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- Tracey Vogel, MD – NOMA.AI consultant & operator of The Empowerment Equation LLC website

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PA PQC

Pennsylvania Perinatal Quality Collaborative

Learn more at www.papqc.org

Mission: The PA PQC provides quality improvement support to healthcare teams to improve the standard of care for pregnant and postpartum people and babies.

Vision: Every birthing person and baby in Pennsylvania receives equitable, safe, and optimal care.

PA PQC
Pennsylvania Perinatal Quality Collaborative

What is a PQC?

Perinatal Quality Collaboratives (PQCs) are networks of multidisciplinary teams, working to improve outcomes for maternal and infant health.

- PQCs advance ***evidence-informed*** clinical practices and processes using ***quality improvement*** (QI) principles to address gaps in care.
- PQCs work with clinical teams, experts and stakeholders, including patients and families, to spread best practices, reduce variation and optimize resources to ***improve perinatal care and outcomes***.
- The goal of PQCs is to achieve improvements in ***population-level outcomes*** in maternal and infant health.

47 states, including PA have a statewide Perinatal Quality Collaborative

The 2026 PA PQC Initiatives:

A Family Approach to Services and Transitions for Opioid Use Disorder & Neonatal Abstinence Syndrome

A Family Approach to Postpartum Discharge Transition

Alliance For Innovation On Maternal Health Patient Safety Bundle

Prenatal and Postpartum Depression Initiative

We know that a trauma informed approach, specific to perinatal healthcare, can improve maternal and infant health

We recognize the importance of provider and staff trainings and how it supports the work being done in your hospital toward the PA PQC Substance Use Disorder initiative

All PA PQC Healthcare Teams are asked to answer the following survey question on a quarterly basis…

Has your hospital developed trauma-informed protocols in the context of substance use?

These Trauma Informed Care trainings are being provided by the

PA PQC

Pennsylvania Perinatal Quality Collaborative

The Empowerment Equation

Understanding trauma in obstetrics and working towards more collaborative and culturally sensitive care.

Tracey M Vogel MD
anesobstories@gmail.com
@TraceyVogelMD

Disclosure

NOMA.AI

The Empowerment Equation LLC

Learning Objectives

- Realize the widespread impact of trauma in our society
- Recognize signs and symptoms of unresolved psychological trauma in patients
- Understand the consequences of a traumatic birth on the trauma survivor and her child
- Understand the importance of collaborative care and shared decision making to improve outcomes in this patient population

An Interesting Situation

- An individual (G1P0) with preeclampsia with severe features
- Transferred from a midwife center
- Refusing all standard treatment modalities
- Her “irrational” behavior prompted requests for consultation with the psychiatric service, the hospital’s ethics committee, social services, and the legal department.
- She had no documented history of any mental health issues, but she did have a remote history of abuse

Implications

- Risk for harm for the mother and the child
- Extensive utilization of resources
- Calls into question the legal rights of this mom- do fetal rights trump maternal rights?
- Negative impact on the staff
- Many providers are ill-equipped to identify the risks, signs and symptoms of psychological disease processes

What is trauma?

- *"Psychological trauma is an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities.* ***Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning….*** *Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life…. They confront human beings with the extremities of helplessness and terror and evoke the responses of catastrophe."*

- Judith Lewis Herman, *Trauma and Recovery The Aftermath of Violence - From Domestic Abuse to Political Terror*

Trauma from the Past

- DSM V Definition
  - The person was exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):
    - Direct exposure
    - Witnessing the trauma
    - Learning that a relative or close friend was exposed to a trauma
    - Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

What is Trauma?

Individual vs. collective

- Individual-any trauma that affects the individual uniquely including childhood adversity and abuse, intimate partner violence, sexual assault and rape, birth trauma
- Collective-trauma that impacts the communities or specific groups of individuals that includes historical trauma such as racial trauma, public experience of trauma, war, natural disasters

Trauma-awareness as part of a cultural change

- A system that is not “trauma-aware” is “trauma-denied”[1]

1 Elliott DE, Bjelajac P, Fallot RD, et al. Trauma-informed or trauma-denied: principles and implementation of trauma-informed services for women. J Community Psychol 2005;33(4):461–77.

What is Trauma?

Individual Trauma as the "3 E's"

*"Individual trauma results from an **event,** series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life threatening and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."*

Substance Abuse and Mental Health Services Administration.

Interpersonal Trauma

- Approximately 20-33% of females will be the victims of childhood sexual trauma [1]
- Approximately 33% of female veterans will self-report a history of military sexual trauma [2]
- 1 in 4 women will experience severe physical violence from IPV in their lifetime [3]
- Up to 44% of women report their birth experiences as traumatic [4]
- Pregnant teens have a mean ACE (Adverse Childhood Experiences) score of 5.1 [5]

1 US Department of Justice, Sobel, et al. *Obstet Gynecol* 2018, Seng ,et al. *J Midwifery Womens Health* 2013, Felitti, et al. *Am J Prev Med* 1998

