to collect herself and mentally prepare for an exam that normally takes 20 or 30 seconds. Even trauma-sensitive clinicians must struggle with the tension between the desire to provide reassurance and extra time for a vulnerable, panicked patient and the tremendous pressure to keep the office running efficiently so as to avoid inconveniencing other patients. Any expression of frustration or even mild annoyance can heighten a woman’s already acute sense of embarrassment and shame.

**Micro-triggers in the Doctor-Patient Relationship**

Beyond the triggers that might arise during a physical exam, the very nature of the doctor-patient relationship can trigger certain posttraumatic stress reactions during the course of prenatal care. Many adult survivors of interpersonal trauma have described their uneasiness stemming from relationships in which they feel powerless or controlled by another (Seng and Hassinger 1998, 289; Simkin and Klaus 2004, 53). By virtue of the unequal balance of power between a physician and patient, who is necessarily the more vulnerable and dependent party in the relationship, certain relational aspects of the physician-patient interaction can heighten a
trauma survivor’s perception of this power imbalance. While this power differential is readily apparent when a physician has a firm, authoritative communication style, it can be a factor even with a mild-mannered, nurturing caregiver. According to the normative traditions of the health care delivery system, clinicians generally have a higher level of medical expertise, knowledge, and hierarchical status relative to the patient (Seng and Hassinger 1998, 289). This power differential can result in a sense of vulnerability that may be exacerbated in pregnancy, when common symptoms like the sensation of fetal movement and unavoidable bodily changes occur. These sensations can signify a loss of control that can be extremely disturbing for some trauma survivors. The additional pressure to trust and depend on an authority figure, the obstetrician in this case, can further intensify the experience of vulnerability (Simkin and Klaus 2004, 121).

The power dynamics in the patient-doctor relationship appear to be particularly important for the woman with a history of trauma resulting from sexual abuse in childhood. Childhood sexual abuse (CSA) appears to confer a higher risk of PTSD and associated pregnancy implications than any other form of trauma (Lev-Wiesel and Daphna-Tekoah 2009, 877). CSA survivors may display a variety of avoidance or hypervigilant behaviors that can affect prenatal care. Some women may avoid seeking prenatal care until late in pregnancy, forget to complete prenatal laboratory testing, and miss appointments. Others may schedule numerous visits and become obsessed with bodily changes that are normal in pregnancy (Leenersa et al. 2006, 877-8). Many victims of childhood sexual abuse previously learned to dissociate, or mentally escape from their bodies, in order to endure past episodes of abuse. As these trauma survivors mature into adulthood, residual dissociative tendencies can lead to emotional dysregulation that increases the risk of PTSD and other mental health disorders (Lev-Wiesel and Daphna-Tekoah 2009, 877). Emotional dysregulation can become apparent in personal relationships, as many survivors have
difficulty interpreting or trusting the actions and intentions of other people. A resulting tendency to exhibit extreme reactions of anger to seemingly minor events can lead to a cycle of unstable relationships, fear of abandonment, clingy behavior, impulsive or self-harming behavior, and further emotional reactivity that threatens the stability of new relationships (Sperlich and Seng 2008, 25). During pregnancy, a survivor struggling with emotional dysregulation is likely to exhibit similar interpersonal reactions with her prenatal care provider. Physician responses to excessive neediness, avoidance behaviors, or apparent refusal to comply with medical advice often determine the acuteness of micro-triggers related to emotional dysregulation that arise during those interactions.

Some women with a history of childhood sexual abuse manifest hypervigilance by asking numerous questions during prenatal visits, frequently calling their obstetric providers, and anxiously recording every new sensation or discomfort during pregnancy (Hobbins 2004, 490). In some cases, anxiety-related symptoms such as persistent vomiting or preterm contractions can become so severe and distressing that they lead to multiple emergency room visits for abuse survivors with PTSD (Seng et al. 2001, 17). A clinician who is not aware of a survivor’s potential challenges with regulating emotion may not recognize the micro-triggers arising from seemingly benign but short physician responses to questions about common physical discomforts of pregnancy. What the clinician may view as an opportunity to give prompt reassurance about fetal well-being, the survivor may perceive as an attempt to minimize or brush over her legitimate concerns about troubling symptoms (Simkin and Klaus 2004, 45). On the other hand, a physician’s attempt to answer multiple phone calls can eventually become exhausting and difficult to manage logistically in the setting of a busy obstetrical practice with time constraints and other physician responsibilities. Explaining the limitations of office visits or after-hours
access to one’s primary obstetrician may trigger strong emotions in a hypervigilant abuse survivor. Although the patient may have misinterpreted the caregiver’s good intentions, those physician responses that she views as insensitive or patronizing may trigger an acute sense of powerlessness, reactive expressions of anger, and in some cases, the decision to avoid future prenatal visits with that caregiver.

A patient’s tendency to miss numerous visits or to appear passive and disengaged during prenatal care visits may be signs of posttraumatic avoidance behavior. Avoidance often takes the form of detachment, the symptom most strongly associated with PTSD in pregnant women (Seng et al. 2010, 182). Survivors have described detachment as a blunted awareness ranging from emotional numbness to dissociation as a method of coping with stressors (Seng et al. 2002, 367). One childhood abuse survivor recalled “becoming submissive again” during her pregnancy as she reflected, “I was completely passive . . . I didn’t advocate for myself at all . . . and my prenatal care, I think I dissociated during my visits . . . I don’t have good recall with what exactly went on” (Seng et al. 2002, 367). Patients who seem to be distant, nonchalant, or lacking interest in self-care can present challenges for a caregiver, who may not recognize these as posttraumatic signs of detachment. A busy obstetrician who encounters a patient after several missed appointments may reasonably document that this patient is noncompliant with her prenatal visits, inquire briefly about any barriers to keeping her appointments, warn her about the dangers of insufficient prenatal care, and move on to the next order of business related to her abdominal exam and an evaluation of fetal well-being. Although in this case emotional dysregulation does not necessarily disrupt the clinical encounter, it does impair the physician-patient interaction. Rather than encouraging the patient to become actively engaged in her own self-care, a
physician’s visible disappointment or attempt to motivate her with stern warnings about potential fetal harm may inadvertently trigger further detachment and avoidance.

Just as emotional dysregulation can be associated with extreme irritability or emotional numbing, it can also trigger maladaptive self-soothing tendencies in the form of smoking or substance abuse (Strine et al. 2012, 14; Seng, Sperlick, and Kane Low 2008, 514-515; Lopez, Konrath and Seng 2011, 427; Dejin-Karlsson 1996, 33-34). Studies of tobacco use among adult women exposed to childhood abuse have suggested that nicotine actually helps to regulate emotional instability and reduce psychological distress in women previously exposed to various forms of childhood trauma (Strine et al. 2012, 13; Lopez, Konrath, and Seng 2011, 423; Blalock et al. 2011, 659). While smoking is a known risk factor for adverse perinatal outcomes, and it is typically viewed as irresponsible in the setting of pregnancy, smoking may actually serve an important function for mood regulation in the absence of psychotherapy. Clinicians who fail to recognize the connection between emotional dysregulation and attempts at self-soothing with tobacco, alcohol, disordered eating, risky sexual practices, or other high risk behaviors are liable to miss the underlying trauma history when counseling these patients to avoid such practices during pregnancy. A physician’s frustration, exasperation, or even chastisement in response to a woman’s apparent noncompliance with medical advice may not only be ineffective, but it may also trigger an exacerbation of shame, anger, and the impetus to continue the same unhealthy self-soothing behaviors.

Moreover, a physician’s approach to shared decision making regarding a patient’s delivery preferences can trigger various reactions in prenatal care. By the end of the third trimester of pregnancy, a woman and her doctor have most likely discussed the anticipated timing and type of delivery. This conversation is usually straightforward, with the majority of patients
desiring and the majority of physicians recommending a spontaneous vaginal delivery in the absence of other complicating factors. However, the ethical obligation of the obstetrician to respect patient autonomy through an approach of shared decision-making involves active collaboration and consideration of patient values and priorities (Kukla et al. 2009, 2). This may present challenges for physicians in the case of patients with a history of abuse or PTSD. Because women with chronic symptoms of PTSD exhibit persistent avoidance behaviors from a subconscious need to block out associations and reminders of the original traumatic event, some may never voice their delivery concerns. Others may request a cesarean delivery in order to avoid what they anticipate to be an unbearably distressing vaginal delivery (Hofberg and Brockington 2000, 84-85). A woman may be at high risk for PTSD relapse if she feels ill-equipped to cope with the stressors of a vaginal delivery and if she feels powerless to influence the mode of delivery recommended by her obstetrician.

**Micro-triggers in the Preparation for Delivery**

Shared decision making between the patient and health care provider regarding the mode of delivery appears to be particularly important for the woman with a history of sexual abuse. A case series of 26 women by Hofberg et al. demonstrated that an intense phobia of childbirth, termed “tokophobia,” was highly associated with a history of childhood sexual abuse or sexual assault (Hofberg and Brockington 2000, 84). Half of the women in that study requested a planned cesarean delivery. Those women whose delivery expectations were ignored by their providers developed a high rate of postpartum depression and posttraumatic stress symptoms after unplanned vaginal delivery or emergent cesarean section (Hofberg and Brockington 2000, 84-85). Likewise, Eberhard-Gran et al. determined that women with a history of sexual abuse had a four-fold increased risk of developing an intense fear of labor (Eberhard-Gran, Slinning, and Eskild
2008, 259). Ideally, a fear of childbirth should be explored and addressed in prenatal care long before the day of delivery.

The obstetrician’s recognition of delivery fears, level of concern, and approach to counseling may have a significant impact on micro-triggers that emerge around upcoming plans for delivery. While it is clear that a healthcare provider must consider a patient’s values and priorities when formulating recommendations for the optimal plan of care, it is challenging to determine how shared decision-making should be approached with a patient whose trauma history has led to priorities that primarily reflect avoidance tendencies and heightened anxiety. The physician caring for such a woman requesting a cesarean section may have underlying reservations about elective cesarean delivery at maternal request with no apparent medical indication. If this obstetrician launches into a discussion of the risks of elective surgery, insists on recommending a vaginal delivery, and quickly dismisses the underlying concerns of this obviously anxious mother, then decision-making has been usurped by the provider rather than shared. Unspoken fears may involve concerns about physical pain, losing control, or emotional pain from intrusive memories of past abuse (Sperlich and Seng 2008, 85). Failing to inquire further about a survivor’s labor fears in a serious and thoughtful manner can certainly exacerbate the power imbalance between the physician and patient in a way that triggers a sense of powerlessness that has the potential to re-traumatize.

On the other hand, the physician who has no reservations about honoring the cesarean delivery requests of an anxious patient may not be aware that elective cesarean delivery may not completely avoid the woman’s underlying source of fear (Beck et al. 2011, 225). A planned cesarean delivery still involves discomfort, uncertainty about potential complications, and a certain loss of control as the surgeon takes over the delivery process while the patient lies
motionless and confined on the operating room table. Approaching the delivery decision with the intention of doing whatever the mother requests without understanding the motivations for that request may not prove to be in her best interest. In light of these suboptimal approaches to shared decision-making, some physicians choose to offer a choice of delivery options from which the patient can select her preferences without directed counseling. Even this strategy may overwhelm an anxious trauma survivor rather than empower her (Kukla et al. 2009, 3). In the end, the acknowledgment or dismissal of a survivor’s delivery preferences and underlying fears may have a significant impact on her risk of posttraumatic stress exacerbation. The mother’s level of comfort with her provider, the extent of patient-doctor collaboration, the tone of the conversation, and the degree of affirmation and reassurance communicated by the doctor all present occasions for micro-trigger exacerbation of posttraumatic stress symptoms.

