Preventing Violence in Obstetric Care Settings: A Trauma-Focused Perspective

The University of Cologne

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Woman: Doctor Told Me to "Shut Up and Push"

Doctor intentionally made delivery painful, woman says

By Matt Bartosik • Published December 16, 2008 • Updated on January 6, 2009 at 7:38 pm

If you've had a child, you know giving birth can be one of the most physically and emotionally demanding experiences in a woman's life.

Catherine Skol, a former Chicago police officer, was well aware of this when she arrived at Rush University Medical Center in March to have her fifth child. However, nothing could have prepared her for the horrible ordeal she was about to face.

According to a civil suit filed Monday, Skol arrived at the hospital at about 4 a.m. Her usual doctor was out of town, so Dr. Scott Pierce filled in. The lawsuit alleged that Pierce showed up at Rush four hours later, and when he did, he allegedly reprimanded Skol for not calling before coming in. The lawsuit claims he said there was not enough time to administer pain medication.

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Obstetric Violence in the United States[2]

The amount of times I felt coerced into decisions or was mocked or rushed...my original ob/gyn practice was rude and insulting to me and said that I risked having child protective services being called if I refused antibiotics due to being GBS positive.[2]

I hated being shouted at and lied to by the midwife.. I never dreamed that a woman would treat a laboring woman that way… I felt like I lost my autonomy over my own body. ... I felt like a child and I felt so unlike my usual self. These professionals broke my spirit.[2]

The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States

Saraswathi Vedam[1*], Kathrin Stoll[1], Tanya Khemet Taiwo[2,3], Nicholas Rubashkin[4], Melissa Cheyney[5], Nan Strauss[6], Monica McLemore[7], Micaela Cadena[8], Elizabeth Nethery[9], Eleanor Rushton[1], Laura Schummers[10], Eugene Declercq[11] and the GVtM-US Steering Council

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Obstetric Violence in the United States[2]

- 1 in 6 patients (17%) reported at least one form of mistreatment
- 28% of patients delivering in hospital reported mistreatment
- Most common was staff “shouting at” or “ignoring” patients
- BIPOC are 1.5 times more likely to experience mistreatment than whites, regardless of income / insurance

Nothing Protects Black Women From Dying in Pregnancy and Childbirth

Not education. Not income. Not even being an expert on racial disparities in health care.

by Nina Martin, ProPublica, and Renee Montagne, NPR News, Dec. 7, 2017, 8 a.m. EST

- Most common forms of mistreatment during childbirth around the world ranked[3]:

(1) physical abuse

(2) sexual abuse

(3) verbal abuse

(4) stigma and racial-ethnic discrimination

(5) failure to meet standards of care

(6) poor provider-patient communication

(7) health system conditions and constraints

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Obstetric / Medical Violence

ILLUSTRATIONS BY RICHARD WATKINS / A

The #MeToo movement and public outcry over Dr. Larry Nassar's sex abuse have not reformed the system that disciplines doctors.

"INFORMED REFUSAL"[6]

MEDICAL MALPRACTICE LAW & STRATEGY

Update: The ACOG's New Opinion on Obstetric Violence

In June, informed refusal and obstetric violence were the topics of a panel counsel discussion at the American Conference Institute's 13th Annual Advanced Forum on Obstetric Malpractice Claims. Also in June, ACOG an opinion on Refusal of Medically Recommended Treatment During Pregnancy. With the maturing of the topic in the media and legal discussions, it's time to take a look at the recent developments.

OCTOBER 2016

FACEBOOK TWITTER LINKEDIN

PRINT

Since our previous article on the subject of "obstetric violence" (available at http://bit.ly/2cprH21), interest in this and related topics has increased. For instance, in January of this year, a doctor who performed a refused episiotomy that was captured on camera surrendered his license. See

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What's in a Name?

Is it violence … or "Refusal of Treatment"?

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 664 • June 2016 *(Replaces Committee Opinion Number 321, November 2005)*

Committee on Ethics

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Ethics in collaboration with committee members Mary Faith Marshall, PhD, and Brownsyne M. Tucker Edmonds, MD, MPH, MS. The Committee on Ethics wishes to acknowledge the assistance of Ashley R. Filo, MD, in the development of this document.

While this document reflects the current viewpoint of the College, it is not intended to dictate an exclusive course of action in all cases. This Committee Opinion was approved by the Committee on Ethics and the Executive Board of the American College of Obstetricians and Gynecologists.

Refusal of Medically Recommended Treatment During Pregnancy

ABSTRACT: One of the most challenging scenarios in obstetric care occurs when a pregnant patient refuses recommended medical treatment that aims to support her well-being, her fetus's well-being, or both. In such circumstances, the obstetrician–gynecologist's ethical obligation to safeguard the pregnant woman's autonomy may conflict with the ethical desire to optimize the health of the fetus. Forced compliance—the alternative to respecting a patient's refusal of treatment—raises profoundly important issues about patient rights, respect for autonomy, violations of bodily integrity, power differentials, and gender equality. The purpose of this document is to provide obstetrician–gynecologists with an ethical approach to addressing a pregnant woman's decision to refuse recommended medical treatment that recognizes the centrality of the pregnant woman's decisional authority and the interconnection between the pregnant woman and the fetus.

- "Incredibly rare scenario"[7]
- "Always ethically impermissible"[7]
- Acknowledges power differentials, gender inequality
- Aims to prevent coercive intervention and incursions against bodily integrity
- Emphasizes respect for patient autonomy
- Calls for interdisciplinary team approach

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Is Obstetric Violence “a problem” in the United States?

CONCEPT ANALYSIS

NURSING FORUM AN INDEPENDENT VOICE FOR NURSING WILEY

A concept analysis of obstetric violence in the United States of America

Lorraine M. Garcia MA, MSN, WHNP-BC, CNM

College of Nursing, Anschutz Medical Campus, University of Colorado, Aurora, Colorado

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Lorraine M. Garcia, MA, MSN, WHNP-BC, CNM, College of Nursing, Anschutz Medical Campus, University of Colorado Denver, 13120 East 19th Avenue, Ed 2 North Room 3250, Aurora, CO 80045.
Email: Lorraine.Garcia@cuanschutz.edu

Abstract

The aim is to clarify the concept of “obstetric violence in the United States of America.” Obstetric violence (OV) is a poorly defined and rarely applied concept in the United States that causes significant harm and requires recognition. The design is a concept analysis to examine the structure and function of OV in the United States. An English language literature review with no date restrictions was performed using CINAHL, PubMed, and Google search. The search was expanded to the related terms

“It is … necessary to address OV in the United States in a concept analysis because the term is becoming more widely used worldwide at the human rights level with scarce attention … in the United States.

The greatest amount of attention to OV in the United States is currently from **advocacy groups and scholars** outside of the health care sphere.”[8]

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Definition of Medical Abuse and “Violence”

The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.[9]

World Health Organization, 2019

Dr. Larry Nassar

“Obstetric Violence” vs. “Patient Refusing Care”

Broken Health System or Broken Patient?

Is there an alternative framework?

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Trauma-Focused Lens

SAMHSA Definition

"… 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."[10]

DSM 5 Definition

"actual or threatened death, serious injury, or sexual violence"[11]


ACOG
The American College of Obstetricians and Gynecologists

ACOG COMMITTEE OPINION

Number 825

Committee on Health Care for Underserved Women

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women in collaboration with committee members Colleen McNicholas, DO, MSCI, Serina Floyd, MD, MPH, and Melissa Kottke, MD, MPH, MBA.

Caring for Patients Who Have Experienced Trauma


Journal of Midwifery & Women's Health www.jmw

Review

Integrating Trauma-Informed Care Into Maternity Care Practice: Conceptual and Practical Issues

CEU

Mickey Sperlich, CPM, PhD, MSW, Julia S. Seng, CNM, PhD, Yang Li, MS, RN, Julie Taylor, PhD, RN, FRCN, Caroline Bradbury-Jones, PhD, RM, RN, HV

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Traumatic Childbirth

Approximately **20%** of births meet DSM 5 Criterion A definition of traumatic event[14]

Up to **45%** label childbirth as "traumatic" according to subjective reports[15]

Childbirth: A Miracle or a Traumatic Experience?

By Neal S. Gainsberg | June 21, 2021

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"A ***sense of control*** over themselves and their environment…"[17]

Perceived control and maternal satisfaction with childbirth: a measure development study

Natalie R. Stevens[1], Kenneth A. Wallston[2] & Nancy A. Hamilton[3]

[1]Rush University Medical Center, Behavioral Sciences, Chicago, IL, USA, [2]Vanderbilt University, School of Nursing, Nashville, TN, USA, and [3]University of Kansas, Psychology, Lawrence, KS, USA

	Perceived Control	Childbirth Satisfaction	Postpartum PTSD Sx
PCCh	--	**.63***	**-.23***
SWCh	--	**--**	**-.19***

* = $p < .01$

N = 187

- Community sample drawn primarily from hospital in the Midwestern US
- 85% white
- 65% university-educated

Perceived Control in Childbirth Scale (PCCh)

Sample Items[18]

1. I was able to participate in making decisions about how to manage my labor and birth.
3. I did not feel that I was in control of my birth environment.