2 Sadler, et al. *J Womens* Health 2011

3 CDC's National Intimate Partner and Sexual Violence Survey 2017

4 de Graaff, et al. *Acta Obstet Gynecol Scand* 2017

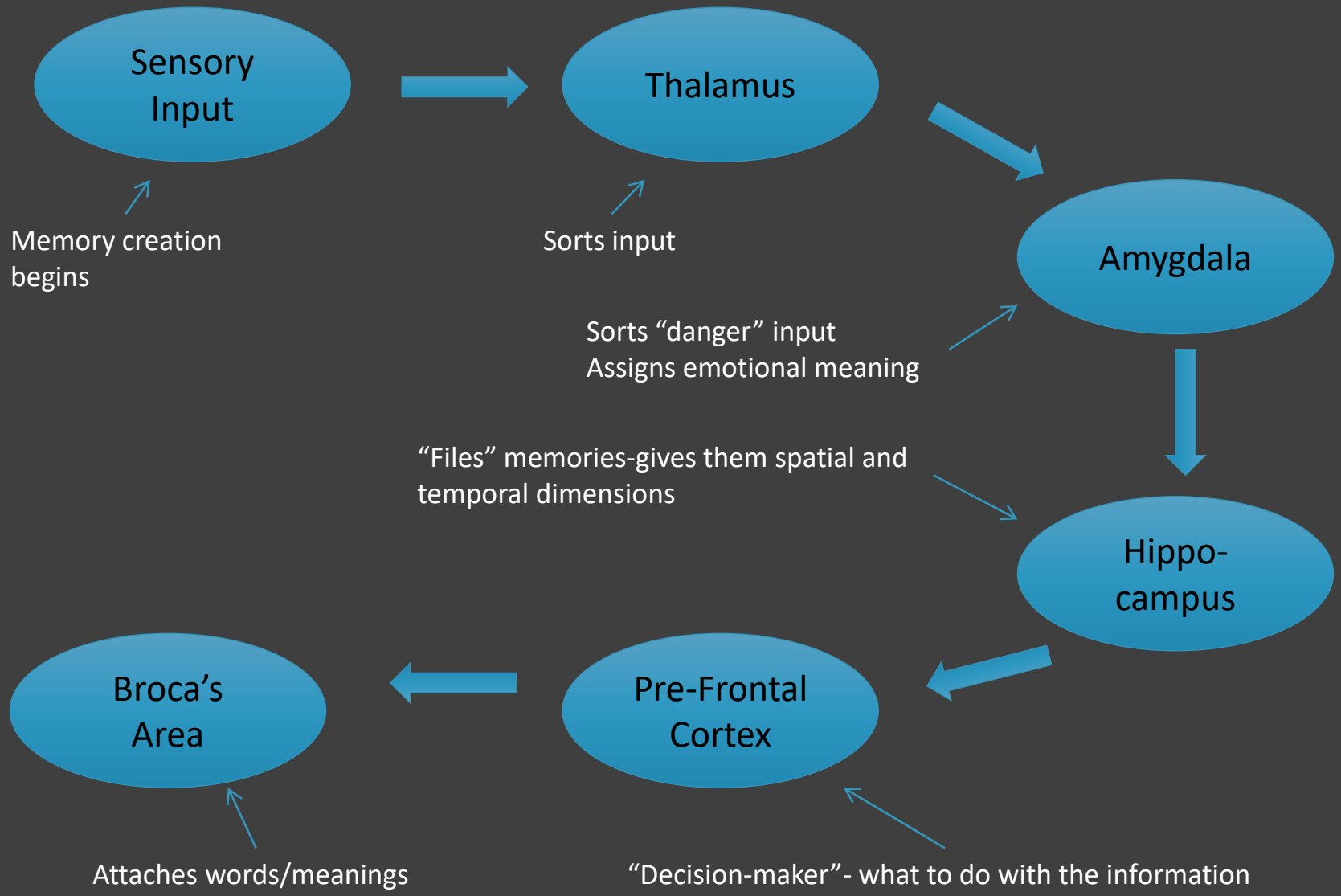
5 *Millar HC, et al. J Ped and Adolescent Gynecology 2021*

Interpersonal Trauma

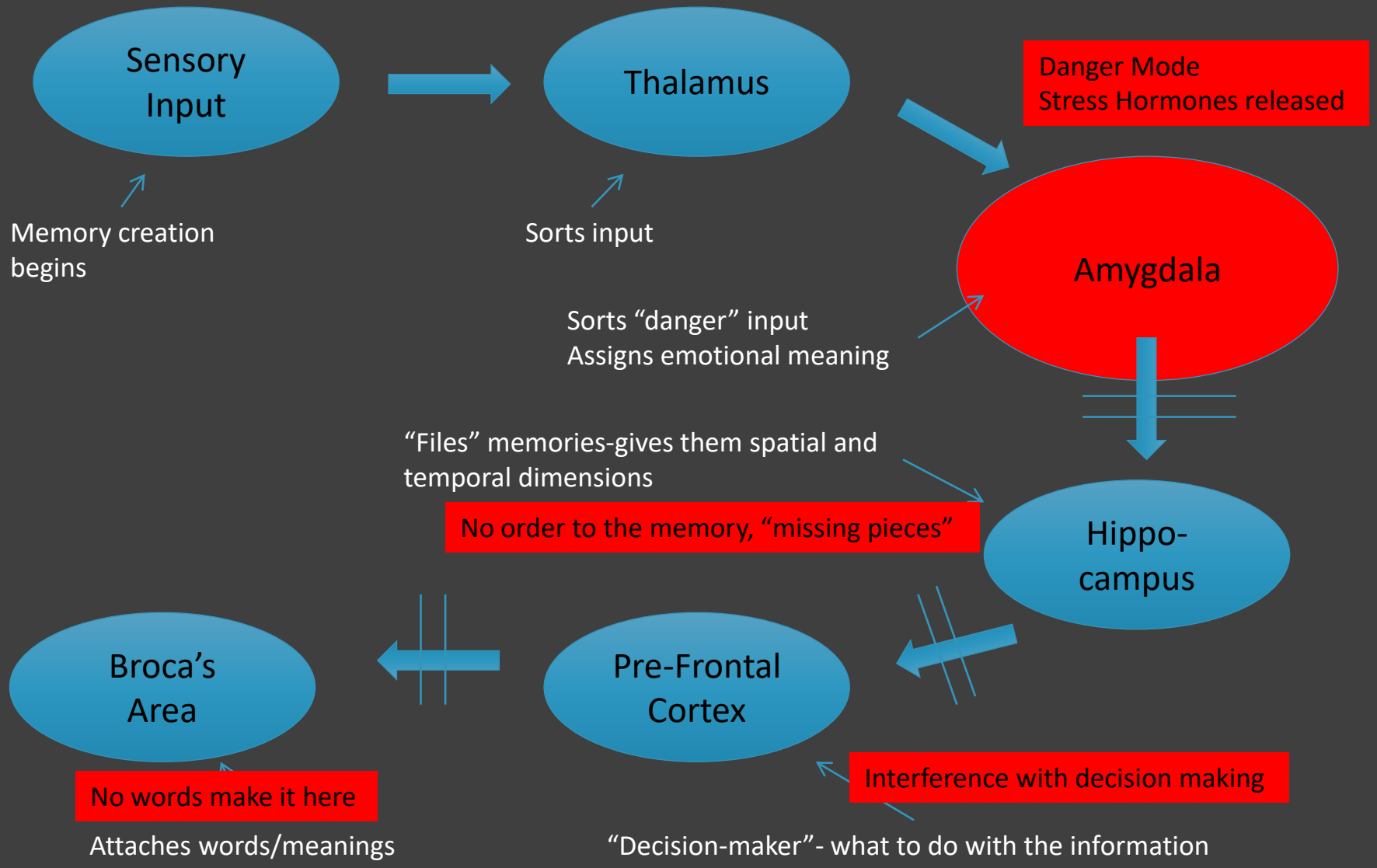
- 9% will meet criteria for a diagnosis of PTSD when they present to an obstetric provider during pregnancy [1]
- Many adult survivors have unaddressed and unresolved trauma issues
- 18% of obstetricians and obstetric residentsreport clinically significant PTSD symptomsin the UK [2]
- 20.8% attending anesthesiologists withprobable PTSD after COVID-19 [3]

1 Seng ,et al . *Obstet Gynecol* 2009.
2 Slade, et al. BJOG 2020.
3 Afonso, et al. Anesthesiology 2024

Normal Brain Response to Events



The Brain on "Trauma"