**Micro-triggers in Labor**

Obstetricians with limited knowledge of the effects of past trauma on labor are often unable to adequately prepare survivors for some unique challenges that they may face once labor contractions begin. Common stressors of childbirth can generate extreme anxiety, intensify pain, and cause an overwhelming perception of powerlessness for some trauma survivors (Sperlich and Seng 2008, 96). Heightened anxiety, which is a chief characteristic of posttraumatic stress disorder, causes the release of higher levels of epinephrine and norepinephrine. These hormones, in turn, amplify the stimulation of nerve pain fibers and the perception of pain at the level of the brain cortex (Lowe 2002, S20). The subsequent exacerbation of pain then tends to increase anxiety, and the resulting cycle can lead to elevated levels of distress. Suffering may be further intensified for women who feel helpless and unable to cope with labor. Because the original traumatic event likely generated a response of intense fear and helplessness, a sense of
powerlessness in the setting of childbirth may lead to a snowball effect of anxiety and pain that can affect the course of labor. In a study of 115 first-time mothers, more intense pain and more expressions of distress than coping in the first phase of labor predicted a longer course of labor, the need for more obstetric interventions at the time of delivery, and more fetal heart rate abnormalities (Lowe 2002, S20-21).

Women with a history of childhood sexual abuse may especially benefit from obstetric providers who are familiar with common patterns of coping and the potential micro-triggers arising in early labor. Once labor begins, women with a history of childhood sexual trauma have various coping styles that can be divided into four distinct categories: fighting, controlling, surrendering, and retreating (Hobbins 2004, 490; Rhodes and Hutchinson 1994, 216-218). Most women with a history of childhood sexual abuse employ a “fighting” style of resisting the involuntary changes that take place with the onset and progression of labor. These women may appear to be panicked, stiff, and struggling against the waves of contractions. The stage of labor that involves pushing can be frustrating for both the patient and the obstetric provider, as labor may ultimately stall from ineffective pushing. The provider is then forced to consider obstetric interventions such as vacuum assistance or cesarean delivery, either of which might further traumatize the patient. A woman who fights against labor may easily experience micro-triggers that awaken bodily memories of struggling against an abuser who overpowered her and caused her physical pain (Hobbins 2004, 491).

The “controlling” style of coping with labor involves multiple attempts by the mother to assert control over her body, her surroundings, and the staff taking care of her (Hobbins 2004, 491). She may respond to the nurses and obstetric providers with hostility and suspicion, make frequent demands, present a detailed and rigid birth plan, or request pain medication long before
feeling intense pain in an effort to avoid any loss of control. This may result in early epidural anesthesia, which blocks pain signals while causing simultaneous leg numbness. Immobilization after epidural placement can lead to a heightened sense of anxiety and a perceived loss of control, which can act as a micro-trigger for posttraumatic stress symptoms (Hobbins 2004, 491).

Women who protected themselves from repetitive acts of childhood sexual abuse by mentally escaping or dissociating from their bodies may employ a “surrendering” coping style in labor (Hobbins 2004, 491). These women often appear calm, accommodating, and able to easily open their legs for male or female obstetric providers to perform exams. However, they may at times appear to be mentally absent and unable to respond to nurses or the obstetric providers. For some women, dissociation is intentional, and it allows them to cope with the labor process (Rhodes and Hutchinson 1994, 218). For others, an involuntary period of dissociation may trigger distressing memories of abuse.

Finally, the “retreating” coping style involves emotional withdrawal and a “stoic” appearance during labor (Hobbins 2004, 492). These women may mumble softly or scarcely communicate at all as they mentally retreat and silently endure the bodily changes and discomforts that accompany labor. Each of these four coping styles has particular implications for the micro-trigger exacerbations of underlying anxiety and posttraumatic stress symptoms.

While knowledge of labor coping styles can be invaluable for the hospital delivery staff to respond promptly to the patient’s needs, it is often impossible to identify or prepare for a coping style prior to the onset of labor for a first-time mother. Even comprehensive preparation for a trauma survivor who has undergone prior psychotherapy and is well-informed about the labor and delivery process can experience unanticipated stressors and micro-triggers in labor that
may challenge both the patient and the hospital staff. As one midwife who was also a childhood rape survivor recalled, “I knew that rape could interfere with the birth process . . . When my water broke and the contractions began the pain in my womb felt to me like the pain of forced penetration. It felt like rape. I panicked . . .” (Sperlich and Seng 2008, 75). In this survivor’s case, her health care provider also panicked and was not able to provide the trauma-informed help she needed to regain a sense of safety or empowerment (Sperlich and Seng 2008, 75). Avoiding a similarly ineffective response requires clinicians to take a closer look at the experience of women who are admitted to the hospital in active labor. The process from hospital admission to postpartum recovery reveals several other potential micro-triggers for PTSD relapse that clinicians should be prepared to encounter.

Labor and Delivery Micro-triggers: The Admission Process

If the decision is made to attempt a vaginal delivery, a woman in labor who is admitted to the hospital is typically interviewed by nurses, attending physicians, midwives, residents, students, or a combination of these individuals. By design, the admission process entails several rounds of questions that overlap and are redundant. This is done, in part, to ensure that allergies, medications, and critical elements of the medical history are recorded accurately by more than one health care provider in order to reduce the possibility of medical errors. Many patients express frustration, however, at the degree of repetition, the apparent lack of communication between members of the medical team, and the sheer number of medical personnel claiming to care for them during labor. For the “controlling” trauma survivor, intense frustration with the admission process and the structure of the medical team may heighten anxiety and trigger the resurgence of acute stress symptoms.
Administration of Pain Medication

Once labor has begun, much of the laboring mother’s satisfaction with her birth experience is predicated on her expectations of pain, the availability of pain relieving measures, and other effective coping strategies. A woman with a history of posttraumatic stress may experience a higher level of anxiety in labor that heightens her perception of pain (Lowe 2002, S20). The decision to request narcotic administration or epidural analgesia may be an urgent one, especially if the laboring mother has begun to sense that she is not able to cope with the intensity of labor pains using relaxation techniques. Unfortunately, not all labor and delivery units have a dedicated anesthesiologist who is available to administer epidural analgesia at any time. Unforeseen delays in the availability of pain-relieving interventions may significantly impact those women who have an expectation of immediate pain relief, weak coping skills, and high levels of baseline anxiety. As a result, the failure to prepare such women for the possibility of limited anesthesia availability may trigger psychological distress and PTSD symptom relapse.

Alternatively, women who express a desire to attempt natural childbirth without pharmacologic intervention may have developed a sense of self-efficacy and confidence that they possess the capacity to withstand anticipated labor pains. Constant reminders by the medical team that pain medication is available, frequent comments about the laboring mother’s apparent suffering, or suggestions that the mother re-consider pain analgesia in labor may also trigger a loss of confidence, a diminished sense of self-efficacy, and acute stress symptoms.

Language that Triggers Intrusive Memories

Another potential micro-trigger for post-traumatic stress symptom exacerbation involves the use of certain words, phrases, and styles of communication directed towards women who are
admitted to the hospital in labor. Although intending their words to be a source of comfort, nurses and physicians who are unfamiliar to the patient but address her as “Honey” or “Sweetie” may not recognize the potential significance of following that greeting with phrases such as, “Try to be quiet” or “Don’t fight the pain, just relax” (Sperlich and Seng 2008, 95). Especially for a “fighting” trauma survivor of childhood sexual assault, these words may not only be incomprehensible, but they may also remind her of similar words whispered by her assailant at the time of the attack (Hobbins 2004, 491). Suggestive language, particularly when uttered by male physicians towards female patients with a history of sexual abuse, assault, or other form of sexual trauma, may contribute to the resurgence of intrusive flashbacks.

Examinations in labor

Women who have been victims of prior sexual trauma may have varied reactions to vaginal examinations during labor. During an exam, the clinician generally sits or stands at the foot of the hospital bed, inserts two fingers into the vaginal opening, then deeper into the cervix, and finally measures the extent of cervical dilation based on the distance between the fingers. Exams are generally uncomfortable for women in labor because they involve additional stretching of the already-sensitive vaginal tissue and cause increased pelvic pressure. They can also be psychologically disturbing for women with a history of sexual trauma. Women are typically exposed with their thighs spread apart and the hospital bed sheet pulled back so that the obstetric provider can easily perform the cervical check. For some women, the vulnerability of this position and the intrusive nature of vaginal examinations can trigger extreme anxiety and memories of past abuse (Sperlich and Seng 2008, 101).
Current obstetric practice in the active management of labor generally requires serial vaginal exams to be performed at two hour intervals. While “surrendering” women may be able to tolerate this system of checking labor progression, others appear overwhelmed and extremely anxious about any vaginal examinations. Some “fighting” women show signs of panic and express discomfort well before a vaginal exam even begins. If the obstetric provider insists on performing or pressuring the anxious woman to endure frequent examinations, such pressure may serve as a micro-trigger for excessive surges of anxiety and potential PTSD symptom relapse. Since much patient-doctor communication takes place during the performance of vaginal examinations, any consoling but condescending language at this sensitive time of patient exposure and vulnerability may intensify anxiety symptoms and compound the micro-trigger effect of the vaginal exam itself.

Delivery

The sensation of pushing a fetus through the birth canal has the potential to awaken physical and psychological memories of past sexual abuse. Hobbins illustrates that for childhood sexual abuse survivors, the stage of labor that involves opening the hips wide and pushing “can elicit terror, flashbacks of abuse, dissociation, or a loss of the survivor’s sense of reality” (Hobbins 2004, 492). During and after delivery of the infant, various bodily fluids are typically released. The odor or sensation of these fluids, which typically include blood, urine, amniotic fluid, and sometimes feces, may also trigger memories of bodily fluids released during prior abuse. Furthermore, the stretching of the vagina during the final stages of delivery often results in vaginal tears. Patients with a history of sexual abuse may have suffered similar vaginal lacerations at the time of their assault (Hobbins 2004, 489). Caregivers who fail to appreciate the significance of these body memories may repair lacerations to the vagina with a rough technique
or may not hasten to clean bodily fluids. A lack of attentiveness to the mother’s needs during the final stages of birth can trigger the resurgence of posttraumatic stress symptoms.

In the event of an obstetrical emergency requiring the use of special maneuvers or surgical interventions to expedite delivery, micro-triggers can arise very quickly. Emergency cesarean deliveries and the use of forceps or a vacuum during vaginal delivery were described by some women as equally traumatic events that induced a sense of helplessness and panic (Creedy, Shochet, and Horsfall 2000, 108).

**Postpartum Micro-triggers -- Breastfeeding**

Immediately after delivery, women are typically encouraged to begin breastfeeding. For a woman whose prior sexual abuse involved breast fondling or suckling, the thought of allowing her infant unlimited access to her breasts may trigger intrusive memories of abuse as well as resentment towards her needy newborn (Hobbins 2004, 492). Breastfeeding involves potential micro-triggers from breast exposure, secretions dripping from the nipples, strong physical and emotional sensations from the infant sucking, and sometimes family onlookers either encouraging or discouraging the act (Simkin and Klaus 2004, 98). One such mother reflected:

*Unfortunately, the problem didn’t go away after I had the baby. My nipples were sore in the beginning and every time my baby latched on to nurse, I would be slammed with a flashback. This was happening constantly throughout the day as my baby nursed as often as every 45 minutes sometimes. (Sperlich and Seng 2008, 44).*

Undue pressure for an abuse survivor to initiate or sustain breastfeeding may therefore serve as a micro-trigger for posttraumatic stress symptom relapse.
Maternal Bonding and Responding to Infant Needs

After being discharged home from the hospital, many survivors experience disturbing triggers in their attempts to interpret and respond to their infant’s needs. For some, care for a newborn when bathing them, feeding them, and bonding requires such intimate touching that memories of inappropriate touch from their own childhood are awakened. One woman described being anxious when changing her newborns’ diapers or touching their genitals without a wipe because it was “like a violation to touch them with [her] bare hand” (Sperlich and Seng 2008, 160). Others revealed a hidden fear that others would secretly view them as abuse perpetrators if they showed too much affection in public (Sperlich and Seng 2008, 160). Still others expressed difficulty managing anger and resentment when they misinterpreted the infant’s crying and apparent neediness as an attempt to manipulate their attention, something that an infant is incapable of intending. As one survivor recounted, “When [the baby] sometimes [would] cry in anger . . . it filled me with adrenaline as though my life were in danger . . . I had to get him to stop . . . I was afraid I’d hit him or shake him to get him to stop it, so I’d find myself sitting outside on the front stoop while he wailed in the safety of his crib . . .” (Sperlich and Seng 2008, 119).