During my labor and birth, I felt…

4. That I could not question my medical care provider's decisions.
8. That what I said or did made no difference in what occurred.

From the time I arrived at the hospital or birth center, I felt… (or, from the time my care providers arrived at my home)

9. At a loss to know what I would be experiencing.
12. If I asked my care providers to do something differently during labor and delivery, they usually did it.

Perceived control during childbirth is associated with[19-21]:

- Childbirth satisfaction
- Less risk of dissociation during labor
- Lower childbirth-related posttraumatic stress
- Fewer postpartum depression and anxiety Sx
- Birthing environments that give control to the patient!

How can the birth environment "give control"?[21,22]

- Midwife-led continuity of care
- Physiological vs. instrumental birth
- Telemetry vs. wired fetal monitoring

OR ….

- Is it less to do with model of care or instruments and more to do with ***a relationship and its context?***

On the West Side of Chicago:

Trauma is prevalent and has lasting consequences

- OB/GYN patients ages 18-45:[23]
  - >70% History of at least 1 traumatic event
  - 44% History of child abuse
  - 37% History of child abuse AND recent intimate partner violence
- Pregnant patients with PTSD and depression Sx:[24]
  - Less likely to express concerns / preferences
  - More likely to experience health encounters as traumatizing

ELSEVIER

Available online at www.sciencedirect.com

ScienceDirect

Behavior Therapy 44 (2013) 152–161

Behavior Therapy

www.elsevier.com/locate/bt

Emotion Regulation Difficulties, Low Social Support, and Interpersonal Violence Mediate the Link Between Childhood Abuse and Posttraumatic Stress Symptoms

Natalie R. Stevens
James Gerhart

JOURNAL OF PSYCHOSOMATIC OBSTETRICS & GYNECOLOGY, 2017
VOL. 38, NO. 2, 103–110
http://dx.doi.org/10.1080/0167482X.2016.1266480

Taylor & Francis
Taylor & Francis Group

ORIGINAL ARTICLE

Posttraumatic stress and depression may undermine abuse survivors' self-efficacy in the obstetric care setting

Natalie R. Stevens[a], Vanessa Tirone[a], Teresa A. Lillis[a], Lucie Holmgreen[a], Allison Chen-McCracken[b] and Stevan E. Hobfoll[a]

[a]Department of Behavioral Sciences, Rush University Medical Center, Chicago, IL, USA; [b]Department of Obstetrics & Gynecology, Rush University Medical Center, Chicago, IL, USA

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Screening for PTSD in Routine Prenatal Care

at Rush University Medical Center

Routine PTSD Screening at Initial Prenatal Visit

		EPDS	
PCL-2		Negative	Positive
Negative		1034 (80%)	35 (3%)
Positive		161 (13%)	58 (5%)

N=1,416 Patients Screened[25]

75% Black/AA or Hispanic/Latina

13% SCREENED POSITIVE FOR PTSD WHO SCREENED NEGATIVE FOR DEPRESSION

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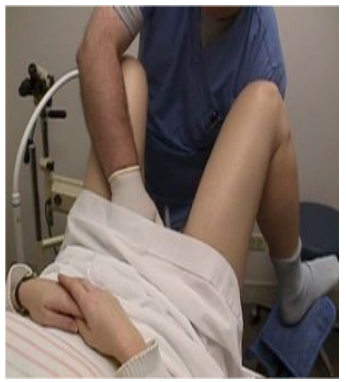
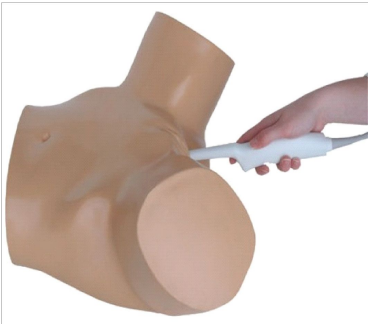
Trauma-sensitive Obstetric care to promote Control, Anxiety-Reduction, and Empowerment[26]

Rush University Medical Center (2012-2017)

TO-CARE
Trauma-sensitive Obstetric Care

- **Multidisciplinary team**
  - Obstetrician / Residency Director
  - Labor & Delivery Nurse
  - OB Hospital Unit Director
  - Medical residents and nursing students
- **Identify barriers and facilitators to trauma-sensitive care**
- **Develop Residency Curriculum Goals:**
  - **Minimize traumatization / trauma-evoking aspects of obstetric care**
  - Enhance patient self-efficacy
  - Reduce PTSD and depression





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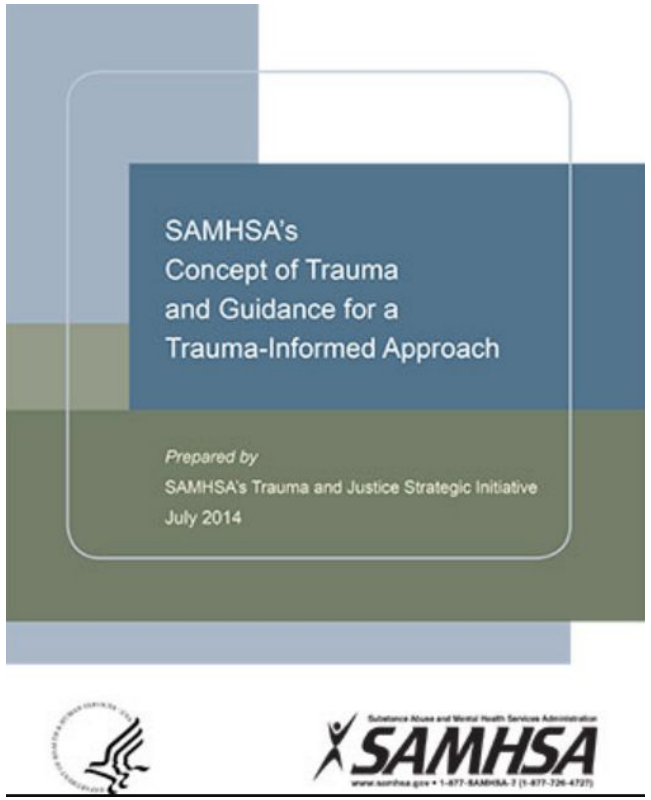
Trauma-sensitive Obstetric CARE
Rush University Medical Center

TO-CARE
Trauma-sensitive Obstetric Care

4 "R"s of Trauma Informed Care[10]



- Realize
- Recognize
- Respond
- Resist Re-traumatization

TO-CARE Provider Training

- Assess trauma history
- Assess patients' individual care preferences
- Recognize and Respond to discomfort IN VIVO during invasive procedure
- Reinforce patients' preferences

=

Maximize sense of control

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Trauma-sensitive Obstetric CARE[26]

Rush University Medical Center (2012-2017)

TO-CARE for Patients:

1. Cognitive-behavioral coping skills
2. Empowered communication
3. Role-Play

RESULTS

- N = 45 Pregnant patients with PTS
- Planned 6 sessions
- Low overall completion rate:
  -- n= 21 (46%) completed core components

TO-CARE for Providers:

1. Trauma screening
2. Assess patient preferences for care
3. Recognize and respond to discomfort IN VIVO
4. Reinforce patient preferences

RESULTS

- N = 9 providers
- 2-hour Didactic Curriculum
- Trauma-sensitive pelvic exam simulation (co-led by Residency Director)
- Direct clinical observation

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JOURNAL OF PSYCHOSOMATIC OBSTETRICS & GYNECOLOGY, 2017
https://doi.org/10.1080/0167482X.2017.1398727

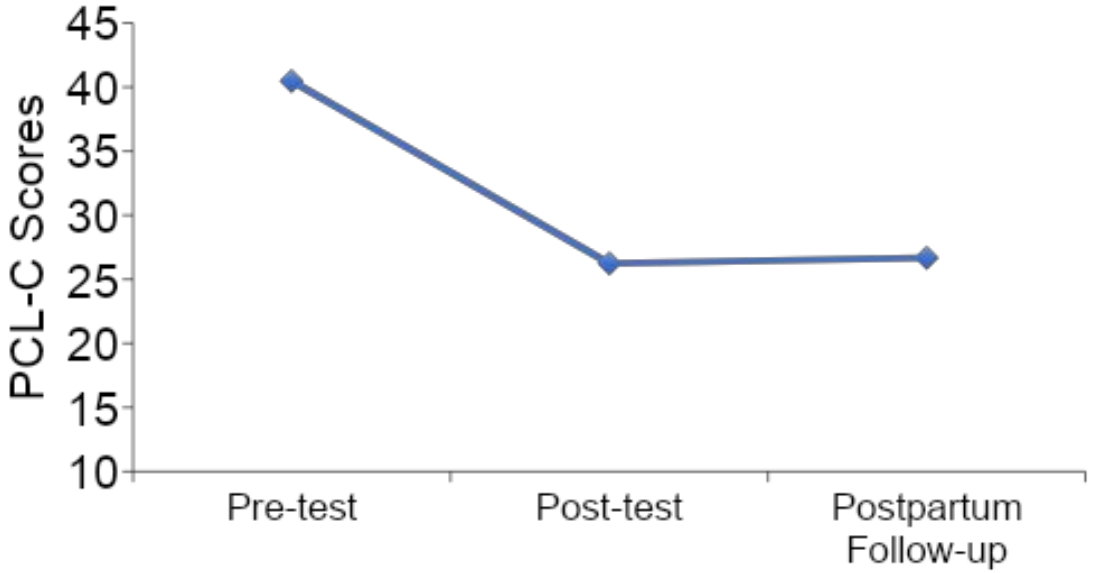
ORIGINAL ARTICLE

A feasibility study of trauma-sensitive obstetric care for ethno-racial minority pregnant abuse survivors

N. R. Stevens, T. A. Lillis, L. Wagner, V. Tirone and S. E. Hobfoll

Rush University Medical Center, Chicago, IL, USA

At least 3 sessions of TO-CARE



"Gotta talk about the operation room. Liked learning to talk and voice opinions but when in operating room it went right out the window."