DSM Diagnostic Criteria

Criteria	**Real life Behaviors**
Stressor	
Re-experiencing	Flashbacks/nightmares/triggers
Avoidance &Numbing	Passive, “check out/dissociate” No attention to danger Often the victims in relationships People pleaser, sacrifices their own feelings
Arousal	Hypervigilant Hostile Panic behaviors Paranoid
Negative cognitions and mood	Guilt/negative feelings about oneself/lost interest in activities
Duration, Disability	

TRAUMA CYCLE

Trauma

PTSD

- Negative or lack of coping mechanisms
- Disconnected

Re-Traumatized

Vulnerability to Re-traumatization

Adverse Childhood Experience (ACE) Study

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect

- Mother treated violently
- Household substance abuse
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

Felitti, et al. *Am J Prev Med* 1998

ACE Study Results

- Smoking
- Obesity
- Physical Inactivity
- Depression
- Suicide

- Alcoholism
- Illicit Drug Use
- Injected Drug Use
- 50+ sexual partners
- STDs

Philadelphia ACE Study

7/10 adults had experienced one ACE
2/5 had experienced four or more.

Philadelphia Expanded ACE Questions look at Community-Level Adversity	
Witness Violence	How often, if ever, did you see or hear someone being beaten up, stabbed, or shot in real life?
Felt Discrimination	While you were growing up...How often did you feel that you were treated badly or unfairly because of your race or ethnicity?
Adverse Neighborhood Experience	Did you feel safe in your neighborhood? Did you feel people in your neighborhood looked out for each other, stood up for each other, and could be trusted?
Bullied	How often were you bullied by a peer or classmate?
Lived in Foster Care	Were you ever in foster care?

Long term Effects of Unresolved Trauma

- Sleeping difficulties
- PTSD
- Dissociation
- Substance Use Disorders/Addictive behaviors/Eating disorders
- Anxiety/depression
- Decreased Self Esteem
- Suicidal ideation
- Fatigue
- Physical Issues -hypertension, gastrointestinal problems, migraines, chronic pain conditions including pelvic pain, poor immune function, fibromyalgia, decreases in cognitive function, earlier hysterectomy in female veterans

van der Kolk, et al. Traumatic Stress. Guilford 2007
Felitti, et al. *Am J Prev Med* 1998
Herman, J. Trauma and Recovery. Basic Books 2015
Chichowski S, et al. *Military Medicine* 2017

The Intersection of psychological trauma and obstetrics:

Before, during, and after delivery

MimiPrints

Prior Sexual Trauma and the Parturient

- Intrinsic Triggers
  - Painful contractions
  - Nausea and vomiting
  - Bloody excretions
  - Instinctual reactions (moaning, grunting)
  - Change in appearance

Simpkin P, Klaus P. When survivors give birth. Seattle, Washington: Classic Day Publishing, 2004

Prior Sexual Trauma and the Parturient

- Extrinsic Triggers
  - Sights, smells, sounds of the hospital environment
  - Hospital environment, beeping equipment, bright lights
  - Lack of privacy
  - Lack of respect for the woman's modesty
  - Separation from loved ones
  - Vaginal exams, injections, arm straps, physical restraint

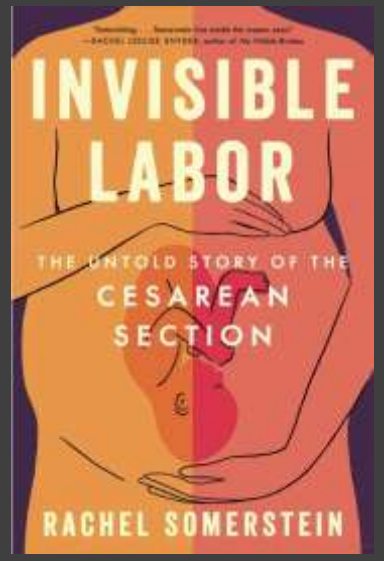
Simpkin P, Klaus P. When survivors give birth. Seattle, Washington: Classic Day Publishing, 2004

The New York Times

For Serena Williams, Childbirth Was a Harrowing Ordeal. She's Not Alone.

TODAY

Olympic star Allyson Felix speaks out about her traumatic birth experience



JOURNAL MOTHERS REPORT ON

Cruelty in Maternity Wards

By GLADYS DENNY SHULTZ

Various Types of Birth Trauma

- Obstetric Related
  - Severe Hemorrhage
  - Emergency situations
  - Severe maternal complication/illness
- Anesthesia Related[3]
  - Inadequate anesthesia for surgical delivery
  - Needle trauma/difficulty with block/neurologic complications
  - Severe headache
- Fetal/Neonatal
  - Intrapartum emergency events
  - Unexpected diagnosis/ loss of a child (at any time during pregnancy)
  - Loss of a child to Child Protective Services [6]

Contributing Factors: [1-5]

- Feelings of helplessness/loss of control
- Minimal support during childbirth
- Fear
- Negative subjective experience of childbirth

1 Farren J, Jalmbrant M, Ameye L, Mitchell-Jones N. Post-traumatic stress, anxiety and depression following miscarriage or ectopic pregnancy: a prospective cohort study. Am J Obstet Gynecol 2020; 222:367.e1-367.e22.
2 Andersen LB, Melvaer LB, Videbech P, Lamont RF. Risk factors for developing post-traumatic stress disorder following childbirth: a systematic review. Acta Obstet Gynecol Scand 2012; 91:1261-72.
3 Lopez U, Meyer M, Loures V, Iselin-Chaves I. Post-traumatic stress disorder in parturients delivering by caesarean section and the implication of anaesthesia: a prospective cohort study. Health Qual Life Outcomes 2017;15:118.
4 Soet JE, Brack GA, DiIorio C. Prevalence and predictors of women's experience of psychological trauma during childbirth. Birth 2003;30:36-46.
5 Simpkin P, Klaus P. When survivors give birth. Seattle, WA: Classic Day Publishing, 2004.
6 Wall-Wieler,E, et al. Mortality among mothers whose children were taken into care by Child Protection Services: A Discordant Sibling Analysis. *Amer J of Epidemiology* 2018; 187:1182-88.

Unresolved Trauma and the Parturient

What might we see as providers?