Responding to an infant’s needs can pose serious difficulties for those suffering from underlying detachment symptoms prior to delivery (Seng et al. 2010, 183-85). Dissociating, for example, can be problematic when it occurs during infant crying spells and renders the mother incapable of soothing her newborn. Since most follow-up visits for normal vaginal deliveries take place six weeks after leaving the hospital, challenges with parental bonding produce micro-triggers that women rarely discuss with their health care providers. As a result, many feel isolated as they attempt to conquer early parenting challenges with the added stressors related to past abuse and posttraumatic stress micro-triggers.

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Involvement of Family Members

Isolation and detachment can be reduced when supportive family members and friends help the new mother with infant care and with her own self-care. That support, however, can introduce tremendous psychological stressors and triggers when a member of the family is the former perpetrator of childhood abuse (Simkin and Klaus 2004, 91). Setting clear boundaries restricting access to the home can become challenging for survivors during the vulnerable period of healing, sleep deprivation, and family visits that often characterize the postpartum period.

Consequences of Acute Trauma Following Childbirth

The micro-triggers that women with a history of trauma may encounter during pregnancy, labor, delivery, and the postpartum period are not always avoidable, for many elements of childbirth are unpredictable. Fortunately, most trauma survivors report overall positive birth experiences in spite of some unavoidable stressors and triggers (Soet, Brack, and Dilorio 2003, 44). In some cases, however, women describe their childbirth experience as traumatic. Even in the absence obstetrical or neonatal complications, a woman may carry intense negative memories into the postpartum period from feelings of powerlessness during labor, invasive interventions that she secretly perceived to be unnecessary or harmful, guilt or shame, sudden unanticipated changes in the plan of care that undermined her sense of safety, or other disappointing experiences (Simkin and Klaus 2004, 92-93). Negative memories, particularly those associated with losing control during labor or with hospital staff behavior that seemed disrespectful, can linger for many years and affect a mother’s feelings about parenting her newborn (Simkin and Klaus 2004, 60). When the delivery appeared normal and the baby is medically healthy, it can be difficult for a mother struggling with disappointment, anger, or
resentment to discuss these unresolved emotions with her caregiver or her family (Simkin and Klaus 2004, 93).

Acute trauma symptoms are more likely to emerge in the wake of negative birth experiences. A prospective study by Creedy et. al determined that 5.6 percent of 499 Australian women developed PTSD as a result of a traumatic birth event. In that same study, a surprising 33 percent of women did not meet criteria for the disorder but still reported at least three acute trauma symptoms, which included intrusive memories or flashbacks of the birth, avoidance of associated stimuli or reminders of the event, and a state of hyperarousal (Creedy, Shochet, and Horsfall 2000, 104). Similarly, a two-stage United States national survey of approximately 1500 mothers found that 18 percent of women had elevated scores on screening tests for posttraumatic stress symptoms, and 9 percent of the women met criteria for the diagnosis of PTSD after delivery (Beck et al. 2011, 222). The risk of posttraumatic stress symptoms was highest in those births marked by both a high level of obstetric intervention and the mother’s overall dissatisfaction with her care during labor (Creedy, Shochet, and Horsfall 2000, 108). Given the concerning rate of posttraumatic stress symptom in these studies of women without a known history of trauma, it is not surprising that women with a trauma history appear to be at increased risk of posttraumatic stress symptoms and negative birth perceptions after delivery (Soet, Brack, and Dilorio 2003, 44). Soet et al. demonstrated that survivors of past sexual trauma were 12 times more likely than other women to describe their childbirth experience as traumatic (Soet, Brack, and Dilorio 2003, 44).

A traumatic birth experiences may have significant consequences for maternal and child health, particularly for those women with a history of trauma and posttraumatic stress symptoms at baseline. In addition to grappling with the resurgence of intense hyperarousal, avoidance, and
intrusive memories, these mothers also have an increased risk of postpartum depression (Söderquist et al. 2009, 678). Some evidence suggests that PTSD and depression share overlapping risk factors and may interact to compound suffering and impaired functioning (Söderquist et al. 2009, 678; Beck et al. 2011, 225). Various studies have shown that major depression later develops in over 40 percent of individuals who initially develop PTSD after a traumatic event (Söderquist et al. 2009, 678; Shalev et al. 1998, 632; Breslau et al. 2000, 907).

Difficulty with sleeping, eating, extreme fatigue, poor concentration, detachment from others, feeling of guilt, and sometimes suicidal thoughts can overwhelm a trauma survivor who is unknowingly suffering from postpartum depression (Sperlich and Seng 2008, 123-124). These symptoms can have devastating effects on the mother’s overall wellbeing, her capacity to bond to her newborn, and her ability to function with the other members of her household (Söderquist et al. 2009, 678). As one new mother reflected, “This was much more severe than the normal blues . . . I became physically weak with it to the point that I slept almost constantly and couldn’t function well enough to properly care for my children” (Sperlich and Seng 2008, 124). In severe cases, women with postpartum depression or posttraumatic stress symptoms can also have disturbing thoughts of harming their infants. The consequences of untreated posttraumatic stress and concurrent depression have the potential for such serious maternal and child harm that Sperlich and Seng emphasize, “Nothing is more important to the well-being of a child than his or her mother’s mental health” (Sperlich and Seng 2008, 145).

Increasing attention has focused on the complex cycle of childhood abuse that has the potential to affect multiple generations within families. Children who have survived abuse or neglect are at increased risk of substance abuse, high risk behaviors, and other maladaptive stress coping mechanisms that may contribute to later interpersonal and household dysfunction in
adulthood (Gilbert et al. 2009, 68; Felitti et al. 1998, 155). This intergenerational abuse cycle appears to have widespread effects that elevate the significance of healthy parent-child attachment to a public health concern. A 1998 study of adverse childhood experiences funded by the Centers for Disease Control showed that children exposed to various forms of abuse or household dysfunction had an increased risk of later developing chronic health conditions such as obesity, mood disorders, ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease (Felitti et al. 1998, 249-250). In current medical practice, postpartum attachment difficulties stemming from a mother’s history of abuse, challenges with emotional dysregulation, and untreated posttraumatic stress or depressive symptoms are often overlooked. Failing to address this component of postpartum care may have serious consequences for at-risk families.

**Summary**

The multiple points along the continuum of prenatal care, labor, childbirth, and the postpartum period are fraught with potential micro-triggers for some trauma survivors. Numerous aspects of the birth experience and common physician practices during childbirth add layers of complexity to the delivery experience that can be perceived as re-traumatizing. Labor and delivery share elements reminiscent of past abuse that may have involved pain, a loss of control, a feeling of being overpowered, nakedness, unwelcomed touch, and extreme fear (Sperlich and Seng 2008, 80). Even women who have undergone previous psychotherapy and believe that the trauma-related emotional scars have been “dealt with” may find themselves facing triggers that they did not anticipate (Sperlich and Seng 2008, 75). Nonetheless, the women most likely to report positive birth experiences seem to be those who have anticipated their most likely triggers, devised strategies to minimize their negative impact, and found comfort
in talking through unexpected triggers or disappointments after the event (Sperlich and Seng 2008, 80). It follows that medical caregivers who are aware of these potential triggers will be more equipped to provide trauma-informed care that avoids a re-traumatizing delivery. Only then can attention turn to achieving the overarching goal of patient empowerment and resilient growth through the unique challenges of pregnancy and childbirth.
CHAPTER 5

BEST PRACTICES FOR POSTTRAUMATIC STRESS RELAPSE PREVENTION

Health care providers can help or hurt depending on their personal backgrounds and the view from which they enter your lives. . . I would ask them to be more open to not following standard, rote procedures. . . Listening with the actual intent to hear can be a great kindness.

-- Mickey Sperlich and Julia S. Seng, Survivor Moms: Women’s Stories of Birthing, Mothering and Healing After Sexual Abuse

In the United States, 51 percent of women have reported exposure to a traumatic event at some point during their lives (Kessler et al. 1995, 1052). Estimates from the National Intimate Partner and Sexual Violence Survey suggest that approximately 1 out of 5 women have suffered completed or attempted rape during their lifetimes, and for over 40 percent of these assault survivors, their sexual trauma occurred before the age of 18 (Black et al. 2011, 1-2). These rates are likely underestimated because a substantial number of women who have been victims of childhood sexual abuse or sexual assault never report their experiences. Trauma has impacted such a large segment of the female population that healthcare providers who specialize in women’s health must understand the unique consequences of trauma on the longstanding physical, psychological, and emotional well-being of women.

For a significant number of trauma survivors, the experience of childbirth can involve physical and psychological stressors reminiscent of past traumatic episodes and may cause distressing reactions. Childbirth itself can become a re-traumatizing event characterized by emotional and physical memories of prior trauma, extreme fear, and a sense of helplessness (Simkin and Klaus 2004, 66). A traumatic birth experience for a mother who already has an underlying history of posttraumatic stress can lead to a resurgence of acute posttraumatic stress
symptoms, postpartum depression, impaired mother-infant bonding, and other disturbing consequences for the mother, her newborn, and her entire family (Hobbins 2004, 485; Söderquist J 2009, 677).

Although the American College of Obstetricians and Gynecologists (ACOG) recommends that physicians elicit an abuse history for every patient (ACOG 2011, 393) and a trauma history during early pregnancy (AAP and ACOG, 2012, 463 Appendix A), guidelines remain unclear about how to best obtain this history or what approach to PTSD screening is most appropriate during prenatal care (AAP and ACOG, 2012, 463 Appendix A).

While the practice of trauma screening is inconsistent in clinical practice, inquiring about past trauma is not a new concept. Obstetricians are accustomed to screening frequently for intimate partner violence with brief questions about a woman’s immediate sense of safety in her intimate relationships (ACOG 2012, 414-15). When a woman discloses current abuse, the clinician’s pressing concern is to assist her in securing a safe environment for herself and her family (ACOG 2012, 415; Seng et al. 2002, 368). However, it may seem less urgent and certainly less actionable to elicit a woman’s remote history of child abuse. When the life-threatening event has already occurred in the distant past, and the patient does not complain of psychiatric sequelae, many obstetricians tend to view this history as regrettable but not particularly relevant to current healthcare management (Seng, Sperlick and Low 2008, 511--512). Since many obstetric providers have not been trained to recognize the impact of past trauma and posttraumatic stress on elements of childbearing, screening often does not occur, signs of posttraumatic stress are overlooked, and no interventions are offered. As a result, clinicians risk doing further harm and can miss the opportunity to meet the needs of trauma survivors entering prenatal care.
What Should Change in Current Obstetrical Practice

Meeting trauma survivors’ needs will require some adjustments to current obstetrical practice in three key areas. First, trauma screening practices are generally inconsistent and need to be standardized. Some evidence suggests that in roughly one half of cases, physicians do not inquire about childhood abuse or past interpersonal trauma during the course of routine prenatal care (Seng, Sperlick, and Low 2008, 515). Those who do inquire about trauma as part of the initial patient interview are often unclear about how to elicit this history effectively. For instance, briefly asking about “trauma” or “violence” as part of a checklist suggested in current guidelines for perinatal care is likely insufficient to identify women who have in fact been victims of rape, childhood sexual abuse, physical assault, war-related injuries, natural disasters, or other potentially traumatic events (AAP and ACOG, 2012, 463 Appendix A). Furthermore, since prior trauma does not necessarily cause posttraumatic stress disorder or chronic symptoms, further PTSD screening is necessary to determine which patients may require mental health referrals. However, few obstetricians know how or when to screen for PTSD, and a stepwise approach to trauma and PTSD screening generally does not occur.

Second, many clinicians are unsure about what the immediate next steps should be after identifying a history of trauma or PTSD. Many would agree that referral to a mental health provider is a reasonable course of action. Yet actual psychiatric referral practices tend to vary, and such referrals are often viewed as optional instead of obligatory. Thus, current practice has not endorsed mental health referral as a necessary part of follow-up for trauma survivors with chronic posttraumatic stress symptoms.
Third, obstetricians do not commonly regard trauma and posttraumatic stress as risk factors that warrant a tailored obstetrical care plan. After identifying a trauma survivor with a positive PTSD screen and referring her to a mental health provider, the obstetrician must still avoid re-victimizing her over the course of prenatal and delivery care. Even if such a patient does not ultimately meet criteria for PTSD upon further psychiatric evaluation, her history of trauma and her posttraumatic stress symptoms are still relevant risk factors that should ideally prompt her obstetric provider to generate a specific plan of care for avoiding micro-triggers and for encouraging methods of stress-coping in preparation for delivery. This kind of tailored approach to trauma-informed obstetrical care is a critical but missing element in current obstetrical practice.

