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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

ABSTRACT: Trauma is experienced throughout the life span, and traumatic experiences may be remote events or current and ongoing. The health care community continues to learn the many ways in which trauma affects an individual's health, relationships, utilization of the health care system, health care experience, and ability to adopt health-related recommendations. 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. Although trauma spans all races, ages, and socioeconomic statuses, some populations are exposed to trauma at higher rates and with greater frequency of repeated victimization. A number of health effects that may be associated with trauma are seen frequently in obstetrics and gynecology, including chronic pelvic pain, sexually transmitted infections, unintended pregnancy, conflicted feelings about pregnancy and sexuality, and difficulty with infant attachment postpartum. 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.

Recommendations and Conclusions

The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions regarding a trauma-informed approach to the health care visit.

- 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.

Background

Trauma is experienced throughout the life span, and traumatic experiences may be remote events or current and ongoing. Traumatic events can include a variety of experiences ranging from sexual abuse to natural disasters or even encounters with the health care system. These experiences can affect one's mental and physical health and may result in a range of conditions from anxiety and depression to cardiovascular disease. The manner in which survivors approach health and health care can be influenced by their

trauma. Trauma-informed care practices seek to create physical and emotional safety for survivors and rebuild their sense of control and empowerment during interactions. 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. Doing so will not only support healthy autonomy, but also foster resiliency and improve overall health outcomes.

The health care community continues to learn the many ways in which trauma affects an individual's health, relationships, utilization of the health care system, health care experience, and ability to adopt health-related recommendations. Although there is no single definition of trauma, a useful framework recognizes that "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" (1). Traumatic experiences may be current and ongoing or associated with more remote events of childhood and early life (2). These experiences may include intimate partner violence; sexual assault and rape, including military sexual trauma; violence perpetrated based on race or sexual orientation; neglect during childhood; combat and service trauma; natural disasters; repeated exposure to community violence; refugee and immigration status; or family separation (3–5). Specific to obstetrics is the increasing acknowledgement of traumatic birth experiences, which may include unexpected outcomes, procedures, obstetric emergencies, and neonatal complications (6–9). The term "obstetric violence" is a nonmedical term that has been used to refer to situations in which a pregnant or postpartum individual experiences disrespect, indignity, or abuse from health care practitioners or systems that can stem from and lead to loss of autonomy (10). These situations may include, for example, repeated and unnecessary vaginal examinations, unindicated episiotomy, activity and food restrictions during labor, and forced cesarean delivery. More subtle manifestations may include minimization of patient symptoms and differential treatment based on race, substance use, or other characteristics (11–13). Immediate and long-term responses to trauma are unique to each individual but have the potential to negatively affect health outcomes.

The prevalence of trauma is sobering. The early defining studies of adverse childhood experiences found that 63.9% of their sample of primarily white, non-Hispanic individuals with some college education had experienced at least one adverse childhood experience, and 12.5% had experienced four or more (14). A survey of a more diverse sample of adults who had completed high school confirmed those findings with 83.2% of respondents reporting at least one standard or community-level adversity and 37.3% reported four or more (15). Although trauma spans all races, ages, and socioeconomic statuses, some populations are exposed to trauma at higher rates and with greater frequency of repeated victimization. For example, families struggling with substance use disorder, chronic economic stress and poverty, or homelessness, and military families disproportionately experience trauma (16). In a 2009–2011 survey, 41% of female veterans reported a history of military sexual trauma (17). Individuals who are incarcerated and their families, those with disabilities, and sexual and gender minorities also experience trauma at higher rates than their counterparts. Additionally, indigenous communities continue to bear multigenerational and historic trauma as a result of policies aimed at relocation and assimilation to the majority culture (18).

Effect of Trauma

There are many ways in which trauma affects long-term physical and mental health outcomes (14, 19). Trauma history has been associated with premature mortality through a variety of mechanisms, some of which are better understood than others. Trauma's effects on the brain and body are real, resulting in neurobehavioral, social, emotional, and cognitive changes (20). Trauma survivors also are at risk for unhealthy behaviors, which are used in many instances as coping mechanisms, such as eating disorders, substance use, or self-harm (21). Individuals who have been exposed to trauma may experience a wide range of mental health conditions including anxiety, depression, posttraumatic stress disorder, and suicide attempts (19). The interplay of trauma's effects also is associated with chronic disease. As an example, higher posttraumatic stress severity is associated with lower high-density lipoprotein levels, higher triglycerides, higher blood pressure, greater body mass index and, in survivors of childhood sexual trauma, greater total number of cardiovascular risk factors (22). A history of trauma has been associated with lung, liver, and heart disease as well as autoimmune disease.