- Anxiety/depression
- Substance Use Disorders
- Fear of losing control or of being strapped down
- Resistance to vaginal/cervical exams
- Refusal of care
- Request for general anesthesia
- Anger and hostility
- Phobias
- Unusual affect
- Request for no male providers
- Physical issues- hypertension, tachycardia

Unresolved Trauma and the Parturient

Qualitative Studies

- Trusting environment
- Communication of disclosure
- Concise, but specific birth plans outlining collaborative goals/expectations
- Clear explanations when and how procedures are to be done
- Acknowledgement that women have control over timing, pace, termination of exams
- Minimal number of examinations and examiners

- Sobel, et al. *Obstet Gynecol* 2018
- Roller, et al. *J Midwifery Womens Health* 2011

Unresolved Trauma and the Parturient

Qualitative Studies

- Respect for privacy- knock before entering
- Ability to wear their clothes/ minimize bodily exposure
- Consider elective cesarean section after appropriate counseling
- Recognize some women are comfortable with male providers, but routine assessment is important
- Some women with a history of sexual abuse may choose not to breastfeed

- Sobel, et al. *Obstet Gynecol* 2018
- Roller, et al. *J Midwifery Womens Health* 2011

Consequences of a traumatic birth experience on the trauma survivor:

- Dissociation with no memory of the childbirth experience
- Hyper-arousal with agitation/ anger with caregivers/ hostility
- Psychological harm impairing the maternal-fetal, and maternal-neonatal bond
- Increased risk for maternal mental health complications
- Negative alterations in pain perception
- Lifelong negative association during the anniversary of the trauma
- Negative impact on future reproduction
- Avoidance of the operating room

Vogel T, et al. *Br J Anaesth* 2020
Vogel T. *Curr Anesthesiol Rep* 2021)
Beck CT. *J Perinat Educ*. 2017
Lopez, U. *Health Qual Life Outcomes*. 2017.

Consequences on the **provider**:

- Hyper-arousal with agitation/ anger with patients/ hostility/ distrust
- Increased risk for mental health complications
- Increased risk of job dissatisfaction/burnout

Yates, S. *The Amer J of Medicine* 2020

Maternal Mortality due to trauma-related conditions

- Accidental poisoning (SUD)/Assault/Intentional self harm accounted for over 60% of pregnancy related deaths in Pennsylvania in 2018

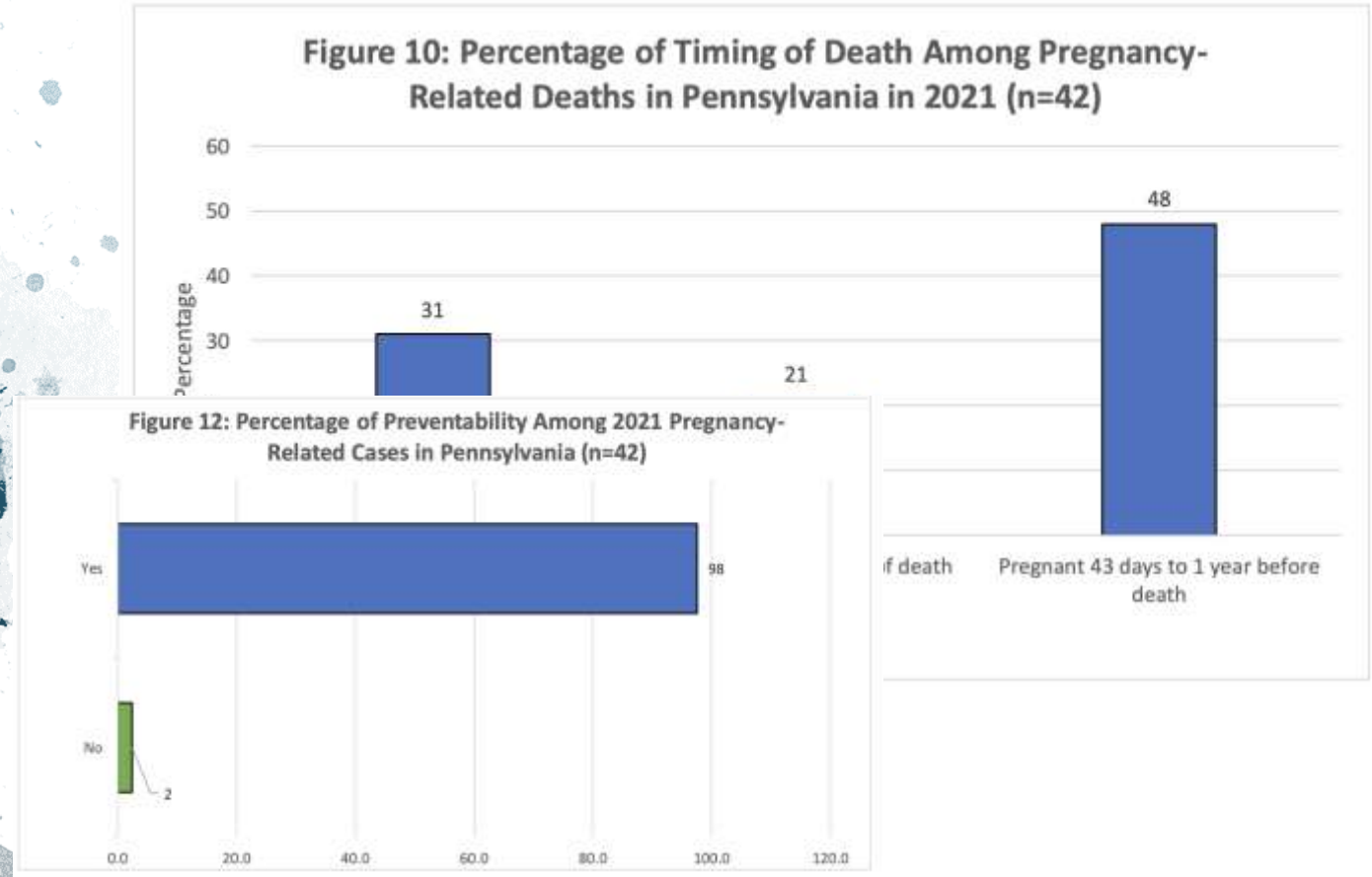
PA Maternal Mortality Review :2021 Report

Maternal Mortality due to mental health and trauma-related conditions

Table 1: Categories of Leading Causes of Death for 2021 Pregnancy-Associated Deaths in Pennsylvania (n=129)		
Category	**n**	**%**
Mental health condition	61	47.3
Injury	19	14.7
Cardiac and coronary condition	18	13.9
Hemorrhage	8	6.2
Infection	6	4.6
Metabolic/endocrine condition	5	3.9
Pulmonary condition	5	3.9
Cerebrovascular accident	3	2.3
Cancer	2	1.6
Embolism	1	0.8
Undetermined	1	0.8

PA Maternal Mortality Review :2025 Report

Maternal Mortality 2021



PA Maternal Mortality Review :2025 Report

Maternal Mortality due to mental health and trauma-related conditions

- Mental health problems, SUD, and IPV are preceding circumstances to pregnancy-associated suicide and homicide [1]
- One-third of all maternal deaths occurred outside of a medical facility [2]
  - Domestic violence, homicide, suicide, and illegal drug use are modifiable social factors
- CDC Data from MMRCs in 36 states, 2017-2019 [3]

  For the 1st time mental health conditions were a leading underlying cause of deaths

  Reflective of the largest number of deaths among white, Hispanic, and American Indian or Alaska Native populations
- Pregnancy-related deaths in the US, 2018-2022[4]
  - Mental and behavioral disorders and drug-induced and alcohol-induced death contributed to 21.2% of later maternal deaths

1 Modest A. et al. Pregnancy-associated Homicide and Suicide. *Obstet Gynecol* 2022;140:565-73

2 Burgess, et al. Pregnancy-related mortality in the United States, 2003-2016: age, race, and place of death. *Am J of Obstet & Gynecol.* 2020;222:489.e1-8

3 Trost SL, Beauregard J, Njie F, et al. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Service 2022

4 Yingxi, C, et al. Pregancy-related deaths in the US, 2018-2022. JAMA Network Open. 2025;8(4).

What does Trauma Informed Care look like?