These three problematic aspects of present-day obstetrical practice can serve as points of re-exploration for identifying new approaches that better serve trauma survivors in need of competent, trauma-informed prenatal care. The following sections of this thesis will address both ethical and practical considerations that should inform best practices related to trauma screening, referral, and the creation of an obstetrical care plan that encompasses micro-trigger avoidance as well as resilient stress-coping in preparation for delivery. Finally, this thesis will outline a new three-part strategy for best practices by which obstetricians can identify and refer women at greatest risk for PTSD relapse prior to childbirth, adopt practical techniques for avoiding micro-triggers in the course of routine obstetrical care, and ultimately facilitate positive birth experiences through resilience-focused, stress-coping support.

**PART I: ETHICAL JUSTIFICATION AND PRACTICAL CONSIDERATIONS FOR A NEW STRATEGY**

A closer look at the ethical justification for these proposed changes to obstetrical practice will clarify why a strategy of appropriate PTSD screening and referral followed by both micro-
trigger avoidance and resilience-focused delivery preparation are so necessary to incorporate into obstetrical practice. These strategies involve not just aspirational goals but obligatory components of trauma-informed care that obstetricians have a duty to provide.

The Justification for Standardized Trauma and PTSD Screening

An obstetrician’s duty to endorse the core principles of beneficence and nonmaleficence underlies his or her duty to conduct comprehensive trauma screening. In essence, failing to inquire about past trauma in a responsible way will not only prevent the physician from doing what is in the survivor’s best interest, but it can also significantly harm her.

To begin, beneficence refers to the principle that obliges a physician to act in a manner that benefits the patient and advances his or her well-being. (Beauchamp and Childress 2009, 197-207). While this principle often entails the promotion of health-related factors leading to positive health behaviors and outcomes, it also requires the prevention of avoidable risk factors and behaviors that lead to adverse outcomes. In obstetrical practice, beneficence compels clinicians to identify risk factors for adverse perinatal outcomes before they become maternal or fetal emergencies.

Although data is limited on perinatal outcomes in PTSD-affected pregnancies, early studies have revealed some alarming findings. Untreated posttraumatic stress is a known risk factor for poor maternal health outcomes related to major depression (Söderquist and Thorbert 2009, 678), substance abuse (Eggleston et al. 2009, 421; Seng, Sperlick, and Low 2008, 514-515), self-harm (Seng, Sperlick, and Low 2008, 516), and suicidality (Eggleston et al. 2009, 420). Even though more research is needed to capture the fetal impact of PTSD, some evidence suggests that it may be a predictor of low birth weight (Seng et al. 2011, 1333; Rosen et al. 2007,
1310-11) and preterm delivery among child abuse survivors (Noll et al. 2007, 1242-3). In cases of maternal tobacco or substance use as stress coping mechanisms, fetal complications from placental dysfunction and intrauterine growth restriction are significant concerns (Quesada et al. 2012, 1222; Ergaz, Avgil, and Ornoy 2005, 305). Furthermore, there is emerging evidence that fetal exposure to a high level of maternal stress is associated with early neurodevelopmental disorders including attention deficit disorder, delayed language development, and other behavioral problems (Talge et al. 2007, 250). While the mechanisms for these outcomes are not well understood, the effects of severe stress may be related to both maternal and fetal alterations in the production and responsiveness to the stress hormone cortisol (Talge et al. 2007, 255-256).

Because obstetrical providers may have an opportunity to affect these neonatal outcomes associated with untreated PTSD, the principle of beneficence makes it obligatory to screen women for a past history of trauma and for PTSD when appropriate.

Beyond these quantifiable health outcomes, maternal well-being is also at stake. Promoting beneficence becomes especially important when physicians are caring for certain vulnerable patient populations. It is clear that pregnant trauma survivors constitute a heterogeneous population of women with varying degrees of recovery following their traumatic experiences. The majority do not develop chronic posttraumatic stress symptoms, but a significant number do experience debilitating alterations in their sense of identity, control, bodily integrity, self-efficacy, and ability to interact safely with those around them (Brison 2002, 18). While every laboring woman might have difficulty feeling “in control” at various stages in the delivery process and may thereby experience a certain degree of vulnerability (Namey and Lyerly 2010, 773), the sense of powerlessness that a trauma victim once experienced may resurface in a way that increases her vulnerability. A childhood abuse survivor who has a flashback and panics
during the pushing stage of labor becomes vulnerable to the very real perception that she is being harmed, even though the obstetrician urging her to push does so with no mal-intent. Beneficence requires that obstetricians first screen women for a history of trauma and posttraumatic stress in order to identify those in need of help to maintain those elements of control that may reduce their vulnerability during prenatal care and childbirth. Failure to do so not only prevents the obstetrician from promoting their well-being; it also has the potential to do harm.

Clinicians have long embraced the ethical principle of nonmaleficence in medical practice. This principle holds that at the very least, physicians have an obligation to refrain from harmful actions or courses of treatment that will predictably worsen the patient’s condition (Beauchamp and Childress 2009, 151). In the case of physicians caring for trauma survivors, nonmaleficence also underlies the duty to screen appropriately for trauma.

It may not be immediately apparent that the lack of routine trauma screening in obstetrical practice constitutes harm. While nonmaleficence usually entails a duty to refrain from actions that inflict harm, it also applies to cases of negligence in which there is a failure to meet the standard of “due care” (Beauchamp and Childress 2009, 153-154). Since “due care” refers to a set of professional standards that are considered sufficient to avoid undue harm, the absence of due care exposes patients to unjustifiable harm (Beauchamp and Childress 2009, 153). Opting not to screen despite guidelines that recommend routine trauma inquiry as part of the medical history marks a departure from the standard of due care. Although physicians who decide not to screen for trauma might be motivated by their concern about strong emotional reactions some patients may have in response to questions of past abuse, the conclusion that it would be better to refrain from uncovering any painful memories may still harm those patients. As a result of not screening, physicians risk re-traumatizing patients during certain standard, medical encounters
that could have been modified if only the physician had asked about their trauma histories. In this way, failing to screen for trauma involves a form of negligence.

Yet some clinicians rightly point out that trauma screening itself may pose some degree of risk. Indeed, the potential for psychological harm from trauma screening is a valid concern. Inquiring about past trauma without a plan for responding sensitively may aggravate posttraumatic stress symptoms and heighten a survivor’s sense of alienation and powerlessness. By screening poorly, then, a physician certainly risks harming the survivor. Hence, nonmaleficence entails not just the duty to screen, but the duty to screen appropriately.

Fortunately, studies that have investigated trauma survivors’ perceptions of screening reveal that negative reactions to trauma-sensitive questions are uncommon (Friedman et al. 1992, 1188). Despite the finding that less than half of sexual abuse survivors would initiate a discussion of their sexual trauma history, a study by Friedman et al. revealed that 85 percent of those patients would favor routine physician inquiry about sexual abuse (Friedman et al. 1992, 1188). According to an analysis of survivor disclosure patterns, patients simply choose not to disclose their trauma history if sharing the information is too upsetting at the time of inquiry (Seng, Sperlick and Low 2008, 516). In the end, the patient’s capacity to exercise control of disclosure at her own discretion and the risk of negligence from failing to screen outweigh the threat of psychological harm from purposely inquiring about past trauma. Based on the underlying principles of both beneficence and nonmaleficence, obstetricians have a clear duty to inquire sensitively about past trauma and to screen trauma-exposed women for PTSD.
Practical Considerations: Warranted and Actionable Standardized Trauma Screening

Certain practical considerations must also be factored into a new approach if it is to be evidence-based and feasible. Screening for PTSD as part of a comprehensive trauma history can be practical only when it is highly prevalent, if there are tools to reliably identify it, and when there are meaningful interventions that can diminish the consequences of the condition. In this case, routine screening for trauma and PTSD screening for those who disclose a trauma history would meet all three of these requirements.

First, pregnant women have reported rates of past physical and sexual abuse ranging from 30 percent in a demographically diverse group of women to 47 percent among women residing in an inner city environment (Seng, Sperlick, and Low 2008, 513-514). Stevens-Simon showed a similar rate among pregnant adolescents, with 33 percent reporting a history of sexual and physical abuse prior to conception (Steven-Simon 1994, 571). Moreover, the 7.7 to 7.9 percent prevalence of current PTSD is actually higher in the pregnant population than the 4 to 5 percent prevalence in the general United States female population (Loveland Cook, et al. 2004, 712; Seng, Low, et al. 2009, 843). With 1 in 13 women meeting criteria for the diagnosis of PTSD during pregnancy, the rates of past abuse and PTSD among pregnant women are both alarming and sufficiently high to warrant routine trauma screening for all obstetrical patients with further PTSD screening for those who report a trauma history.

Second, there are reliable tools for identifying patients likely to have PTSD. Since it is not appropriate for obstetricians who are not trained in psychiatry to conduct formal psychiatric evaluations to diagnose PTSD, and it is not feasible to refer every patient with a trauma history for psychiatric evaluation, screening trauma-exposed women for PTSD is a reasonable means of
distinguishing which patients could most benefit from mental health evaluation. This approach is possible because at least 13 validated PTSD screening instruments exist that are rarely used in obstetrical practice. Most of these screening tools range from 4 to 17 questions, can be self-administered by the patient herself, require only a few minutes to complete, and can reliably identify women likely to have PTSD (Brewin 2005, 55-56). Screening for PTSD is therefore practical when such brief, inexpensive, time-efficient, and reliable screening instruments are available.

Finally, screening is actionable even when trauma occurred in a woman’s distant past. Once a patient discloses a trauma history and screens positive for probable PTSD, an obstetrician’s next actions are twofold. Referring her for psychiatric evaluation and treatment is the first clinically meaningful action. This is necessary to confirm her PTSD diagnosis and to effectively manage uncontrolled symptoms. The second action is generating a trauma-informed prenatal care plan for avoiding micro-triggers and for resilience-focused delivery preparation. Although no current randomized trials have tested the efficacy of micro-trigger avoidance or trauma-informed delivery planning for symptom reduction, qualitative analysis of patient narratives suggest that obstetricians can create a decisive plan to avoid common triggers and thereby make the encounter safer (Coles and Jones 2009, 235). The fact that there are practical ways to help a trauma survivor who screens positive for PTSD further supports the feasibility of standardized screening.

Still another barrier to effective screening is reluctance on the part of many survivors to disclose a history of trauma. With available data showing that less than 30 percent of pregnant women reveal their history of childhood or adult abuse when asked, disclosure rates of sexual assault or abuse are typically very low in the outpatient obstetrical care setting (Seng, Sperlich
and Low 2008, 515). The reluctance to share this information appears to stems largely from the perception that this remote history is not relevant to the current pregnancy or to their prenatal care (Seng, Sperlick and Low 2008, 515). Other survivors hesitate to reveal information that might compromise their privacy. As Leis and colleagues highlighted in a series of focus group interviews, women may be apprehensive about disclosing any risks for mental health disorders to their obstetric providers due to the cultural stigma attached to psychiatric disorders, concerns about privacy, suspicion about the impact of disclosure on job security or the potential involvement of Child Protective Services, and the expectation that a referral to mental health services will result in drug therapy, which many women wish to avoid (Leis, et al. 2011, 316-317). This suggests that clinicians can help to facilitate patient disclosure by framing the questions with a statement that explains the purpose, potential benefits, and confidentiality of screening for trauma in pregnancy. Any realistic set of best practices must therefore consider a sensitive approach to framing trauma questions in addition to the specific tool that is used for screening and the appropriate response to a positive PTSD screen.