In addition to affecting physical and mental health, a history of trauma can have a profound effect on attitudes toward medical care (23). Trauma induces powerlessness, fear, and hopelessness, while also triggering feelings of shame, guilt, rage, isolation, and disconnection (1). Symptoms of previous trauma may explain why survivors have high rates of acute and emergency care utilization, but low rates of preventive care utilization (24–26). Individuals who have experienced trauma may have anxiety about specific medical examinations and procedures or even about being in medical settings altogether (1). A number of health effects that may be associated with trauma are seen frequently in obstetrics and gynecology, including chronic pelvic pain, sexually transmitted infections, unintended pregnancy, conflicted feelings about pregnancy and sexuality, and difficulty with infant attachment postpartum (27–29).

Re-traumatization is a "conscious or unconscious reminder of past trauma that results in a re-experiencing of the initial event. It can be triggered by a situation, an attitude or expression, or by certain environments that replicate the dynamics (loss of power/control/safety) of the original trauma" (30). From a patient's perspective, any number of experiences during the clinical encounter could be re-traumatizing. These range from personal questions that may be distressing or result in a sense of loss of or lack of privacy, to physical touch and removal of clothing for invasive procedures including pelvic examinations. Vulnerable positions required for examinations are another example of common clinical scenarios that can re-traumatize a survivor. Any of these may be amplified by the gender of the clinician, the power differential in the patient–physician relationship, or repetitive interviews or examinations by multiple clinicians as is common in settings with trainees (1). 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.

Box 1. Signs and Symptoms of Trauma

- Agitation
- Irritability, emotional swings
- Anxiety, depression, fear
- Outbursts of anger
- Easily startled by noise or touch
- Sudden sweating and/or heart palpitations
- Flashbacks—re-experiencing the trauma
- Difficulty concentrating
- Difficulty trusting
- Self-blame, guilt or shame
- Feeling disconnected or numb

Data from Substance Abuse and Mental Health Services Administration. Trauma-informed care in behavioral health services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: SAMHSA; 2014. Available at: https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4816.pdf. Retrieved December 7, 2020.

Trauma-Informed Care

Understanding trauma, its prevalence, and its effect on health is an initial step to improve patient experience but, to fully optimize outcomes for those who have survived trauma, clinicians should become familiar with the trauma-informed model of care and strive to implement this approach. A trauma-informed approach to service delivery is not the same as providing trauma-specific services. A trauma-informed approach to care has been defined as "a strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both practitioners and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (31). The Substance Abuse and Mental Health Services Administration has outlined four assumptions of trauma-informed care. The four "R's" describe the key assumptions of any program, organization, or system that is trauma-informed and include the following: *Realize* the widespread effect of trauma and understand potential paths for recovery; *Recognize* the signs and symptoms of trauma in clients, families, staff, and others involved with the system (Box 1); *Respond* by fully integrating knowledge about trauma into policies, procedures, and practices; and Seek to actively resist *re-traumatization* (1).

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. Everyone in the organization has a role to play in becoming trauma-informed. When staff and clinicians are trained to understand trauma and its consequences and that patient behaviors and ways of relating are often adaptations to traumatic experiences, they are able to have more effective interactions with survivors of trauma. 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. Staff and clinicians should work to create an environment that is safe, calm, comfortable, and clean. Consideration should be given to how punitive policies for late or missed visits might affect survivors of trauma, because many survivors find it difficult to even initiate a visit. Interactions should be compassionate, with expression of genuine concern and support, and survivors of trauma should be treated with respect and without judgment (1, 23, 32) (Table 1). Engaging in patient-centered communication and care can be accomplished by seeking patient input on how best to make them comfortable and can be particularly valuable for establishing trust and rapport. Individuals with a history of trauma often have adopted coping strategies to survive past and present adversities and overwhelming circumstances, and those strategies may involve adopting unhealthy behaviors. It is important to understand that trauma is experienced uniquely by each individual; therefore, the ways in which individuals react to and recover from trauma also will be unique (1, 32). Offering options during care that can lessen anxiety, such as seeking permission before initiating contact, providing descriptions before and during examinations and procedures, allowing clothing to be shifted rather than removed, and agreeing to halt the examination at any time upon request, are all beneficial practices (23).