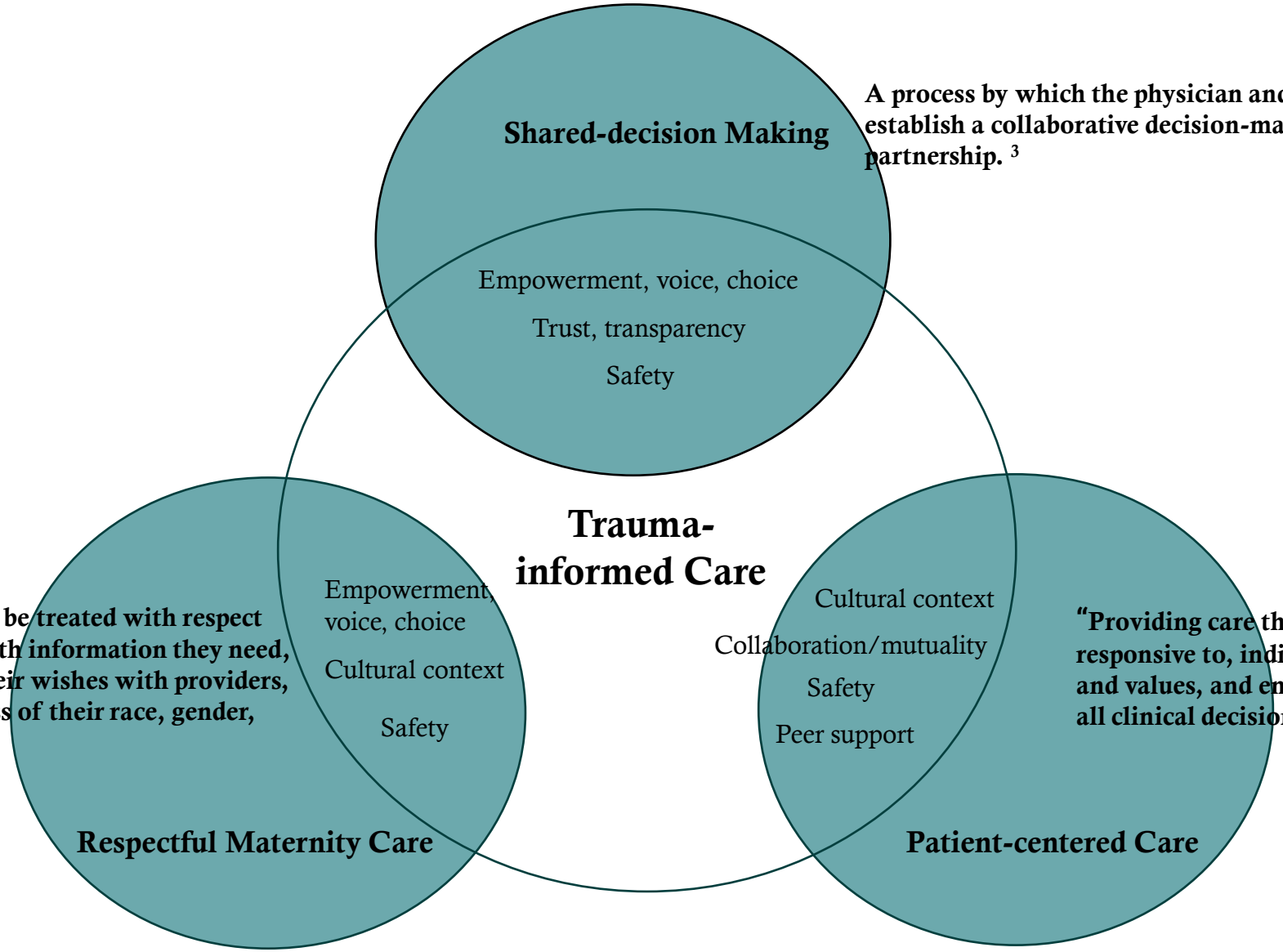
- A shift in practice paradigms from “what I am going to do *to you*” to “what can we do *together*” to achieve mutual goals based on each person’s individual cultural context
- A shift from thinking "what's wrong with you" to "what happened to you?"
- A shift from thinking about individuals as "problematic" to "symptomatic"

Trauma Informed Care

- **Realizes** the widespread impact of trauma and understands potential paths for recovery
- **Recognizes** the signs and symptoms of trauma in patients, families, staff, and others involved with the system
- **Responds** fully integrating knowledge about trauma into policies, procedures, and practices
- Actively seeks to **resist re-traumatization**

Substance Abuse and Mental Health Services Administration

Trauma-informed Care as a Universal Precaution



A process by which the physician and patient establish a collaborative decision-making partnership. [3]

All birthing persons should be treated with respect where they are provided with information they need, feel safe communicating their wishes with providers, and are supported regardless of their race, gender, and socioeconomic status. [2]

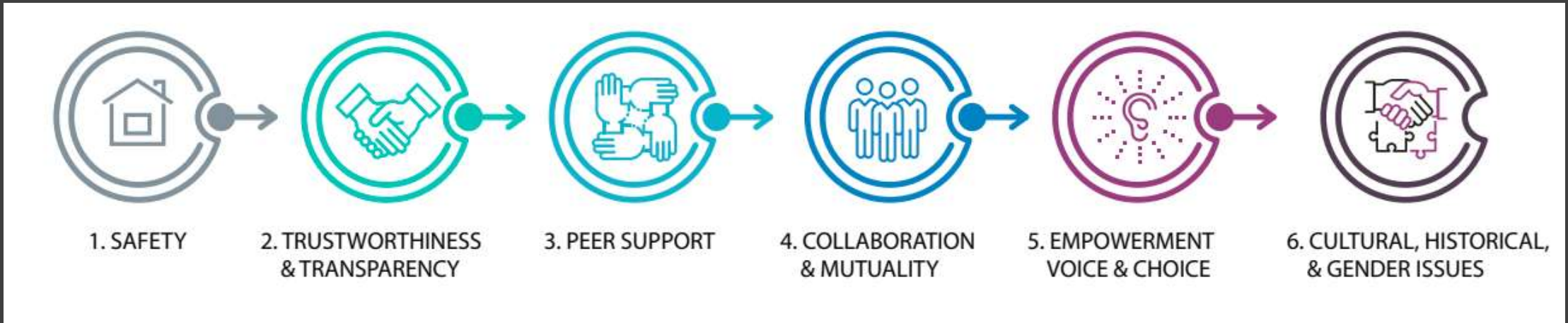
"Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions." [1]