The Justification for Mental Health Referral as an Obligation

In the event that a trauma survivor has a positive screen for PTSD, the obstetrician has a responsibility to recognize posttraumatic stress as a serious condition that warrants an immediate and thoughtful plan of care to address the problem. Many clinicians regard mental health referral as an appropriate treatment option, but referral is actually the first obligatory step in this case.

Given the high prevalence of trauma exposure in the female population, it would quickly overwhelm the mental health resources in almost any location if clinicians were to refer every trauma survivor for psychiatric evaluation. Referral, then, is best reserved for those patients
whose chronic symptoms of uncontrolled posttraumatic stress warrant formal PTSD evaluation and therapy for symptom management. Since the vast majority of PTSD screening instruments are designed to identify uncontrolled posttraumatic stress symptoms (Brewin 2005, 56-57), a positive screen serves as a clear indicator of the need for further symptom evaluation and management. Fortunately, therapeutic interventions are available and effective for controlling stress symptoms. The efficacy of psychiatric treatment lies primarily in the success of cognitive behavioral therapy (CBT) for reducing PTSD symptoms through a combination of progressive exposure to trauma reminders and cognitive restructuring. A randomized trial of CBT compared to problem-solving therapy in childhood sexual abuse survivors showed that CBT led to higher rates of PTSD remission for women who completed treatment, but both forms of therapy were effective for reducing symptoms (McDonagh 2005, 522). Hence, the availability of PTSD screening tools to identify the most at-risk trauma survivors and the effectiveness of available psychiatric therapy elevate the concept of mental health referral from a reasonable option to an obligatory component of beneficent care.

Moreover, it would constitute negligence for an obstetrician to ignore the seriousness of these symptoms and overlook the urgency of providing opportunities for symptom control before the potentially re-traumatizing event of childbirth. Just as a primary care physician would not hesitate to recommend a cardiology referral after identifying concerning symptoms or signs of underlying cardiac malfunction that a patient may not necessarily perceive as urgent, an obstetrician should provide a mental health referral for chronic symptoms of posttraumatic stress that can have a devastating impact on normal functions of daily life.
Practical Considerations for Mental Health Referral and Treatment

Some clinicians will express concern that known barriers to psychiatric treatment impede their ability to provide clinically useful referrals for mental health evaluation or therapy. To be sure, consistent trauma screening and psychiatric referrals are more likely to occur in well-coordinated health systems that have developed a structured program for easy mental health referrals and follow-up (Kim, et al. 2009, 167). Many clinicians also rightly observe that even a highly efficient referral system does not overcome certain patient-related barriers to mental health treatment. Some survivors, who may not yet be ready to confront deeper memories or work through emotional difficulties, may obtain a referral but elect not to pursue psychiatric treatment during pregnancy (Sperlich and Seng 2008, 49). Nonetheless, individual mental health referrals are still warranted in the absence of a structured referral program. No primary physician would withhold a recommended cardiology referral because a patient expressed his or her initial reluctance to see a cardiologist. Providing a paper or electronic psychiatric referral indicates both a high level of concern and the intention to facilitate whatever help the patient is willing and able to accept. A survivor is then able to control how and when to take advantage of this form of therapy.

The Obligation to Create an Obstetrical Care Plan: Micro-trigger Avoidance and Resilience-focused Stress Coping

A positive PTSD screen warrants not only mental health referral; it also requires an obstetrical approach to trauma-informed prenatal care. Whether or not a survivor is formally diagnosed with PTSD by a psychiatrist, a positive PTSD screen has significant implications for the primary obstetrician who will accompany this woman throughout her prenatal care and prepare her for delivery. This obstetric provider must now enact a plan focused on avoiding
triggers and actively helping the survivor prepare to cope with the anticipated stressors that cannot be avoided.

The Justification for Micro-trigger Avoidance

Few would disagree that a harmful medical option or practice should be avoided when refraining from that practice imposes minimal risk and when an alternative option is associated with clear benefit. Therefore, the principle of nonmaleficence provides a justification for avoiding micro-triggers in obstetrical care precisely because they cause unnecessary suffering and can be prevented in many cases. If a survivor is able to anticipate and warn her caregiver about her own triggers, it seems apparent that the physician ought to make a reasonable effort to avoid those triggers when possible. For instance, an obstetrician who knows that a woman has posttraumatic stress reactions associated with nakedness during pelvic examinations should encourage this patient to keep most of her clothes on during the exam if they do not impede the evaluation. Even without knowing the exact nature of a trauma-survivor’s individual triggers, it is possible to avoid certain practices that frequently trigger post-traumatic stress symptoms once clinicians are trained to identify them. Based on the duty of physicians to practice nonmaleficence, trauma-informed care that aims to avoid common triggers is not only possible but obligatory.

In more complex cases, however, physicians must balance concerns about triggering symptoms with more pressing considerations of certain practices that are necessary components of clinical care. A woman who reports that she fears dissociating during vaginal examinations in labor will still require some vaginal examinations if the medical team is to provide appropriate care in most circumstances. Although it may be possible to reduce the number and frequency of
such exams, promising to eliminate them altogether could result in maternal and fetal harm if the obstetrician cannot evaluate or monitor the progress of labor. In an obstetrical emergency, the degree of cervical dilation is a critical piece of information for determining how to best expedite delivery (Gabbe 2012, 355). In this case, the obligation to avoid harm will depend on the degree of risk associated with continuation, complete avoidance, or modification of micro-triggering procedures in practice. Some form of modification may often be reasonable, safe, and consistent with the principle of nonmaleficence.

Practical Considerations for Micro-trigger Avoidance

There is much evidence suggesting that certain triggers actually do increase the risk of posttraumatic stress symptoms and contribute to negative birth experiences. Patient narratives have included testimonies of acute stress reactions from such practices as clinicians touching or surgically cutting women’s genitalia without asking permission (Sperlich and Seng 2008, 84), providers standing over them while they lie in “the victim position” (Simkin and Klaus 2004, 269), and hospital staff expressing annoyance at obvious signs of panic at the time of delivery (Sperlich and Seng 2008, 76). Qualitative studies have identified common responses and safe solutions for avoiding many distressing triggers that arise for survivors in routine clinical encounters (Coles and Jones 2009, 235). Developing an awareness of these avoidable triggers is quite feasible, for obstetricians can readily access a comprehensive list of them from various sources (Simkin and Klaus 2004, 267-276; Hobbins 2004, 489; Coles and Jones 2009, 235). Although some of the most compelling narrative accounts of posttraumatic stress triggers are directed primarily to an audience of trauma survivors rather than clinicians, patient commentaries and vignettes can illuminate the significance of certain triggers in a memorable way that is likely to enhance a physician’s awareness of various triggering practices.
Moreover, a caregiver’s thoughtful attention to patient triggers during labor can help to convey a high quality of patient care, which may become critically important in the event of a negative birth outcome. Narrative accounts suggest that survivors whose clinicians ignore distressing micro-triggers are more likely to perceive those clinicians as disrespectful and as providing substandard care (Sperlich and Seng 2008, 25). Consequently, these same women who have negative interactions with medical personnel are at higher risk of developing posttraumatic stress reactions after the delivery (Sperlich and Seng 2008, 25; Soet, Brack and Dilorio 2003, 41). Such negative perceptions of the birth experience, caregiver’s attitudes, and the poor quality of medical services can greatly influence decisions about whether or not to seek legal recourse in the event of an adverse obstetrical outcome (Sperlich and Seng 2008, 25). It therefore behooves clinicians to gain an appreciation for the potential impact of micro-triggers in order to develop communication and clinical care skills that improve the patient-doctor interaction.

The Justification for Resilience-focused Coping Support

While it is necessary to avoid triggers when possible, labor and delivery will likely present other stressful challenges that cannot be avoided. Because those remaining anticipated stressors are obstetrical in nature, it becomes the responsibility of the obstetrician to encourage stress-coping preparation. Resilience, a person’s capacity for adaptive stress coping, is a critically component of trauma recovery and posttraumatic growth (Agaibi and Wilson 2005, 196). A closer look at the concept of resilience and the applications of this concept to obstetrical care will elucidate why obstetricians have a duty to facilitate one aspect of resilience-building: coping with unavoidable obstetrical stressors.
Posttraumatic resilience refers to an individual’s ability to adapt to high levels of stress exposure and to resume an optimal level of functioning without developing pathologic tendencies (Agaibi and Wilson 2005, 196-97). Resilience is a complex phenomenon, for it depends on an individual’s personality traits, thinking patterns, and styles of behavior that are expressed in moments of adversity (Agaibi and Wilson 2005, 197). According to many researchers, resilience is not a fixed trait. Rather, it appears to be a modifiable behavioral characteristic that can improve based on a person’s access to certain internal and external resources that facilitate the process of coping and adapting to change (Dunkel Schetter 2011, 546; Agaibi and Wilson 2005, 196). These “resilience resources” include opportunities to exercise perceived control or self-efficacy, supportive family and social networks, cultural values or spiritual frameworks that ascribe meaning to life circumstances, and the presence of constitutional factors like cognitive skills and good health (Dunkel Schetter 2011, 546). Modifiable resilience resources serve as potential targets for resilience-building interventions that may be clinically beneficial for trauma-exposed individuals.

A large body of resilience research exists in mental health literature (Mancini and Bonanno 2006 971; Masten et al. 2004, 1071; Richardson 2002, 307; Herman 1997, 57), but the role of resilience-building is an underexplored theme in the field of obstetrics (Dunkel Schetter 2011, 550). Consequently, this is a growing area of interest for clinicians and researchers who have begun to explore the connection between chronic stress, resilience, and poor obstetrical outcomes (Salazar-Pousada et al. 2010, 5; Seng et al. 2011, 1334). While most trauma survivors are resilient and may not need resilience-building resources, the survivors who report posttraumatic stress symptoms at the time of PTSD screening comprise a group at higher risk of adverse outcomes (Seng et al. 2011, 1334). Women with low resilience and chronic stress appear
to be at higher risk of pregnancy complications such as low birth weight, earlier delivery, and altered fetal neurodevelopment (Dunkel Schetter 2011, 545). In addition to the daily life stressors and demands that many patients face in their intimate relationships, work, and financial responsibilities, trauma survivors with chronic posttraumatic stress often carry the additional strain of emotional dysregulation, relationship difficulties, and an exacerbation of stress symptoms during pregnancy (Seng et al. 2010, 176). Pregnant women living with chronic stress who lack resilience are likely to benefit from interventions that provide or enhance those modifiable resilience resources (Dunkel Schetter 2011, 546). Thus, efforts to increase resilience among trauma survivors are clinically relevant and have the potential to improve elements of both physical and mental health. If effective resilience-enhancing interventions are available and feasible, the principle of beneficence dictates that clinicians offer such resources to patients who are likely to benefit from them.

Obstetricians, however, are not trained to provide cognitive-behavioral therapy that would be necessary to improve long-term resilience. The much smaller component of resilience-building that lies in the domain of obstetrical care involves short-term planning for methods of stress-coping in anticipation of stressors that micro-trigger avoidance cannot prevent during prenatal or delivery. Pregnancy is a unique time that tests a woman’s resilience in the face of various stressors, eventually culminating in the highly anticipated, stress-filled, and possibly re-traumatizing event of childbirth. Although both long-term stress resistance and short-term stress coping are aspects of resilience, short-term coping is particularly relevant to the delivery-oriented nature of obstetrical care. Whereas the psychiatrist is trained to address long-term resilience behaviors, the obstetrician is trained to create an obstetrical plan that addresses some of these short-term coping strategies.
The obstetrician has a unique opportunity to influence a survivor’s resilience in the face of obstetrical stressors during prenatal care and delivery. Referral to a mental health provider is certainly obligatory when screening tests for PTSD are positive or when stress symptoms are uncontrolled. Reducing avoidable triggers is also obligatory for preventing unnecessary suffering. Yet, an obstetrician would be remiss to identify a trauma survivor with likely PTSD, offer a referral to mental health services, try to refrain from doing unnecessary vaginal procedures, but fail to address her capacity to cope with the exams and procedures that she does plan to perform. It is unlikely that the psychiatrist is trained to prepare this woman for the particular elements of obstetrical care that only the obstetric provider has the expertise to anticipate. It follows that the trained obstetrician is the very expert who ought to be in the pivotal role of identifying and preparing trauma survivors to encounter stressors that are likely to arise and cannot be prevented in the direct provision of obstetrical care. Just as any surgeon is expected to anticipate and prepare a surgical patient for wound care, make plans for post-operative pain control, and direct pre-operative counseling towards issues of surgical recovery well before doing the procedure, an obstetrician has a responsibility to anticipate and prepare a trauma survivor for likely obstetrical stressors that may require extra coping resources. In practice, this translates into an obligation to provide counseling and available resources for resilience-focused delivery preparation.