"The whole program was nice, but doctors and nurses needed to be taught more about it. Maybe they don't have time."

"I was disappointed that I would get different answers from different doctors. A lot of dealing with the policy because they can't go against their policy."

"I was too scared to say no they can't come in. They always asked is it okay for him to be in there after they're already in the room."

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AAMC Association of American Medical Colleges

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OPEN ACCESS | July 20, 2020

Assessing Trauma History in Pregnant Patients: A Didactic Module and Role-Play for Obstetrics and Gynecology Residents

Natalie R. Stevens, PhD, Lucie Holmgreen, PhD, Stevan E. Hobfoll, PhD, Jamie A. Cvengros, PhD

https://doi.org/10.15766/mep_2374-8265.10925

APPENDICES

A. Didactic Facilitator Guide.docx
B. PowerPoint Slides.pptx
C. Handout 1 Sample Chart of Pregnant Patient With PTSD.docx
D. Handout 2 Communication Template.docx
E. Handout 3 Sample Trauma-Informed Practice.docx
F. Handout 4 Sample Trauma Narrative for Role-Play.docx
G. Pocket Guide for Trauma History Screening.pdf
H. Assessment Tool.docx

Educational Objectives:

1. Identify potential impact of traumatic stress on pregnancy outcomes
2. Identify common barriers to effectively assessing trauma with pregnant patients
3. Demonstrate empirically supported approaches to assess trauma history and respond to disclosures

Obstetric Residents' Experiences of the Curriculum:[27]

"I was really worried about having to listen to all graphic details of the patient's trauma … but that's not what this is about"

"I had a patient who was sexually assaulted. I used one of the phrases on this worksheet and she immediately relaxed."

"I feel like I don't know what to say to these patients … I really need help with this."

"It brought me to reflect on some "stuff" that I face on a day-to-day basis. Separating work and personal life is nearly impossible when I am treating a patient affected by trauma."

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Missing Ingredient:

Pregnancy & Birth are Potentially Traumatizing for Providers, Too!

- Maternal mortality[28]
  - 2018 – 17.4 per 100,000 live births
  - 2019 – 20.1 per 100,000 live births
  - 2020 – 23.8 per 100,000 live births
- For every maternal death there are 70 “near misses” or severe maternal morbidity
- Infant Mortality[29]
  - 2020 – 5.4 per 1,000 births
  - 10.6 vs. 4.5 (Black vs. white)

- Secondary Traumatic Stress[30-35]
  - 35% of Labor & Delivery nurses
  - 50% of NICU nurses
  - 30% of Nurse-Midwives
  - 70% of Obstetricians

How can providers do trauma-informed care while avoiding their own distress?

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Secondary Traumatic Stress is Associated with Provider Burnout and Barriers to Trauma Informed Care

N = 172 Healthcare Providers with 19.5% STS / Burnout Rate[36]

	STS	Burnout	Time Constraints	Difficulty Changing the Medical Environment	Disagreement with Peers / Lack of Support
Secondary Traumatic Stress	--	.58***	.29***	.20*	.21**
Burnout	--	--	.29**	.17*	.19*

** p <.05; ** p < .01; *** p < .001*.

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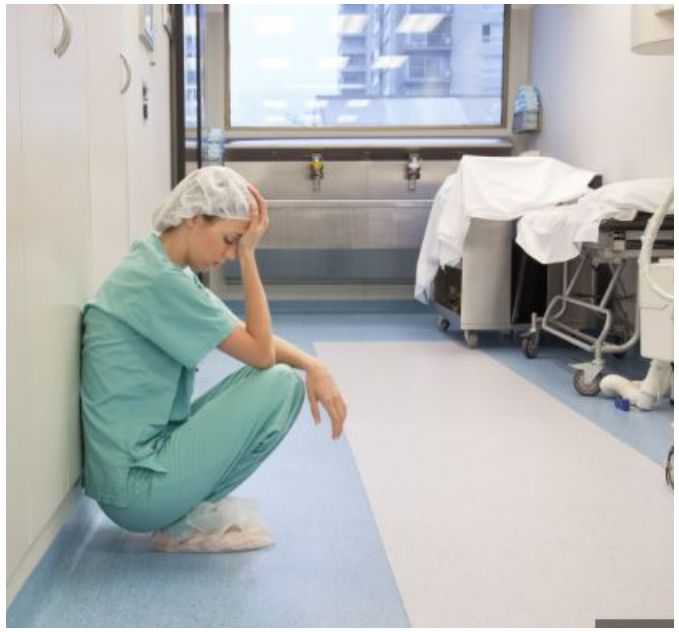
Takeaways from TO-CARE

- Encountered significant provider discomfort with trauma topics in obstetrics
- Local champions are necessary but not sufficient to change a work culture
- Did not touch patient's OR provider's specific traumatic stress material

"Physicians don't allow themselves to be burned, *….we become overwhelmed by chronic competing interests that largely originate from outside sources.…"*[37] ~Roger Young, MD



Collective Avoidance of Survivors' Stories Perpetuates Trauma and Violence

Pregnant and birthing patients described as "vulnerable"[38]

- "Talking about trauma will retraumatize them"
- "It could hurt the pregnancy or detract from other priorities"

Clinicians trained to resolve cases and "move on"[37]

- "Other patients are waiting"
- Processing emotional effects is "extra"
- Abuse is result of "a few bad apples" not systemic

In other words … we don't want to hear it, AVOIDANCE!

RESEARCH: Institutional facilitators and barriers
EDUCATION: Training and interventional support for clinicians

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Reframing the Debate: Impact vs. Intent

VIOLENCE

"The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in, or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."[10]

WHO, 2019

TRAUMA

"… 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."[11]

SAMHSA, 2014

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Trauma-Focused Lens: Obstetric Violence Signals a Systemic Problem that Harms Patients AND Clinicians

- **"What happened to you?"[39]**
  - Instead of "what's wrong with you?"
- **Construct a coherent narrative embedded in context**
- **Avoid "victim" vs. "perpetrator" binary – it is both![40]**
- **"Processing" is based in cognitive neuroscience[41]**
  - Memory, learning and emotional functions of the brain
  - Necessary for consolidating new information for future use

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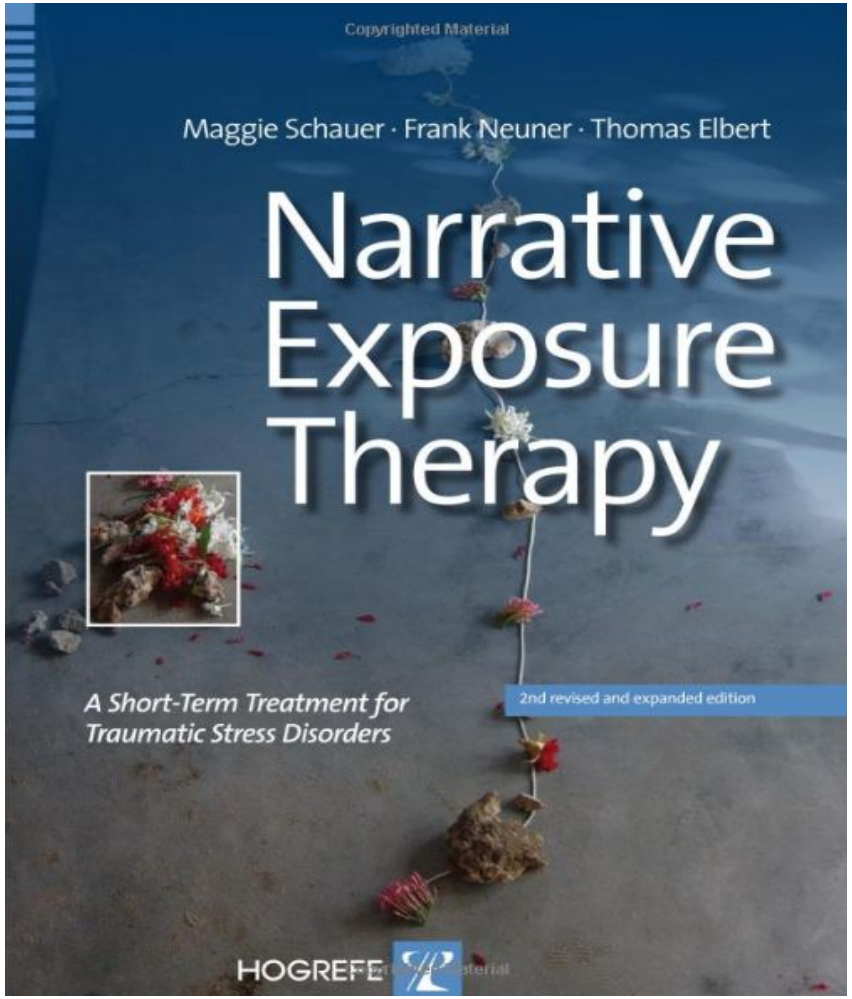
NET is a Mental Health Tool that Treats Trauma in Context and Addresses Systemic Violence