1 Tzelepis F, et al. Measuring the quality of patient-centered care: why patient-reported measures are critical to reliable assessment. Patient Prefer Adherence. 2015 Jun 24;9:831-5

2 Shakibazadeh E, et al. Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis. *BJOG* 2018; 125: 932–942.

3 Barry MJ, Edgman-Levitan S: Shared decision making -the pinnacle of patient-centered care. N Engl J Med 2012; 366: pp. 780-781

Trauma-informed Care Principles



https://www.cdc.gov/cpr/infographics/6principlestraumainfo.htm

ACOG
The American College of Obstetricians and Gynecologists

- It is important for obstetrician–gynecologists and other health care practitioners to recognize the prevalence and effect of trauma on patients and the health care team and incorporate trauma-informed approaches to delivery of care.
- Obstetrician–gynecologists should become familiar with the trauma-informed model of care and strive to universally implement a trauma-informed approach across all levels of their practice with close attention to avoiding stigmatization and prioritizing resilience.
- Obstetrician–gynecologists should build a trauma-informed workforce by training clinicians and staff on how to be trauma-informed.

- Feelings of physical and psychological safety are paramount to effective care relationships with trauma survivors, and obstetrician–gynecologists should create a safe physical and emotional environment for patients and staff.
- Obstetrician–gynecologists should implement universal screening for current trauma and a history of trauma.
- In the medical education system, the benefit of trainee experience must be balanced with the potential negative effect on and re-traumatization of patients through multiple interviews and examinations.

An Interesting Situation (cont.)

Ultimately, utilizing trauma-informed care principles, we were able to develop a plan that was mutually acceptable to her and her providers. She consented to the cesarean section, but we allowed her significant other in the room the entire time, we removed the arm boards from the operating room table, and she kept her arms on her chest throughout the case. She received small doses of midazolam upon her request and had no face mask. She enjoyed skin-to-skin bonding with her baby and was tremendously grateful for what we helped her to do.

Communication Workshop

Learning how to engage with patients and colleagues on the obstetric unit and facilitate collaborative care

Words are singularly the most powerful force available to humanity. We can choose to use this force constructively with words of encouragement or destructively using words of despair. Words have energy and power with the ability to help, to heal, to hinder, to hurt, to harm, to humiliate and to humble.

Yehuda Berg

By emptying the self and by accepting the patient's perspective and stance, the clinician can allow himself or herself to be filled with the patient's own particular suffering, thereby getting to glimpse the sufferer's needs and desires, as it were, from the inside.

Rita Charon, "Narrative Medicine, honoring the stories of Illness"

Language choice

- Avoid language that belittles, blames, or emphasizes the patient as passive or childlike, or that reflects personal frustration or negative judgements
  - Consider:
    - “concern or problem” not “complaint”
    - “patient denies…” may be interpreted by the patient as refusing to admit the truth or existence of something
    - “patient claims…” may also imply disbelief by the provider or suggest dishonesty
    - “patient is non-compliant” reflects patriarchy and authoritarian care- not collaborative
    - “patient is difficult” reflects misunderstanding of the patient’s perspective and authoritarian care
    - “failure to progress” and “poor maternal effort”- places blame on the patient
    - Patient is a “poor historian”