Some might question whether the individual obstetric provider has a duty to conduct this work of delivery preparation. It is not immediately clear that an obligation to provide resilience resources requires those services to be rendered by the primary obstetrician. Many providers work in large group practices or clinic settings in which patients see many clinicians over the course of prenatal care and will likely deliver under the care of an unfamiliar obstetrician. In that
environment, stress-coping preparation is likely to be a shared task. It may be more feasible to obtain a consultation from another maternity care provider trained in both obstetrics and trauma-informed care who can counsel the patient on stressors and adaptive coping strategies in preparation for delivery. This kind of arrangement involves a duty to offer more than referral but no more than “responsible assurance” that he or she will facilitate the necessary provision of resilience resources through a partnership with other clinicians who actually perform the services (Little and Lyerly 2013, 260).

The situation is somewhat different, however, in the case of a primary obstetrician who has an ongoing relationship with the survivor and does expect to perform an obstetrical procedure or to attend the delivery. Although it may seem plausible to refer the survivor to a trauma expert to handle trauma-related preparation and to return to the obstetrician for “real” prenatal care, this approach is problematic. In light of different practice styles that are unique to each provider or reflective of the culture and protocols of a specific labor and delivery unit, preparing for delivery with a plan for adaptive stress-coping cannot be entirely transferrable to another caregiver. While some resilience-focused preparation is applicable to any delivery site, other stressors will arise from the particular practices of the clinicians or staff that a woman is likely to encounter under their care and at their facility. Hence, the degree of obligation to offer resilience resources and to conduct the bulk of preparatory resilience-focused counseling will depend on the degree to which the primary obstetrician is likely to be conducting or overseeing the obstetrical procedures. The responsibility is highest when an obstetrician, as the surgeon, is in a singular position to anticipate and therefore communicate the details of how each planned procedure will likely require stress-coping preparation.
Still, assembling a multidisciplinary team that includes mental health providers, nurses trained in trauma-informed care, social workers, and a case manager is likely to be the most comprehensive strategy for affecting various modifiable components of resilience. There may also be a role for coordinating obstetrical care with other clinicians within the same office or group practice who have more experience with trauma survivors and can more easily spend office time conducting much of this preparatory counseling. In the end, though, the primary obstetrical caregiver should be directly involved in key aspects of resilience-focused childbirth preparation. To the extent that stress coping resources are available, effective, and appropriate for an obstetrician to provide without venturing into psychotherapy, obstetricians have an obligation to offer at least stress-coping counseling as a form of resilience-focused delivery preparation.

Practical Considerations for Resilience-building

The resilience component of trauma-informed care is the most challenging to translate into a feasible set of practices for obstetrical care, for there is limited data on the effectiveness of resilience-building interventions. From the data that is available, interventions that focus on improving the patient’s support network and self-efficacy for labor in advance of delivery are the most practical to address in the course of prenatal care.

External support systems appear to help women adapt to stressors in the moment of adversity. Doula support in labor, for example, seems to encourage adaptive coping in moments of severe stress. The presence of an experienced doula serving as a labor coach has been associated with a reduced need for epidural analgesia (McGrath and Kennell 2008, 92; Simkin and Klaus 2004, 70-72). This may be the case because doulas often provide more consistent support than exhausted or frightened partners, and they are trained to help women draw upon
their own capacity for self-efficacy at the times of highest stress. As one trauma survivor with a doula explained, “The most empowering thing about my birth was my newfound ability to stay in my body, stay aware of my emotions, and move through it moment to moment” (Simkin and Klaus 2004, 71). Doula support, therefore, is a type of resilience-building intervention that combines external support and enhanced self-efficacy by enabling trauma survivors with limited stress coping skills to adapt with renewed focus and self-control in the setting of stress (Simkin and Klaus 2004, 70-72).

Doula support alone, however, does not address those elements of self-efficacy that depend on resilience-focused preparation for anticipated stressful events or obstetrical procedures in prenatal care and delivery. Part of that preparation involves educating survivors about the connection between past trauma and current manifestations of stress that are likely to intensify at the time of delivery. As the end of pregnancy progresses, it becomes necessary to discuss practice-specific and hospital-specific policies that cannot be entirely avoided and may require special preparation on the part of the patient and the obstetrician. This may be a more challenging task for obstetric providers, for it requires time-intensive counseling and delivery planning that can be difficult to provide in a busy office setting. Practical recommendations for best practices will therefore need to present resilience strategies that are time-efficient for use in a prenatal care setting and are able to facilitate obstetric-specific preparation for adapting to anticipated stressors that cannot be avoided.

PART II: PROPOSED BEST PRACTICES FOR TRAUMA-INFORMED OBSTETRICAL CARE

With these ethical and practical considerations in mind, it is now possible to propose a set of best practices for trauma-informed obstetrical care. This thesis suggests an approach involving
consistent, standardized trauma screening that includes formal PTSD screening for women who report a trauma history. Women with positive PTSD screens then warrant simultaneous psychiatric referral and an obstetrical plan that encompasses micro-trigger avoidance and resilience-focused delivery preparation.

BEST PRACTICES FOR TRAUMA SCREENING

In light of the compelling ethical, practical, and clinically meaningful reasons to conduct routine trauma inquiry that includes PTSD screening, attention must turn to the most appropriate and evidence-based screening practices. The American College of Obstetricians and Gynecologists (ACOG) has suggested screening all women for childhood abuse and has provided some recommendations for sexual trauma screening among military veterans seeking gynecological care (ACOG 2011, 393; ACOG 2012, 1540). In outlining best practices for trauma screening in pregnancy, this new proposal draws upon existing recommendations and extends them to include applications for current obstetrical practice and areas for future study that are specifically relevant to obstetrical care. Best practices for trauma screening should therefore address three key components: prefacing the questions appropriately to convey the relevance of screening, asking the right questions with sufficient detail to be understood, and distinguishing those patients in need of formal PTSD screening and further interventions.

There is insufficient evidence to recommend a specific verbal or written prompt that has been proven to improve patient disclosure prior to inquiring about a history of trauma. ACOG Guidelines for prefacing questions about child abuse suggest offering an explanatory statement to normalize the inquiry such as, “About one woman in five was sexually abused as a child. Because these experiences can affect health, I ask all my patients about unwanted sexual
experiences in childhood” (ACOG 2011, 393). A modification of this explanation for use in obstetrics can broaden the scope from only child abuse to past trauma in general, and it can highlight the benefits of disclosure specifically in pregnancy.

A motivated obstetrician can therefore select the first or second prenatal visit to introduce the purpose of trauma screening in his or her own words, with an emphasis on the nature and relevance of inquiring about trauma. For example, an obstetrician might explain:

We recognize that pregnancy is often a happy time. However, it can also be a time of extra stress, fears, and sensations that can sometimes be challenging to manage physically and emotionally. This can be especially true for women who have had stressful life experiences that are happening currently or that have happened in the past. Such experiences are common, for we know that about one out of every five women has been sexually abused as a child, and many women have lived through an assault, a life-threatening accident, or some other extremely stressful event. The questions that I will be asking over the next few visits are helpful for knowing how we can best support you through the pregnancy. Before we begin, I’d like to make sure you know that everything you share with me is confidential.

This type of explanation gives both the obstetrician and the patient a framework for survivor-controlled disclosure either early in prenatal care or later, as trust develops. Since survivors are often reluctant to disclose a trauma history at the time of initial inquiry, the decision to reveal it is often based on a gradual development of trust and an eventual belief that disclosure will be helpful and relevant to their care (Seng, Sperlick, and Low 2008, 515-516; Seng et al. 2002, 369). An opening explanation like this one can make it easier to repeat trauma-related questions at subsequent encounters, a practice that many trauma survivors reportedly appreciate (Friedman et al. 1992, 1188; Seng, Sperlick, and Low 2008, 516). After introducing the rationale for a trauma history, attention can then turn to performing a detailed screen for prior trauma.
Taking a Trauma History

Eliciting a trauma history can itself be daunting, particularly for clinicians who have not been trained as psychotherapists. Of the many possible approaches to this, one that is standardized, time-efficient, and detailed enough to understand is the brief trauma inquiry that Meltzer-Brody et al. tested for use in an outpatient gynecology center (Meltzer-Brody et al. 2004, 771). This study posed the question: “Have you had a severe trauma(s) or stress in which you thought you or another person might die or experience serious harm? Examples include: physical attack, mugging, rape, severe automobile accidents, natural or manmade disasters, being diagnosed with a life threatening illness, or sexual abuse” (Meltzer-Brody et al. 2004, 771-2). Subsequently, those women who endorsed a history of trauma were then asked to describe the traumatic event and administered a formal screen for PTSD. The simplicity, brevity, and specificity of the examples of trauma make this inquiry method particularly well-suited for use in an obstetrical practice.

Of note, clinicians sometimes grapple with how to best respond when a woman discloses a history of sexual assault, childhood sexual abuse, or other form of interpersonal trauma (Simkin and Klaus 2004, 52). The 2011 ACOG Committee Opinion on childhood abuse emphasizes that one of the most important aspects of eliciting a trauma history is to allow the woman to control the degree and timing of disclosure (ACOG 2011, 393). Descriptive studies suggest that after a patient reveals past trauma, it is most appropriate to respond in an attentive but not overpowering tone and body language (ACOG 2011, 393). For example, if a woman quietly utters “Yes, I was assaulted 5 years ago” in response to trauma history questioning, the physician should avoid empty silence or the appearance of ignoring the trauma disclosure (Seng et al. 2002, 369). On the other hand, the physician should refrain from raising his or her voice above the level of the
patient’s to gasp, “I can’t believe that happened to you; that’s terrible!” An overpowering response of this nature could give the impression that the information is too upsetting to the caregiver for any further discussion (Simkin and Klaus 2004, 243). Rather, a more fitting response might be, “I’m sorry to hear that you went through that. It takes courage to reveal something like this, so thank you for sharing it with me. How do you think the event has affected you?” (Sperlich and Seng 2008, 89; Simkin and Klaus 2004, 244) In the event that a physician suspects a trauma history but the woman denies it, studies on survivors’ perspectives and preferences suggest that the appropriate response is to remain aware of any signs of uncontrolled anxiety or posttraumatic stress symptoms, but to abandon further inquiries at that time (Seng et al. 2002, 367).

**PTSD Screening**

Once a woman discloses a history of trauma, further workup is indicated in the form of PTSD screening. The Clinician Administered PTSD Scale (CAPS), the gold standard diagnostic instrument for PTSD, is a 30-item structured interview that the physician or other trained examiner must administer (Blake et al. 1995, 78-9). Most obstetricians, however, are not trained to do this. It would also be impractical to conduct an interview of this length in the busy obstetrical care setting. However, numerous self-administered, validated instruments are available that are more suitable for use during a prenatal care visit (Brewin 2005, 56). In particular, the SPAN screening instrument that has already been recommended for use in gynecological care is an appropriate, brief, validated tool that a motivated obstetrician could begin to use in his or her current practice. The SPAN is a symptom-based, 4-item assessment of a woman’s self-report of being easily startled, anxious, angry, and emotionally numb. Answers
range from “not at all distressing” to “extremely distressing” along a 5-point scale, and administering the scale requires only one minute (Meltzer-Brody et al. 2004, 772).

Patients who screen positive, scoring 5 or greater on the SPAN symptom scale, may have PTSD. However, the diagnosis must still be confirmed in a structured diagnostic interview. It is therefore necessary to refer patients to a mental health service provider for confirmatory PTSD evaluation and possible initiation of treatment. In short, these proposed methods for routine, standardized trauma inquiry and follow-up PTSD screening are suitable for the prenatal care setting, time-efficient, and feasible to put into practice without placing extraordinary burdens on the clinician or the current maternity care system.