- Cumulative or complex trauma in low-resource, high conflict settings
- Strong evidence base
- Culturally-inclusive and adaptable
- Brief
- Theoretical foundation
  - Emotional processing / learning theories
  - Testimony therapy
  - “Lifespan” perspective

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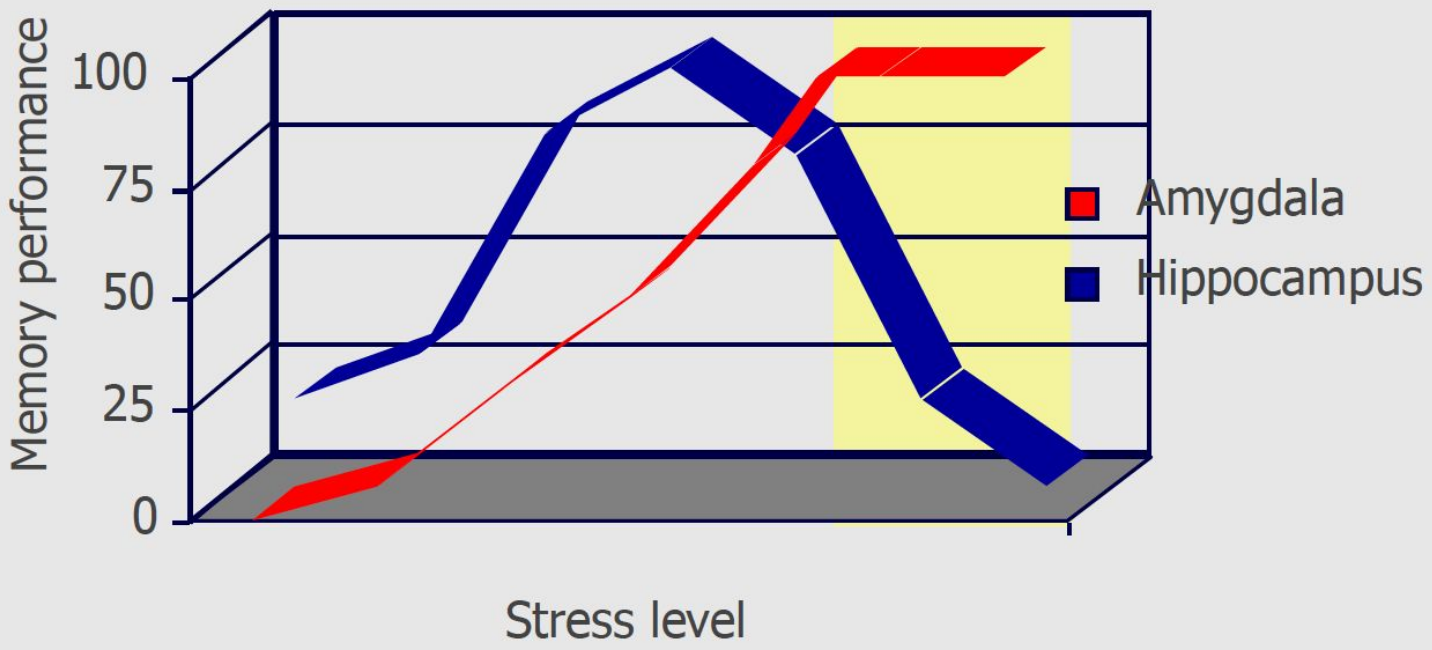
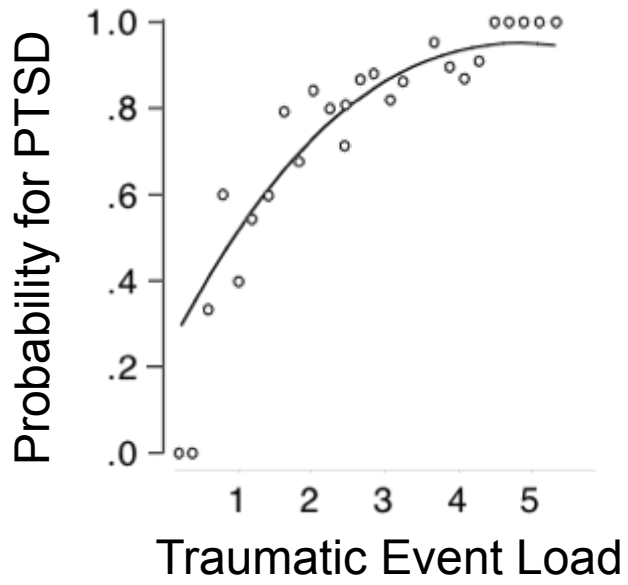
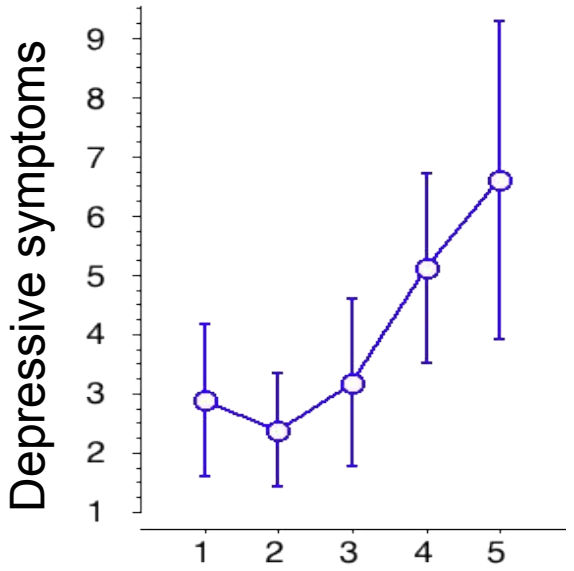
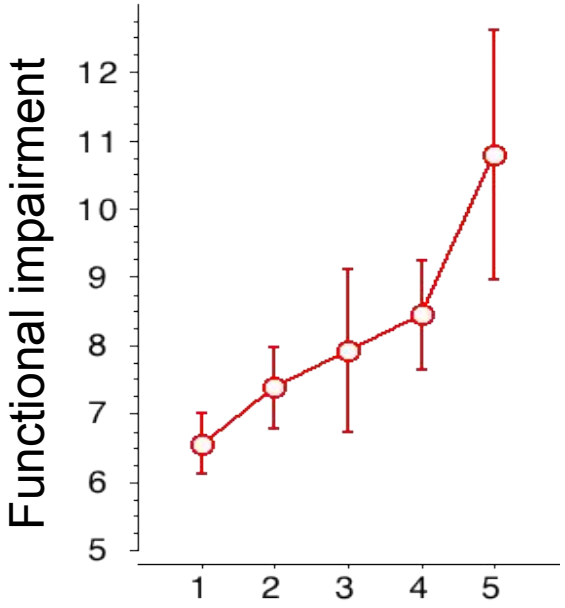
Stress & Memory

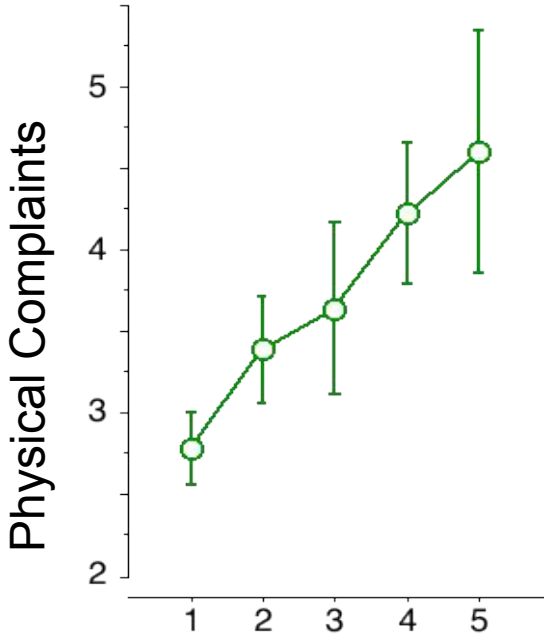


Schauer, E., & Elbert, T. (2010). In*: Trauma rehabilitation after war and conflict* (pp. 311-360). Springer New York.