Cox C, Fritz Z. BMJ 2022
Goddu A, et al. J Gen Intern Med 2018

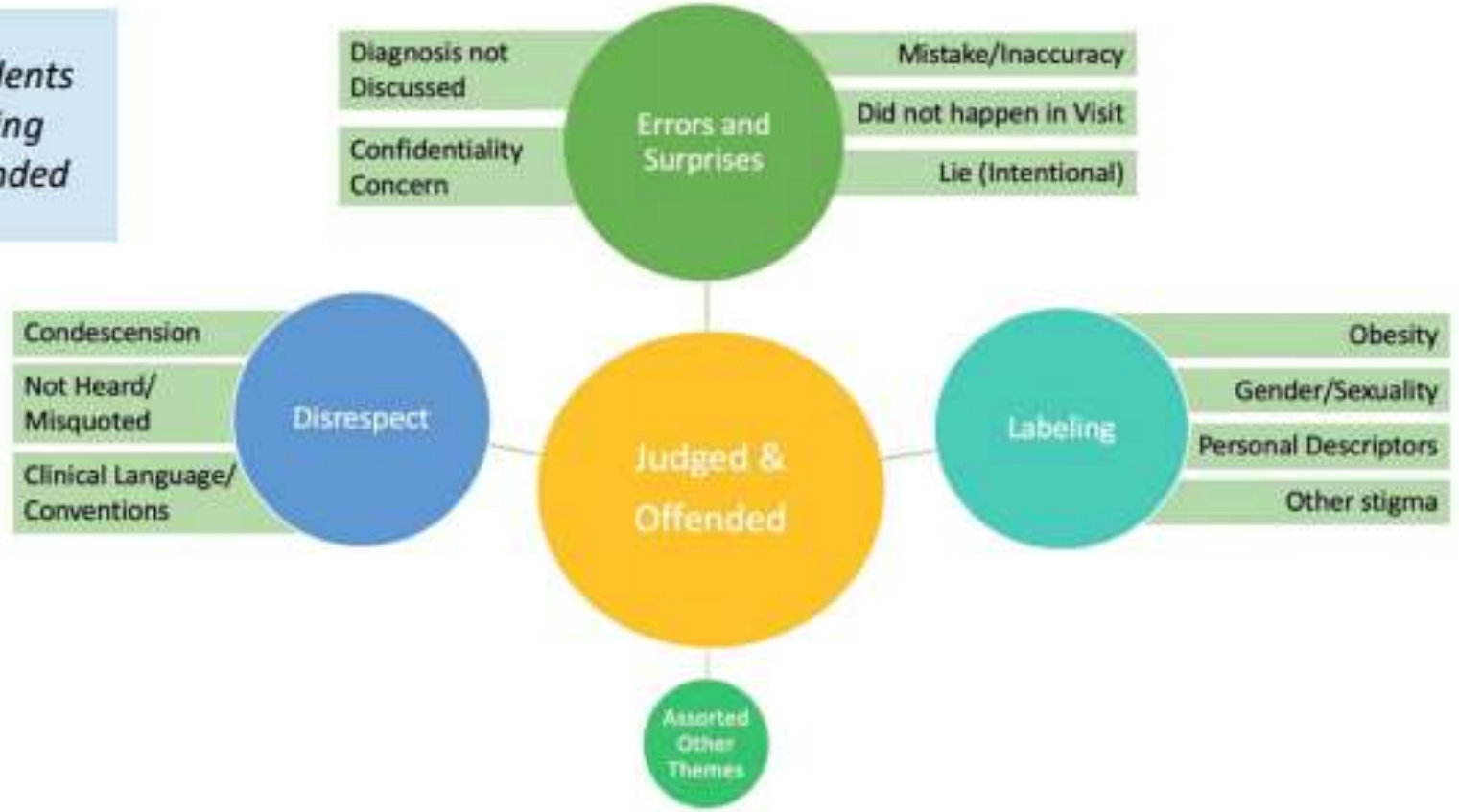
Language choice

- Stigmatizing Language
  - Undermining credibility
    - “Patient states 10/10 pain but chatting on the phone the whole time”
    - Using discrediting verbs/adverbs
      - *Claims*
      - *Insists*
      - *Reportedly*
  - Stereotyping
    - She arrived with an “extensive birth plan”
  - Showing disapproval
    - “you’re not going to be one of ‘those patients’ are you?”
  - Placing Blame
    - “You really tried to die on us during your c-section…”

Goddu A, et al. J Gen Intern Med 2018
Beach, MC, et al. J Gen Intern Med 2021

Words Matter: What Do Patients Find Judgmental of Offensive in Outpatient Notes? [1]

1 in 10 respondents reported feeling judged or offended



Framework for thematic analysis: overarching domains and specific codes.

[1] Fernandez L, et al. J Gen Intern Med 2021.

Written communication

This is a 36 y.o G2P1000 AMA female with a h/o GDMA1, cHTN, who presented to triage with ↓BP, pain and nonreassuring FHR changes- presumed abruption. Code O called. Taken to OR for STAT c/s under GA. Baby delivered within 10 minutes of entering OR, APGARs of 3 and 7. Mother to PACU in stable condition. Infant to NICU on CPAP. EBL 1500ml.

- Specialized shorthand often results in a depersonalized depiction of patients.
- How we write about patients may influence how we think about patients which in turn may influence how we engage with patients

What if we also wrote this…

...she was tearful when separated from SO, shaking in OR, expressed extreme fear for baby's safety. Reassured about baby's safety immediately upon awakening from anesthesia, good pain control but somewhat flat affect in PACU.

- This note conveys a patient's risk for postpartum mental health challenges
- Documentation of vital aspects of the patient's perspective not only communicates this information to subsequent providers, but allows for more appropriate, timely, intervention

Communication Strategies

- LIVES Pneumonic
  - L= listen without judgement
  - I= inquire
  - V= validate
  - E= enhance safety
  - S= support/follow-up

Tarzia, et al. BMJ Open 2020

Active/reflective Listening

- Do not interrupt
- Take notes
- Sit at eye level or lower
- Keep arms uncrossed
- Minimize distractions
- Maintain eye contact
- Don't block the door (ask if the patient is ok with the door closed)
- Approach the individual from the front
- Ask for permission to make physical contact (handshake)

COLLABORATION & MUTUALITY

TRUSTWORTHINESS & TRANSPARENCY

Attitude Shifts

From:

Stigmatization to **normalization**

Disempowerment to **empowerment**

Victimization to **resilience**

Questioning to **believing and validating**

Biases and assumptions to **confronting biases and empathize**

Ades, et al. Obstet Gynecol 2019;133:803-9

Inquire

- Gently ask the patient for details necessary to develop a plan
- Allow for time and space for them to tell their story
- Avoid appearing shocked or disgusted at their story
- Sample language “do you feel comfortable sharing some details…with me? This would give me a better idea of how we can help.”
- Use grounding techniques as needed to de-escalate and respond to acute stress responses
- Respond to the individual's narrative with empowering language

. CULTURAL, HISTORICAL, & GENDER ISSUES

1. SAFETY

Validation

- Acknowledging someone else's experience
- Use language like: "that sounds incredibly scary/frustrating/painful" or "I am so sorry/saddened to hear that happened to you"
- Do not try to "silver-lining" things
- Avoid trying to minimize the experience or triaging their emotional perspective

TRUSTWORTHINESS & TRANSPARENCY

5. EMPOWERMENT VOICE & CHOICE

Empowering Language

- "You are strong; you survived"; "It's okay, this can be hard"
- "It is normal to feel stressed about this "
- "I'm so glad you are sharing this with me."
- "I believe you. It took a lot of courage to tell me about this."
- "It's not your fault. You didn't do anything to deserve this."
- "You survived something very difficult that was not your fault "
- "This has had an impact on your life."
- "I am so sorry that happened.'
- "You are not alone.

Ades, et al. Obstet Gynecol 2019;133:803-9

Ensure Safety

- Ensuring privacy and confidentiality
- Physical Safety
  - Asking for consent at all steps of care ("inform before you perform")
  - Expose only one body part at a time with attention to body integrity
  - Minimize triggers
  - Adress physical complications
  - Address acute stress needs
    - Warmth/thirst/hunger
    - Minimize noise/personnel/overwhelming the individual
- Psychological Safety
  - Grounding skills
  - Coping tools/anxiolysis (pharmacologic and non-pharmacologic)
  - Need for support person

Support Follow-up

- Observe for any changes in affect or mood
- Recognize that any complications could be perceived as a traumatic experience
- Acknowledge any such reports with understanding, validation, and support
- Early referrals to perinatal mental health specialists

What do we perceive?