Refining Best Practices for Trauma and PTSD Screening: Future Research and Administrative Challenges

Further research will be useful to determine what methods of framing trauma-related questions are most effective in facilitating patient disclosure. Rates of disclosure are consistently low, and known barriers to patient disclosure of past trauma are numerous and complex. At the present time, it is unclear if a pre-written prompt designed to be read in the waiting room before the prenatal visit or, alternatively, in the privacy of the patient’s home is superior to a verbal explanation given immediately before eliciting a trauma history. Likewise, more empirical studies are needed to establish whether screening for childhood sexual abuse requires a different preparatory framework than screening for other forms of childhood or adult trauma. Since child abuse can take many forms, and women may not necessarily characterize chronic physical or sexual abuse that did not involve actual penetration as “assault” or even as traumatic, further research may identify specific explanatory wording that is most helpful for explaining the purpose of detailed trauma inquiry when child abuse is suspected.
More research is also needed to test other possible approaches to eliciting a comprehensive trauma history. Although the simplicity of the single-question prompt included with the Meltzer-Brody adaptation of the SPAN scale is attractive to busy clinicians, it may not be the most sensitive measure of trauma exposure. Further studies testing the validity of other trauma screening instruments in the pregnant population will help to identify other useful instruments that are physician-friendly, time-efficient, and highly sensitive. The sensitivity of trauma inquiry to pick up childhood abuse survivors is an area of particular interest. Many childhood trauma survivors may not perceive their childhood abuse as “traumatic” and may therefore not be identified in routine trauma screening.

The Adverse Childhood Experiences (ACE) questionnaire is a straightforward, brief, self-assessment tool that identifies exposures to 10 different forms of childhood abuse and allows for the calculation of an ACE score to assess a patient’s level of risk for adverse health outcomes. The possibility of providing this questionnaire in written form for patients to complete at home would be a potentially time-efficient approach to eliciting a history of child abuse, a topic that many obstetricians find difficult to explore delicately in a time-pressured environment. More research is needed to assess the benefits and drawbacks of this approach to child abuse inquiry among pregnant trauma survivors.

Furthermore, identifying the optimal PTSD screening tool in pregnancy will require further research. Several validated instruments already exist for PTSD screening in the outpatient setting (Brewin 2005, 56), but none are pregnancy-specific. These other self-administered screening instruments will need to be tested in pregnant women to evaluate their usefulness in the prenatal care setting. The development of a combined instrument that screens for both trauma history and posttraumatic symptoms may also be valuable. For example, Seng et al. proposed a
five-item screen that addresses both trauma exposure and the most common PTSD-associated symptoms in pregnancy (Seng et al. 2010, 182-184). Future empirical studies on this and other instruments can assess the comparative utility of a combined rather than stepwise approach to trauma inquiry and PTSD screening.

Finally, best practices will ultimately involve the development of a referral system that coordinates mental health evaluation and follow-up for patients whose initial trauma inquiry and PTSD screens are positive. An extensive body of research on depression screening reveals that clinicians are much more likely to embrace a standardized approach to trauma screening in the setting of a well-developed mental health referral system that allows physicians or midwives to “talk to a mental health professional right away and get the patient in to be seen quickly” (Kim et al. 2009, 169). Barriers to effective depression screening have included a lack of time during office visits, the lack of training and experience with mental health issues, and the lack of a systematic protocol for follow-up of women who have a positive screening test (Kim et al. 2009, 169, 171). Although screening for a history of trauma requires screening tools that are distinct from those used for depression, similarly centralized programs that facilitate mental health referral and follow-up will likely help to overcome some provider-related and infrastructure-related barriers to consistent PTSD screening and referral for psychotherapy.

Developing an efficient mental health referral infrastructure is likely to require significant administrative effort and expense for many existing healthcare systems. Ideally, coordination at the administrative level of a tertiary hospital or managed care organization would create a comprehensive system that facilitates the transmission of a patient’s referral from the obstetrician to a mental health provider, the scheduling of immediate appointments for formal PTSD evaluation, and the coordination of mental health follow-ups. With such a system in place,
mental health professionals can assess the appropriate cognitive behavioral therapy for individual women early in pregnancy. In addition, a well-designed infrastructure for obstetric and psychiatric co-management of individual patients would allow the obstetrician to devote valuable time to patient care rather than to the administrative hassles associated with coordinating mental health care follow-up. In the end, best practices for effective trauma screening will depend in large part on the effectiveness of the referral system in which screening takes place.

Once trauma screening has identified a woman as a survivor and PTSD screening is positive, the obstetrician has identified “trauma with posttraumatic stress symptoms” as an obstetrical risk factor that warrants an appropriate plan of care. Beyond mental health referral, the obstetrician is obligated to create a plan for avoiding micro-triggers over the course of routine care and for resilience-enhancing delivery preparation.

**BEST PRACTICES FOR MICRO-TRIGGER AVOIDANCE**

At the present time, obstetrician can and should adopt practices that avoid common micro-triggers when it is medically safe to do so. Some general approaches to avoiding common triggers are applicable to all women as a matter of good clinical practice. Others will need to be tailored to individual patients.

Certain general strategies for micro-trigger avoidance are applicable to all women, whether or not there is a known trauma history. It is simply good clinical practice to ask patients how they prefer to be addressed and to call them by their names in place of “sweetie,” “honey,” and other terms that might be intended to comfort but instead may patronize patients (Hobbins 2004, 491). Asking permission prior to touching a patient is a standard element of professionalism that should apply to all women in every circumstance. Likewise, it is generally
important for clinicians to refrain from gestures that may be perceived as overpowering. Sitting on the bed and speaking with the patient at eye level is usually preferable to leaning over her during a discussion or an examination. Furthermore, teaching physicians should routinely explain the role of residents and students prior to their inclusion in the labor and delivery process. These recommendations are simply reinforcing existing standards for professional behavior when interacting with all patients.

When caring for known trauma survivors, however, triggers will differ for each patient depending on the individual circumstances of trauma exposure. Thus, a one-size-fits-all approach to avoiding triggers is unlikely to be sufficient for meeting the individual needs of pregnant patients (Sperlich and Seng 2008, 67). In the context of the initial trauma inquiry, clinicians may appropriately respond to trauma disclosure by asking the woman to characterize the nature of her past traumatic events and by inquiring about how she believes these events have affected her. This question is a natural bridge to discussing the potential link between stressful triggers related to past trauma and the anticipated impact of those same triggers on pregnancy and delivery. Researchers have found that some women who are aware of their own tendencies to develop acute stress reactions to painful or stressful stimuli appear to overlook the relevance of this knowledge in preparing for the acutely painful and stressful elements of childbirth (Seng et al. 2002, 364). It therefore becomes imperative for the obstetrician to make this connection explicit for those patients who are able to articulate their known triggers. Prior to beginning the physical exam, for instance, a clinician might ask, “Since the assault, how would you describe your experience with pelvic exams? Is there anything that I can do to make things easier if you begin to feel stressed during the exam today?” (Sperlich and Seng 2008, 67). While the examination itself is still medically recommended in most cases, this line of inquiry allows both parties to
identify an anticipated trigger and to create a shared plan for minimizing it. The obstetrician and patient can then agree together on an approach in which the patient may raise her hand at any time to stop the exam, choose to keep some of her clothing on, or opt to reschedule the exam for a later time at which she feels more prepared or can arrange for a support person to accompany her during the procedure (Sperlich and Seng 2008, 67). In essence, an emphasis on micro-trigger avoidance should include efforts to ask the patient if she is aware of procedures that are known anxiety triggers for her and if any modifications have been helpful for avoiding a stress reaction in the past.

When specific triggers are not identified, obstetricians caring for known trauma survivors can readily cultivate the practice of avoiding common micro-triggers that may contribute to an experience of re-victimization. In the event that the clinician and medical staff are aware of a patient’s trauma history, it becomes especially critical to avoid phrases that accentuate powerlessness such as, “Just let it happen, you can’t fight it” (Hobbins 2004, 491). If it is possible to avoid alternating providers within the same shift, every attempt should be made to do so. On the other hand, if a shift change necessitates new providers, the medical team can easily inform the patient about this in advance, and introductions should be a priority. These seemingly straightforward approaches to reducing micro-trigger exposures are feasible, require minimal time or expenditure of resources, and may have a large impact on a woman’s perception of control, dignity, and the level of care she is receiving.

Refining Best Practices for Micro-trigger Avoidance: Future Research and Administrative Challenges

While some trauma-informed modifications to current obstetrical practice are feasible to adopt at the present time, other possible strategies for micro-trigger avoidance will require
additional evidence before proposing clinical practice and administrative changes. Some key areas for future study include possibilities for restructuring certain stressful elements of the hospital admissions process, approaches to resident and student education when caring for trauma survivors, and the development of evidence-based strategies for monitoring the progress of labor for women who cannot tolerate the normal frequency of vaginal exams.

It is clear that numerous hospital features may contribute to a sense of alienation, privacy invasion, and chaos for trauma survivors (Simkin and Klaus 2004, 256). In addition to improving the aesthetics of the labor and delivery ward, one procedural feature that could be streamlined to reduce patient anxiety is the multi-step process that some obstetrical care teams follow when admitting a new patient to the labor and delivery unit. For a woman with a sensitive trauma history who may or may not have shared this history with her primary obstetrician, an admission system that requires her to repeat her history to multiple individuals in various roles and at various levels of training has the potential to generate anxiety and frustration. Transforming this process to involve fewer, selected interviews may be useful for reducing patient anxiety.

In some settings, especially teaching hospitals, streamlining history-taking will require a new approach to teamwork and new policies to guide this collaboration. Presumably, such collaborative efforts would involve asking the patient if she has any concerns, questions, or anticipated anxiety triggers. It might also involve reviewing any available birth plan details as a team and with the patient’s involvement. Improving the hospital process for trauma survivors may also entail limiting the number of providers who are assigned to care for the woman in order to maintain an atmosphere of continuity and trust. This can sometimes result in the exclusion of resident and medical students from participation in patient care at the woman’s request. Future research may be able to elucidate how to best train students and residents in methods of trauma-
informed care while, at the same time, acknowledging what trauma survivors find most helpful or particularly disconcerting when residents and medical students are involved in their care. More research will be needed to determine the extent to which trauma survivors actually perceive the admission process as distressing when they present to the hospital in labor. Ultimately, evidence is insufficient to make formal recommendations about changes to the admission process and trainee involvement at this time.

Another area of interest for future study is the potential flexibility of current protocols for examination frequency in active labor. Research is needed to determine the minimal acceptable frequency of cervical examinations for trauma survivors who are unable to tolerate a pelvic examination without developing an acute stress reaction. For an extremely anxious abuse survivor, the prospect of a vaginal exam can sometime generate such fear that the obstetrician finds it very difficult to assess the progress of labor without re-traumatizing the patient. Studies that reconsider the two-hour interval between vaginal exams might be very useful for creating guidelines for the care of this unique group of obstetrical patients.

Best Practices for Resilience-Building Interventions

While much more research is needed to identify evidence-based resilience interventions that improve obstetrical outcomes, a motivated obstetrician can still incorporate some available resources into his or her current practice. This proposed strategy for best practices recommends two methods for enhancing resilience that are feasible for an obstetrician: encouraging doula support and creating a plan for stress-coping in preparation for delivery.
Encouraging a Birth Doula

The first recommended resilience method is encouraging a birth doula for support during childbirth. Doulas are helpful for active coping, likely by virtue of resilience-enhancing affirmation of the patient’s self-efficacy and the presence of constant support during labor. Ideally, obstetricians would introduce the idea of selecting a labor coach early in pregnancy and offer resources for contacting and hiring one who has prior experience working with trauma survivors. Most doulas will try to meet with the woman and her partner at least twice before the time of delivery. These encounters allow the parties to become familiar with each other and to discuss birth plan preferences, other available support services in the prenatal and postpartum periods, and reimbursement (Simkin and Klaus 2004, 176).