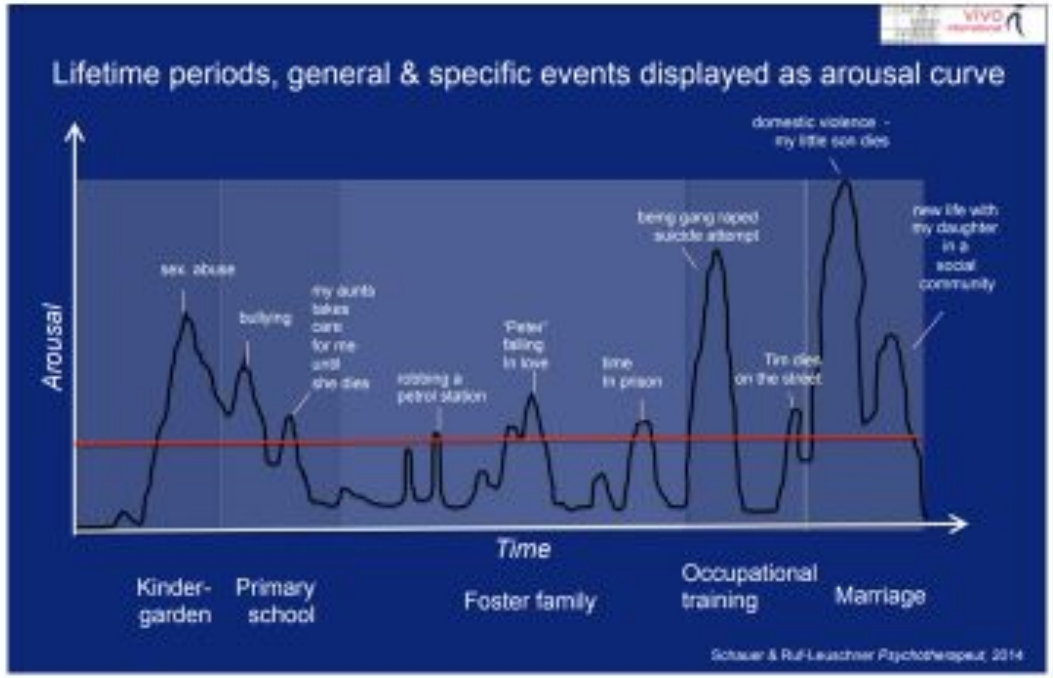






As number of traumatic exposures increases so does likelihood of impairment across multiple domains.[42]

Untangling the Web: Processing Trauma with Narrative Storytelling (Exposure)



[INSERT SCREENSHOT OF SIDE BY SIDE ZOOM]

Most of the time life events – joyful or stressful – are consolidated in autobiographical memory in organized fashion

Images from "This is my story: I am!" NET Symposium Centrum 45 Professor Dr. Maggie Schauer
https://www.centrum45.nl/sites/default/files/domain-6/documents/2014-03-21_net_symposium_centrum45_2014_tein_maggie-6-1448960750922703621.pdf