Table 1. Four C's—Skills in Trauma-Informed Care

Calm	Pay attention to how you are feeling while caring for the patient. Breathe and calm yourself to help model and promote calmness for the patient and care for yourself.
Contain	Ask the level of detail of trauma history that will allow patient to maintain emotional and physical safety, respect the time frame of your interaction, and will allow you to offer patients further treatment.
Care	Remember to emphasize, for patient and yourself, good self-care and compassion.
Cope	Remember to emphasize, for patient and yourself, coping skills to build upon strength, resiliency, and hope.

Modified from Kimberg L, Wheeler M. Trauma and trauma-informed care. In: Gerber MR, editor. Trauma-informed healthcare approaches: a guide for primary care. Cham, Switzerland: Springer; 2019. p. 25–56.

It also is imperative to recognize the value of personal agency. Individuals' strengths and resiliency should be emphasized. True trauma-informed care empowers individuals by recognizing the significance of power differentials and the historical diminishing of voice and choice in past coercive exchanges. Therefore, at every opportunity, patients should be offered the choice to be actively involved in all decision-making regarding their care.

Choosing to use a trauma-informed approach does not mean you must provide trauma-specific services. Although the trauma-informed approach to care addresses organizational culture and practice, trauma-specific services are evidence-based clinical interventions that require particular training and deal more directly with treating the symptoms or conditions that result from traumatic events, including substance use and mental disorders (33–35). Trauma-specific services include treatment models that address cognitive, emotional, behavioral, substance use, and physical issues associated with trauma and are based on a detailed assessment of an individual's trauma experiences. Obstetrician–gynecologists may provide trauma-related care, specifically related to sexual abuse and assault; however, most trauma-specific services are not routinely offered by obstetrician–gynecologists. A practice should assess what services they are and are not equipped to provide. For services not provided, a robust resource list and educational materials should be available to assist with appropriate referrals, recovery, and healing.

Trauma-informed care promotes welcoming and engaging environments for patients who are trauma survivors, but it also includes considerations for staff and clinicians who have often experienced trauma in their own lives. Staff also may experience stress reactions and symptoms because of exposure to another individual's traumatic experiences, commonly known as "secondary trauma" (1). These reactions and symptoms shape clinicians' approach to and interactions with patients. It is important that clinicians and staff learn to care for themselves, both in the moment and in the long term. Caregivers need to learn to balance maintaining compassion and empathy while not over-identifying or re-living patient experiences. It is important to learn the signs of professional burnout and to prioritize good self-care (36). It also is essential for the clinical environment to have supportive policies and practices that prioritize staff well-being (1, 23, 32).

Screening

Educating patients about the health effects of trauma and offering patients opportunities to disclose their traumatic events should be common practice. Screening for specific types of trauma is either required or recommended by multiple agencies and organizations including the Joint Commission, the Women's Preventive Services Initiative, the National Academy of Medicine (formerly the Institute of Medicine), the American Medical Association, and the U.S. Preventive Services Task Force (USPSTF). Screening and management recommendations for intimate partner violence (37), sexual assault (38), and childhood sexual abuse (27) also are included in guidance from the American College of Obstetricians and Gynecologists. There is no one best way to screen for trauma but, when developing tools, consideration should be given to how and when to screen, whether screening will be for current or past trauma, and if screening instruments will be delivered face-to-face or by self-completion (23). Obstetrician–gynecologists should implement universal screening for current trauma and a history of trauma. Individuals may not share current or past trauma at the first or even second encounter, and obstetrician–gynecologists should be open and observant in every interaction, which allows for possible future disclosure. A trusting patient–physician relationship is paramount and may take time to develop. It may be months or even years before a patient chooses to disclose current or past trauma. It is crucial to avoid stigmatizing survivors and to focus on resilience rather than pathology (32).

A framing statement can be used to preface trauma screening, prepare the patient for potentially difficult questions, and to convey the universality of the screening. For example, it may help open up a dialogue to state the following: "Traumatic events are very common and can have direct effects on physical and mental health. For these reasons, I've begun asking all of my patients about any prior difficult experiences they've had and whether or not they feel comfortable sharing them." Regardless of how screening is undertaken, respect should be shown when survivors of trauma do not wish or are unable to discuss their experiences.

Conclusion

It is important for obstetrician–gynecologists to acknowledge that many patients may have experienced trauma. Office staff and clinicians should understand how these experiences might affect health outcomes and implement strategies to prevent re-traumatization, while optimizing care in a way that affords survivors a sense of safety and control.

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