Despite strong evidence that their involvement can be helpful for the patient, working with a doula can sometimes present challenges for clinicians and patients. First, some low-income patients may not be able to afford doula services, which can exceed one thousand dollars and which many insurance plans may not cover. Clinicians should be aware that less experienced coaches or doulas-in-training may offer their services for free or at a significant discount. Some provide their services as hospital volunteers or through community programs (DONA International 2005, under Birth Doula FAQs; Sperlich and Seng 2008, 129). In addition, more experienced doulas frequently offer payment plans that may be more feasible for women with modest incomes. Hence, financial constraints can sometimes limit but will not necessarily preclude access to doula support services.

Second, clinicians and doulas provide distinct aspects of care that sometimes require teamwork to be successful. DONA International, a multinational association of certified birth
doulas, states in its standards of practice that “the doula accompanies the woman in labor, provides emotional and physical support, suggests comfort measures, and provides support and suggestions for the partner” (DONA International 2008, under Standards of Practice for Birth Doulas). Although doulas do not performing clinical tasks or make clinical decisions for the woman (DONA International 2008, under Standards of Practice for Birth Doulas), they do work alongside and may interact with obstetricians during the course of labor. When the two work well together and have similar visions for supporting the laboring mother, all parties benefit. If, on the other hand, the clinician and doula assume adversarial roles by expressing misgivings about the other’s intentions or recommendations, the trauma survivor may end up confused, divided, and even more anxious. It is therefore critical for doulas and clinicians to work collegially if doula support is to be an effective means of building resilience.

While doula support is valuable, and the obstetrician has fulfilled “responsible assurance” by facilitating doula participation in the delivery process (Little and Lyerly 2013, 260), encouraging the presence of a doula will not itself accomplish the work of delivery preparation that the primary obstetrician has a duty to provide during the course of prenatal care.

Resilience-Focused Delivery Preparation

Role-specific obligations to guide the survivor through an obstetrical plan for delivery will require counseling and candid discussions about what events to expect, what procedures are optional versus critical, and what coping strategies may be helpful in the context of necessary obstetrical interventions. While such conversations may uncover certain micro-triggers that can be avoided or substantially lessened, an obstetrician must also focus on preparing the survivor for those processes associated with necessary obstetrical care that cannot be reasonably avoided. In
practice, making this distinction will often rest on the difference between asking what “I can do as your doctor” for trigger-avoidance purposes versus what “you can do” to prepare in case it becomes impossible to avoid a dreaded stressor. A patient who fears being cut surgically may hope to have a controlled, vaginal delivery. Yet there is little role for trigger avoidance if an obstetrical emergency necessitates an urgent cesarean delivery. Without a method for discussing such fears, expectations, and contingency plans systematically, conducting this type of preparatory counseling can be especially challenging.

This proposal recommends the use of a flexible birth plan in the second and third trimesters to facilitate the discussion by supplying a format for systematic review of common procedures and options for delivery planning (Sperlich and Seng 2008, 93; Simkin and Klaus 2004, 151). Without question, the use of birth plans is a source of division in the obstetrical community. While highly desirable to some patients, these plans have significant drawbacks in the eyes of many obstetric providers and maternity care staff (Grant, Sueda, and Kaneshiro 2010, 31). Though patients often cite the sense of empowerment that comes from communicating their detailed delivery preferences, rigid birth plans can be frustrating to the medical team and a source of disappointment to the patient when the unpredictability of labor requires a departure from a pre-written list of demands (Lothian 2006, 296; Sperlich and Seng 2008, 94). Their usefulness in the general population is therefore controversial.

However, a specific type of birth plan for this specific population of trauma survivors can be critical. First, it functions as the clinician’s tool for efficiently and systematically exploring different components of the labor and delivery experience with the survivor. Both the obstetrician and the patient will be able to discuss those parts of the labor process that are unavoidable. Second, the very process of constructing a birth plan together encourages the
obstetrician and the patient to engage in shared decision-making. This collaborative model of decision-making is especially fitting for selecting the ideal mode of delivery, making plans for pain management or freedom of movement in labor, and considering how plans might change in the setting of unexpected or potentially emergent events. Third, it allows the obstetrician to uncover certain misconceptions and unreasonable expectations that the survivor may have about aspects of the labor process. The obstetrician is then able to address those expectations so that they do not become unforeseen sources of anxiety and frustration during the birthing process. This type of birth plan preparation, which aims to encourage flexibility rather than rigid control in anticipation of unpredictable events, may be valuable for enhancing self-efficacy. In the end, a patient who has at least considered how she might respond to deviations from her ideal expectations is more likely to feel prepared and confident in her ability to handle whatever course her labor takes. This is the very goal of resilience-building in obstetrical care.

**Allocating Time for Resilience-Building**

The most significant barrier to adopting this suggested resilience-building approach is time allocation. When clinicians identify hypertension or diabetes in the course of prenatal care, they designate those conditions as significant risk factors that require patient education, counseling, health monitoring, and often additional visit time (Sperlich and Seng 2008, 91). In a similar way, an obstetrician whose patient discloses a history of trauma and posttraumatic stress symptoms will need to recognize posttraumatic stress as a risk factor necessitating some additional visits or more extensive sessions to accomplish the work of education and preparation. By making a concerted effort to document posttraumatic stress, to use billing codes that reflect this diagnosis as a complicating factor, and to spend appropriate time addressing relevant issues, an obstetrician can begin the work of resilience-building. While the prospect of allocating
extensive blocks of time for this counseling is clearly impractical, shorter conversations covering only one or two topics per visit over the course of the second and third trimesters are much more feasible in a time-pressured office setting. It is also possible for nurses and other healthcare personnel to assist in the work of patient education and trauma-informed childbirth preparation. Just as a diabetic nurse educator often shares the task of diabetic counseling with an obstetrician, a similar approach to shared counseling roles can enable clinicians to allot a manageable amount of time for primary obstetrician to engage the survivor in the work of delivery preparation.

**Refining Best Practices for Resilience-Building: Future Research**

Much more research is needed to fully understand resilience and its effects on perinatal outcomes for pregnant trauma survivors with chronic posttraumatic stress. Fortunately, over 15 instruments have been developed to measure resilience. According to a review of resilience measurement tools, those with the most consistent psychometric properties appear to be the Connor-Davidson Resilience Scale (CD-RISC), the Resilience Scale for Adults, and the Brief Resilience Scale (Windle, Bennett, and Noyes 2011, 1). With the availability of these instruments, it is possible to perform empirical research on the efficacy of resilience interventions in prenatal care.

Studies have not yet been done to confirm an improvement in quantitative and qualitative measures of resilience after interventions of unclear benefit. Educational interventions like childbirth education classes, which are often helpful for familiarizing women with hospital procedures, basic birth preparation, and pain coping techniques (Lowe 2002, S21) are often presumed to enhance coping skills by improving self-efficacy. Yet many studies have not shown consistent improvements in outcomes or coping skills beyond the first stage of labor for women.
who have completed childbirth education (Gagnon and Sandall 2007, under Abstract). Thus, more research will be needed to demonstrate the self-efficacy benefits of prenatal birth education. Likewise, the effects of parenting classes on resilience, maternal confidence, self-efficacy, and knowledge about healthy emotional attachment are largely speculative. Well-designed empirical studies may help to confirm the benefits of these approaches.

Other resilience-building interventions that are being developed and studied in pregnancy are not yet widely available. One promising intervention addresses severe childbirth fear in first-time mothers through the use of psychoeducational group therapy during prenatal care and the postpartum period. In a recent study, women randomized to this form of group therapy had a lower rate of cesarean section and a higher rate of satisfaction with their birth experiences than women who did not undergo therapy (Rouhe et al. 2013, 75). Studies replicating this outcome may provide compelling evidence for screening patients for childbirth fear and subsequently referring them to an interventional program modeled after this one. At the present time, however, this intervention is still generally unavailable. Further research, infrastructure, and training will be necessary to recommend this resilience-building method for prenatal care.

Future development of resilience-enhancing interventions may even follow the design of the Surviving Cancer Competently Intervention Program (SCCIP) that combines cognitive-behavioral therapy and resilience-building techniques for empowering cancer patients and their families. Workshop-based, single-day, family-centered programs that involve specific sessions and videos designed to help individual patients and their loved-ones practice the cognitive skills of “reframing beliefs” and maintaining inner control could transform current practices of preparing survivors to gain the confidence to cope with childbirth (Kazak et al. 1999, 180).
Furthermore, empirical studies are needed to determine the optimal resilience-building interventions, especially for special at-risk populations. It will be particularly important to investigate those resilience-enhancing methods that have the highest rates of success for empowering pregnant women who have a history of childhood sexual abuse, which appears to have more damaging long-term effects than other forms of trauma (Lev-Wiesel and Daphna-Tekoah 2009, 877). Future studies may also help to elucidate racial and ethnic differences in childbirth experiences for underrepresented minorities who have a history of PTSD. Known disparities exist between racial groups in the prevalence of PTSD, patient attitudes about mental health therapy, and access to mental health services (Leis et al. 2011, 316-317). When stratified by race, the prevalence of PTSD in pregnancy is four-times higher among African American women than for non-African American women (Seng et al. 2011, 295). The severity of PTSD in pregnancy may also differ between racial groups, for African American women report more posttraumatic stress symptoms than women of other races (Seng et al. 2011, 300). While these differences appears to stem from greater cumulative trauma exposure for African American women, the risk for developing PTSD remains surprisingly consistent across socioeconomic levels (Seng et al. 2011, 302). Moreover, these survivors seem to utilize mental health therapy, social interaction, and self-help materials for stress coping less frequently than other racial groups (Seng et al. 2011, 302). Studies aimed at reducing barriers to mental health treatment and testing methods of resilience-building could identify specific interventions that will be most effective for preventing the development of PTSD or the exacerbation of underlying symptoms after childbirth in this population.
CONCLUSION

This thesis has presented a framework for applying principles of trauma-informed care to current obstetrical practice. The prevention of posttraumatic stress symptom relapse during childbirth for pregnant women with a prior history of PTSD should ideally involve a multilayered approach to obstetric care. Obstetricians can facilitate adequate preparation for a potentially re-traumatizing childbirth by employing a three-part strategy to screen for trauma routinely and PTSD when indicated, to avoid various micro-triggers for symptom relapse in prenatal care as well as during labor, and to build resilience in preparation for overcoming delivery and postpartum stressors. These proposed modifications to routine obstetrical care can better empower this unique population of women to have a successful, healthy delivery and a positive birth experience.

There are far-reaching implications of this proposed three-phase approach to identifying, taking steps to avoid re-victimizing, and empowering trauma-exposed women to adapt resiliently to the stressors of the perinatal period. Health disparities researchers, public health experts, and public policy makers have begun to pay increasing attention to the impact of stress exposure and stress coping on various social determinants of health (Cheng and Kindig 2012, 5; Blanch, Filson and Penney 2012). As research continues to explore the implications of fetal neurodevelopment in the setting of elevated and chronic maternal stress (Talge et al. 2007, 250), those modifiable aspects of maternity care that influence maternal stress coping will be critical to develop. It stands to reason that obstetricians, as clinical experts at the very intersection of maternal and child health, have a unique opportunity and responsibility to play an active role in developing strategies for optimal maternal and child health outcomes.
To be sure, there are limitations to implementing the best practices recommended in this thesis. First, more research is needed to understand the extent to which maternal posttraumatic stress affects obstetrical outcomes such as low birth weight and preterm delivery. Previous studies that have attempted to address these questions have yielded conflicting results, most likely due to inadequate size. Second, some outcome measures that clearly impact maternal well-being and ability to function in the postpartum period are difficult to capture in a research setting and challenging to measure in a community setting. For example, strategies for improving healthy maternal-child attachment for at-risk trauma survivors cannot be tested ethically in a randomized controlled trial with a therapy arm and a control group that is left without any intervention. In addition, much more research is needed to identify evidence-based interventions for enhancing patient resilience in clinical care.

In the end, obstetric providers have an obligation to screen for past trauma, avoid unnecessary triggers, and promote resilience for women at risk for re-traumatization from childbirth. This approach to PTSD relapse prevention offers a framework that obstetric providers can employ to support women in labor who have been the victims of prior trauma. Adopting and continuing to refine these strategies has great potential to promote the physical and mental wellbeing of this unique population of women during the birthing process.