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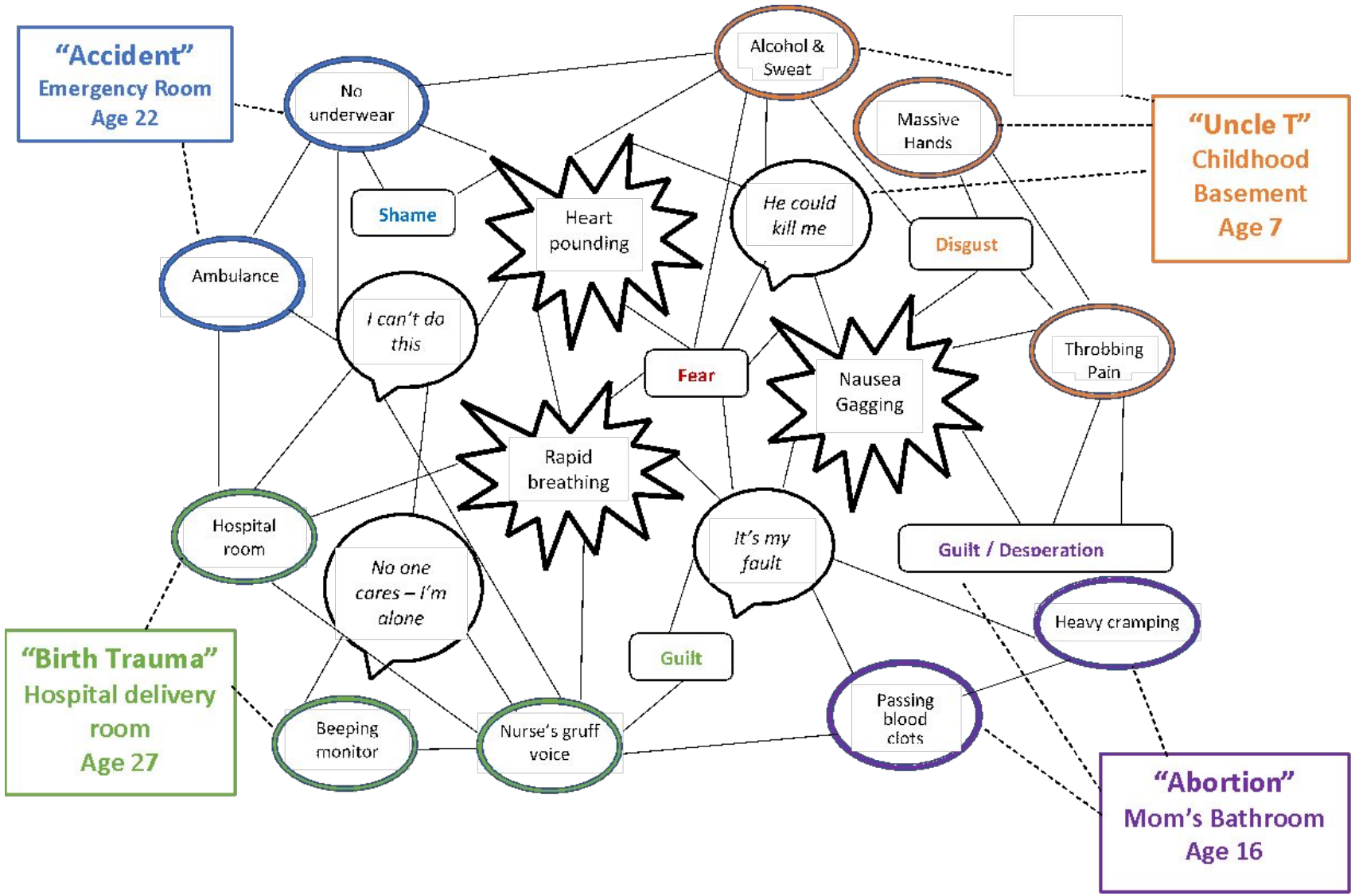
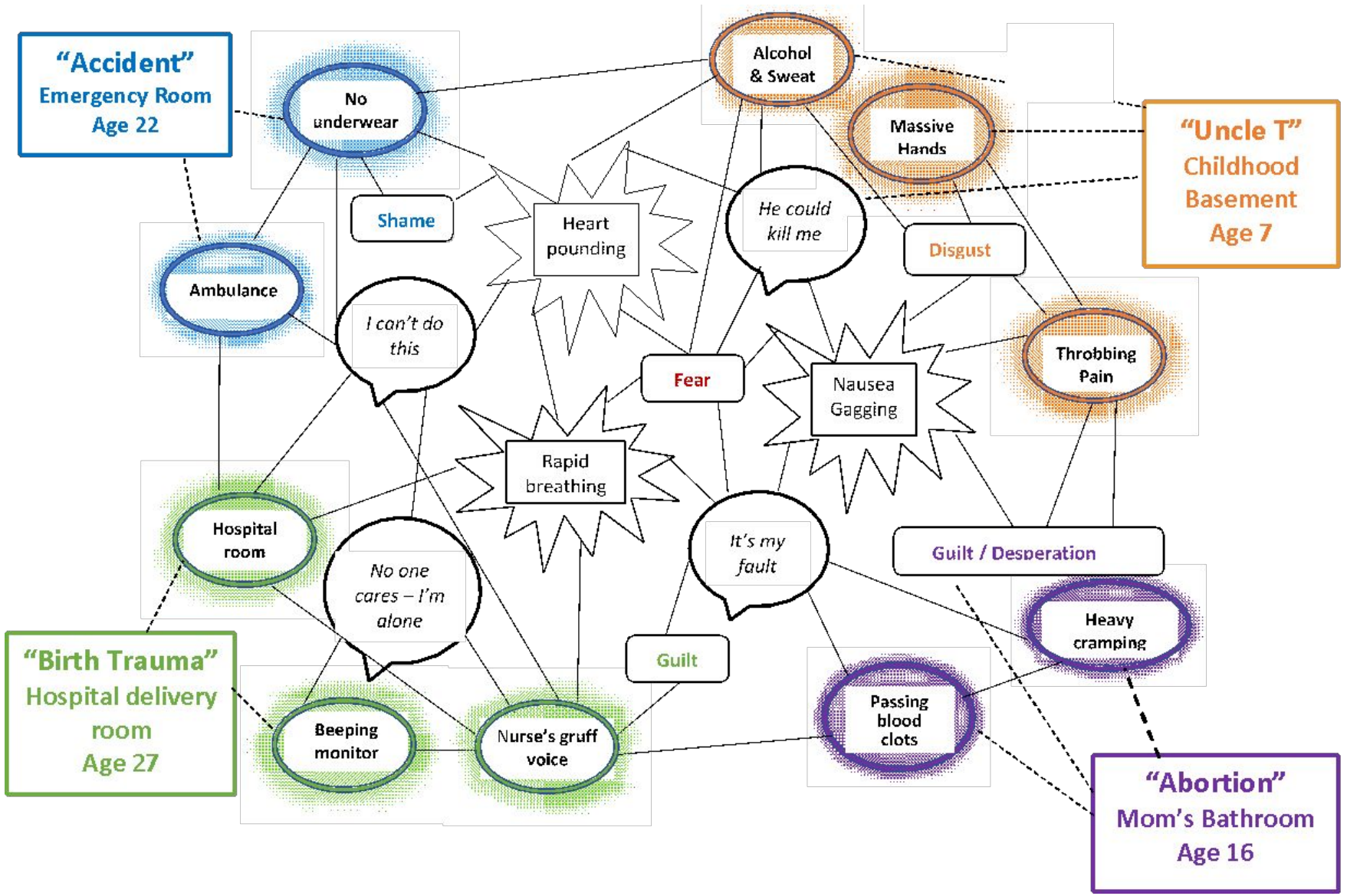
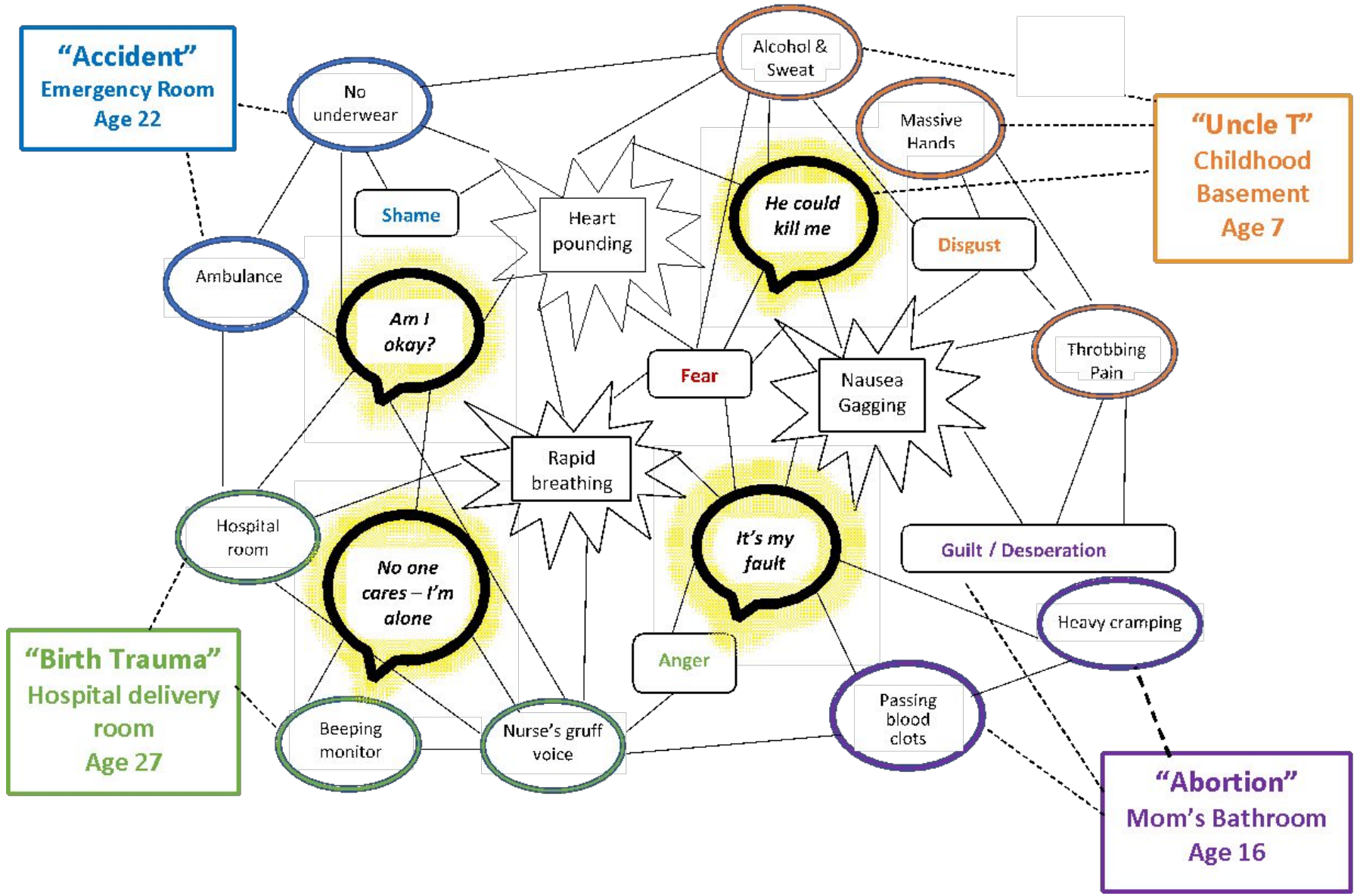
Associative Trauma Memory Network
Complex or "Cumulative" Lifetime Trauma



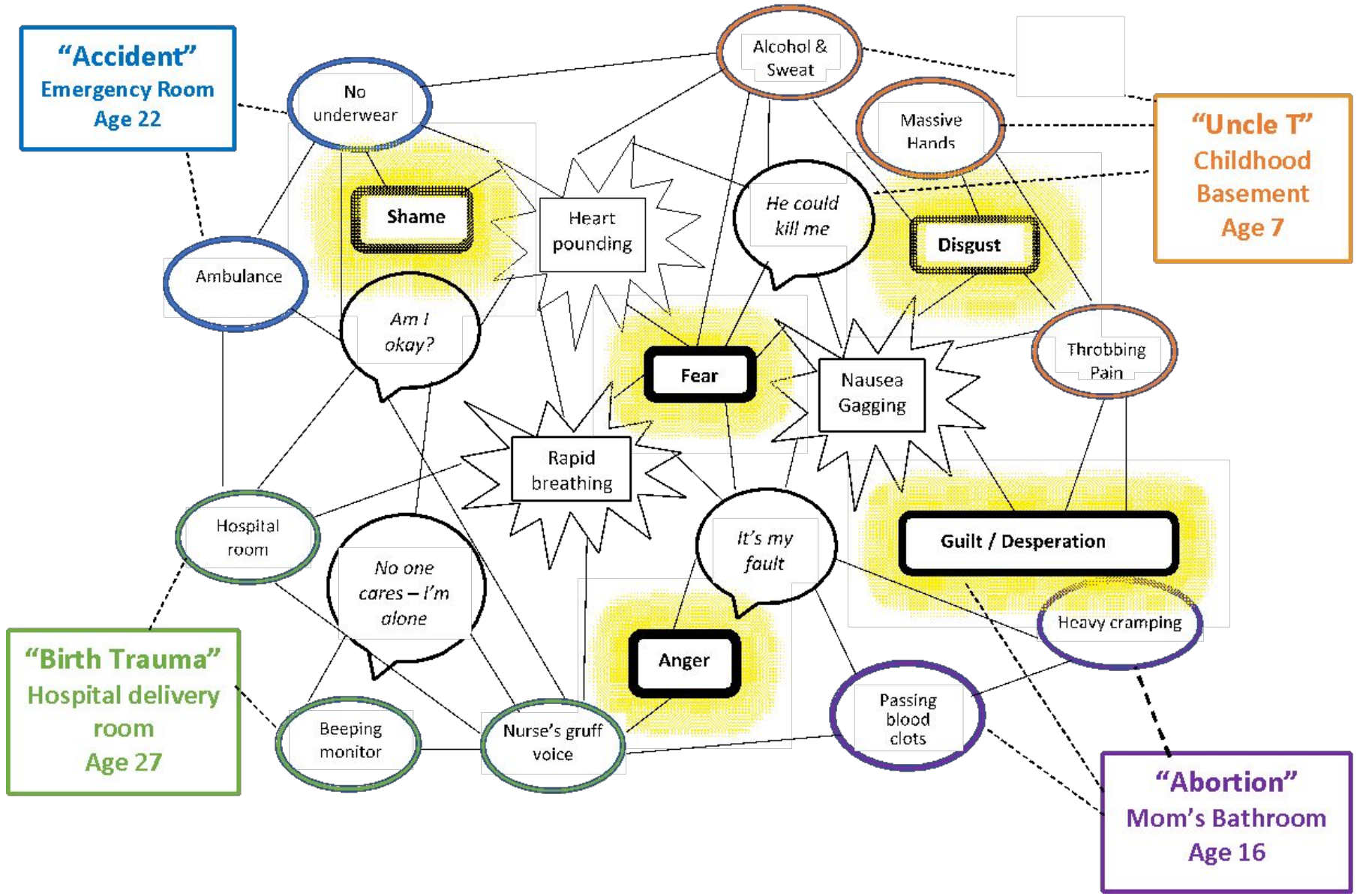
Sensory Memory (Sight-Smell-Sound-Touch-Taste)