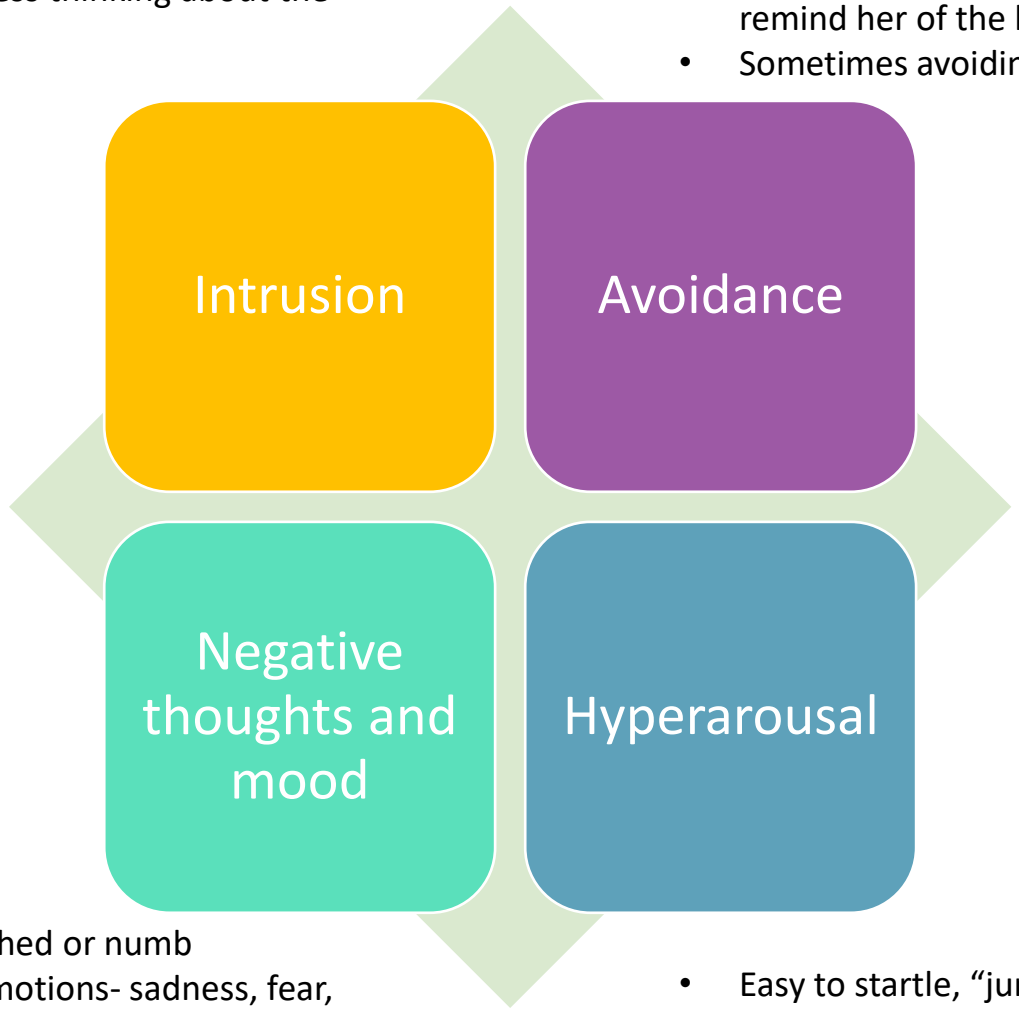
- Language clues (”what they say”)
  - "It's my fault"/"I feel stupid for reacting this way"/"I am such a failure"/"I can't do anything right"
- Behavior clues (“what they do”)
  - Trembling/refusing touch or exam/self-protective posture(huddling, crossing arms)/ constantly on the phone
- Emotional clues (“how they feel”)
  - Crying/dissociation/flat affect/anger and/or aggression/flashbacks
- Physical clues (“how they appear”)
  - Difficulty breathing/increased HR and BP

Ades, et al. Obstet Gynecol 2019;133:803-9

Stress Responses: Acute

- Recurring thoughts
- Nightmares/flashbacks
- Physical distress thinking about the trauma

- Avoiding memories, talking about the birth
- Avoiding places and people that remind her of the birth
- Sometimes avoiding the baby



- Feeling detached or numb
- Conflicting emotions- sadness, fear, guilt, terror, anger, embarrassment, confusion and joy, elation at the same time
- Difficulty experiencing joy

- Easy to startle, “jumpy” ,shaking
- Increased heart rate
- Difficulty sleeping or concentrating

Responding to Acute Stress Responses

Intraoperative

- Do not assume that because individuals have their eyes closed that they are resting comfortably: frequently check in on emotional well-being
- Do not assume that because individuals are no longer screaming that they are not in extreme pain: use open ended questions to elicit type and severity of pain, refrain from directing them to answer the question of “pain versus pressure”, use transparent communication to give them realistic expectations regarding pain during the procedure
- Believe the patient if they tell you they have pain, ACT on this disclosure
- Avoid confirmation, fixation, and continuation bias
- Offer non-pharmacologic and pharmacologic interventions for anxiolysis

OB Hemorrhage Toolkit V3.0 - Appendix V: A Guide to Recognizing Acute Stress Disorder in Postpartum Women in the Hospital Setting

Responding to Acute Stress Responses

Post-operative Period/PACU

- Individuals may need to recover in a different space with minimal stimulation
- Consider safety issues: support person should be there, an extra nurse, frequent information on where they are/what happened to them
- Do not assume that when you explain things to traumatized individuals immediately postoperatively that they a) can concentrate and process information effectively and b) they will remember anything you tell them. Discussions may need to happen at multiple time points so the patient's experience can be validated.
- Communicate the event to all staff/ document clearly in the chart
- Observe for any changes in affect or mood and refer early to perinatal mental health specialists

REVIVE Approach

Redistribute Power

- Elevate Bed
- Take their "emotional temperature"
- Speak to them at eye level

⇐ Safety

Establish Goals

- Ask about the patient's goals for the day
- Share lactation provider's goals
- Share hospital routines that affect goals
- Address potential scheduling issues (NICU/testing/etc)

⇐ Collaboration

Validate Concerns

- Ask about concerns/fear
- Acknowledge patient's concerns as real
- Ask how to mitigate concern or offer to find support, if possible

⇐ Compassion

Endres, Katherine Heatherington et al.
Nursing for Women's Health, Volume 28, Issue 6, 485 – 491.2024

REVIVE Approach

Identify Safe Touch

- Give patient ability to touch first
- Assess outside personal space and move in
- Explain reasons for assessment
- Provide education on danger signs

Communication

Verify Plan of Care

- Confirm goals, concerns, and findings
- Explain care options and recommendations based upon clinical judgement and EBP
- Wait for the "YES"

Autonomy

Educate to Escalate

- Acknowledge complexity of the hospital
- Explain when and how to escalate care
- Provide names and numbers theu can use
- Educate about your work on their behalf

Empowerment

Empathy

[Brene Brown's Empathy]

Trauma is messy.
Sharing control is not easy.
We carry our own trauma burdens.

Taking care of oneself is an essential part of TIC. We can't help others unless we also take care of ourselves.

Instructions to Receive Credit:

PLEASE complete the electronic evaluations by 7-days post session: https://www.surveymonkey.com/r/papqc_TIC_2026

Please select the date and hospital location for the session you attended, and indicate on the evaluation which CEUs you are requesting: CME, CNE or Social Worker credits or a Certificate of Completion.

1. The UPMC Center for Continuing Education will follow up with you, via email, 10 to 14 days after the session with instructions for claiming your credits.
   - ❑ To prepare, you will need to create an account with UPMC CCE via this website https://cce.upmc.com.
   - ❑ Please log in to the UPMC CCE site two weeks after the session to check for your credits. **Credits cannot be issued after 30-days post-session**