Cognition


"Accident"
Emergency Room
Age 22
No underwear
Alcohol & Sweat
Massive Hands
"Uncle T"
Childhood
Basement
Age 7
Shame
Heart pounding
He could kill me
Disgust
Ambulance
Am I okay?
Fear
Nausea
Gagging
Throbbing Pain
Rapid breathing
Hospital room
No one cares – I'm alone
It's my fault
Guilt / Desperation
Heavy cramping
"Birth Trauma"
Hospital delivery room
Age 27
Anger
Passing blood clots
Beeping monitor
Nurse's gruff voice
"Abortion"
Mom's Bathroom
Age 16

Emotion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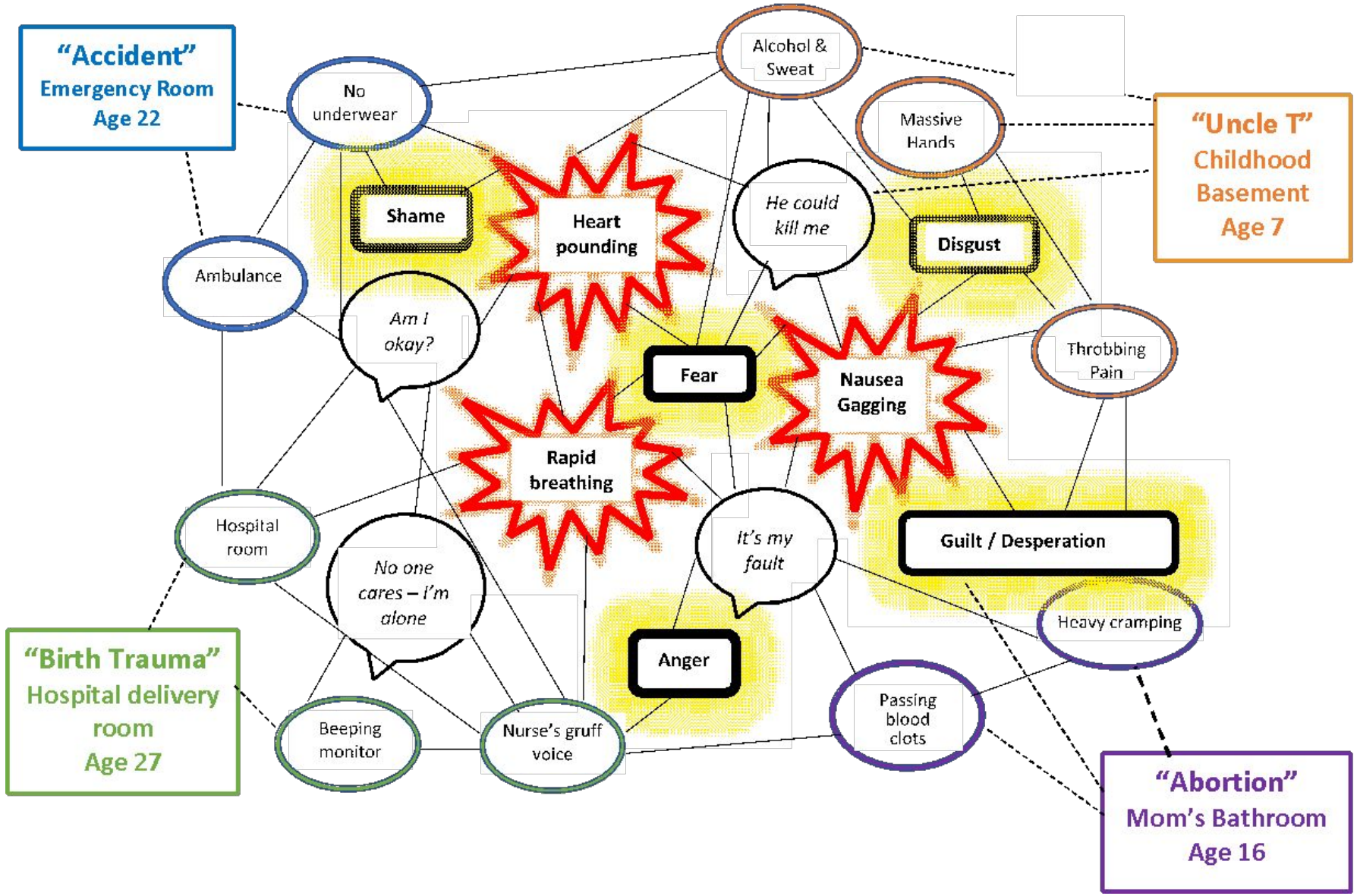
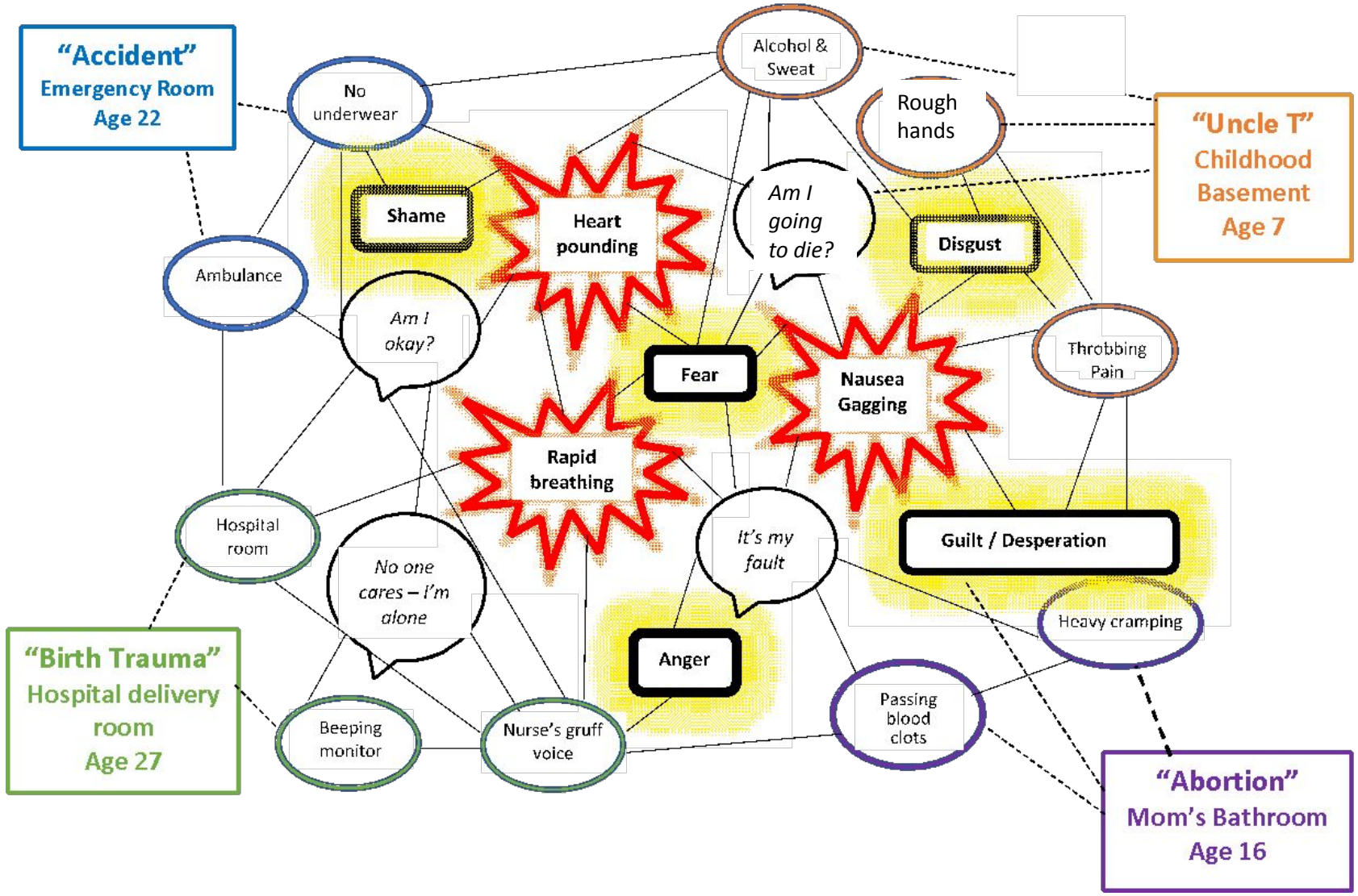
"Birth Trauma"
Hospital delivery room
Age 27
Beeping monitor
Nurse's gruff voice
Passing blood clots
"Abortion"
Mom's Bathroom
Age 16

Body – Physiologic Response



Associative Memory Network:
Sensory – Thoughts – Feelings – Body

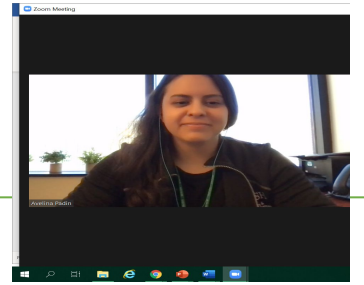


RUSH

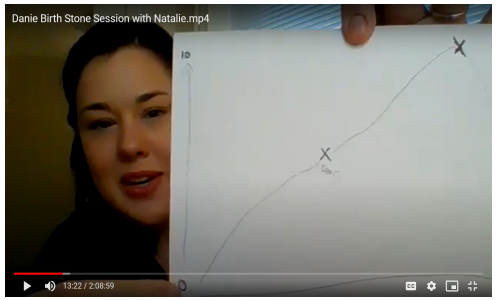
Collect, Organize and Document the Testimony

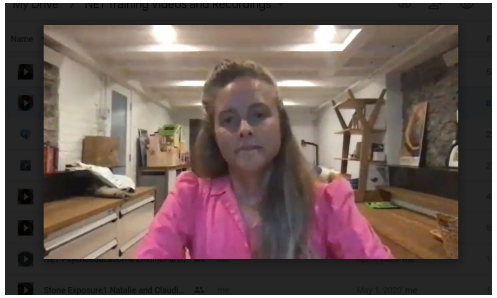
Perinatal NET Study

at Rush University Medical Center (2019-2021)[43]



- Primary Aim: Recruit 30 pregnant patients from hospital-based OB/GYN clinic to receive NET
- Collected trauma histories from 29 pregnant patients with PTSD and followed them through 1 month PP
- 76% (n=22) completion rate
- Treated many types of trauma with NET (Median = 9)

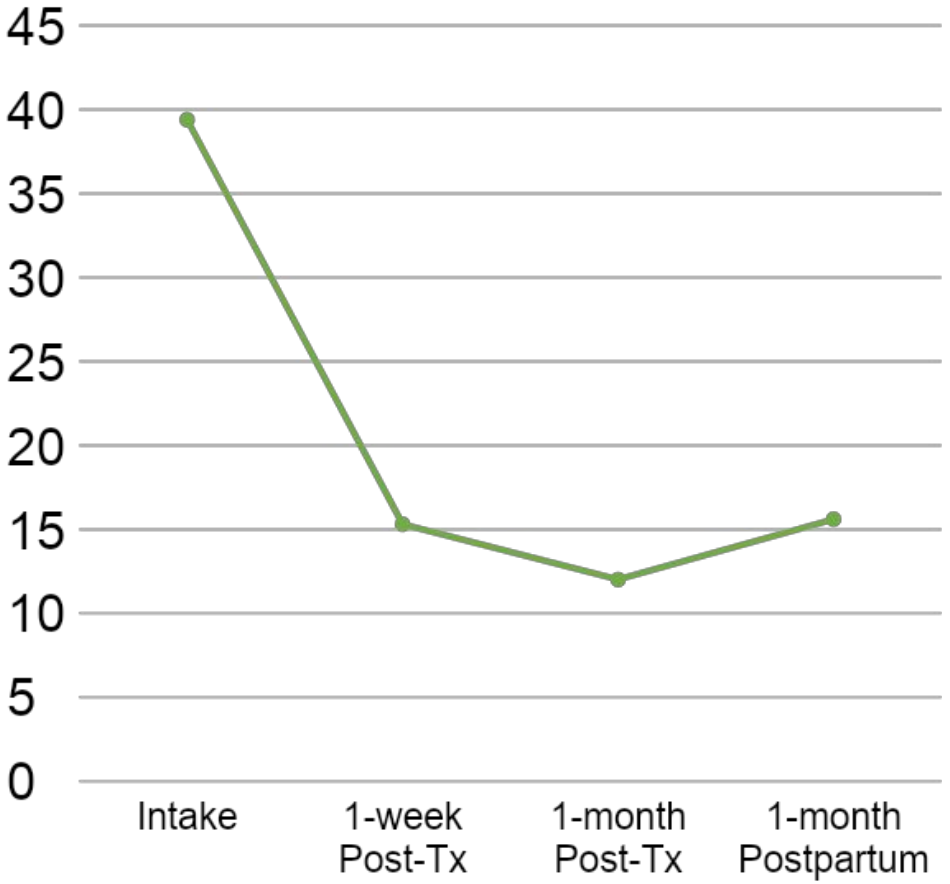




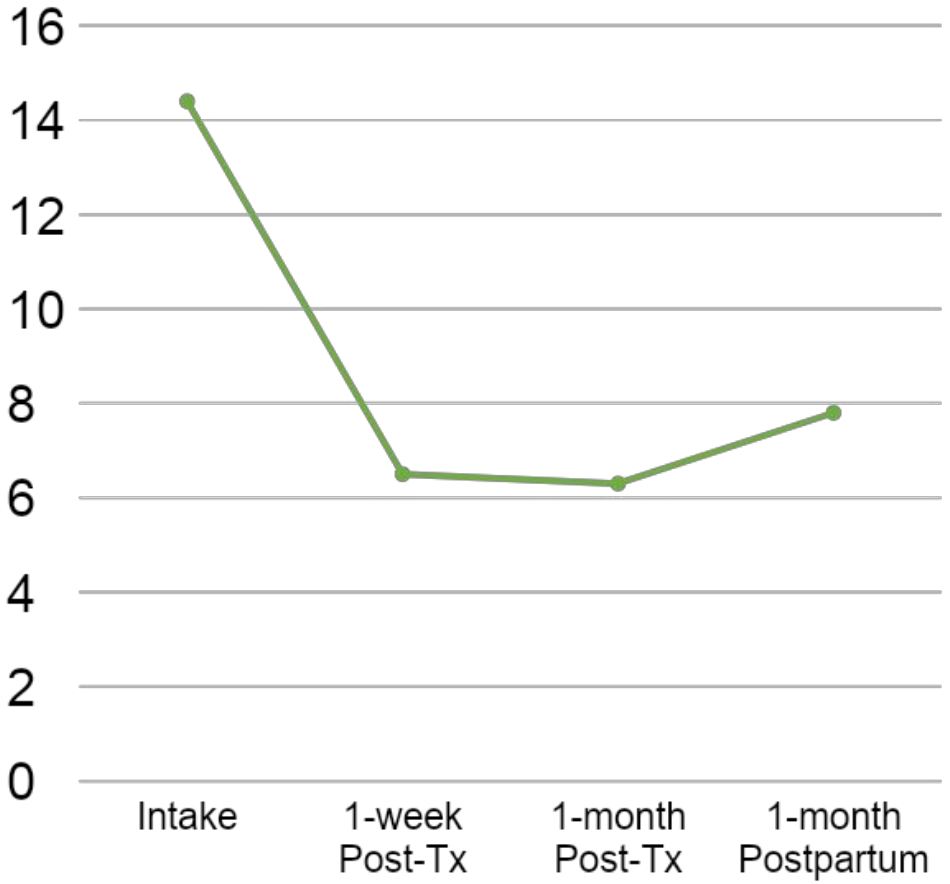
    - Intimate partner violence (IPV)
    - Rape / Sexual Assault
    - Intergenerational trauma
    - Childhood sexual abuse, maltreatment and neglect
    - Miscarriage/Pregnancy loss
    - Physical assault
    - Immigration trauma

Potential Treatment Effects

PTSD (PCL-5)



Depression (EPDS)



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NET is a Tool for Equity, Justice and Stigma-Reduction

SUPR Stigma Project[44]

- Patients who were mistreated in Chicago ED due to substance use
- 50 “lived experience” testimonies
- Collect testimonies from ED providers with secondary trauma

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Summary and Conclusions

- Obstetric violence and trauma ARE a problem in the US
- “a sense of control” is a broad and universal term
- Trauma avoidance is present globally – individual and collective
- Us vs. Them is not helpful: Focus on the system as a whole
- Trauma intervention tools are UNDER-utilized:
  - Mental health care
  - Health services research
  - Implementation science

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* In Memoriam

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