Journal of Clinical and Nursing Research, 2024, Volume 8, Issue 12
http://ojs.bbwpublisher.com/index.php/JCNR
Online ISSN: 2208-3693
Print ISSN: 2208-3685

Advances in Research on Trauma-Informed Care for Perinatal Women

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Abstract: The perinatal period, defined as 28 weeks of gestation to one week postpartum, is a time when women are particularly vulnerable to re-traumatization or the formation of new trauma, significantly impacting their health and well-being as well as that of their families. This article outlines the forms and risk factors associated with trauma, examines the connection between trauma-informed care (TIC) principles and trauma, and reviews the implementation methods and application outcomes of TIC in perinatal care. The aim is to provide a reference for healthcare professionals to advance research related to TIC in perinatal women.

Keywords: Perinatal; Trauma; Re-traumatization; Trauma-informed care; Review

Online publication: January 7, 2025

1. Introduction

Trauma refers to events or circumstances experienced by an individual that result in long-lasting negative physical, psychological, social, emotional, or spiritual consequences. Women are particularly susceptible to gender-related trauma, including sexual assault, intimate partner violence, and childhood sexual abuse. Research indicates that approximately one-quarter of women aged 15–49 worldwide have experienced sexual or physical intimate partner violence during their lifetime. Trauma and its effects can exacerbate pain and feelings of loss of control during childbirth, increase the risk of low birth weight and preterm birth, interfere with breastfeeding, and even lead to maternal or neonatal death. Moreover, trauma adversely affects mental health, with some women turning to substance use, alcohol consumption, or smoking during pregnancy as coping mechanisms. These behaviors significantly jeopardize fetal growth and development.

Trauma-informed care (TIC) is a conceptual framework and therapeutic approach that prioritizes understanding and addressing the effects of trauma. It emphasizes physical, psychological, and emotional safety for trauma survivors while fostering opportunities for restoring control, self-efficacy, and empowerment. This approach has been shown to alleviate post-traumatic symptoms and minimize the risk of secondary trauma.

However, in China, research on trauma-informed care specifically tailored to perinatal women remains in the exploratory phase. This article reviews the implementation and outcomes of TIC in perinatal care, providing a reference for healthcare professionals engaged in related research.

2. Trauma and trauma-informed care

2.1. Risk factors for triggering re-traumatization or trauma formation in perinatal women

The forms of trauma experienced by women during the perinatal period are diverse. Trauma is prevalent within the population and profoundly impacts individuals. The invasive nature of some procedures in perinatal care significantly increases the likelihood of triggering or exacerbating untreated trauma, often resulting in the recurrence of symptoms associated with prior trauma and the risk of re-traumatization [1]. Flashbacks may occur when women are subjected to sensitive questions or required to expose private areas; when women with a history of sexual assault undergo cervical examinations, vaginal deliveries, breastfeeding, or other care related to previously assaulted areas; and when women with experiences of intimate partner violence or childhood sexual abuse are physically restrained by fetal heart monitors, intravenous lines, or bed rails, potentially inducing panic and distress. Additionally, factors such as healthcare professionals' implicit biases, obstetric violence, and fetal anomalies can directly contribute to the development of trauma in perinatal women [2].

Consequently, healthcare professionals should adopt a patient-centered approach, respecting patient autonomy and avoiding language or behaviors that may provoke trauma. Addressing perinatal trauma through timely identification, prevention, and mitigation is both urgent and essential.

2.2. Principles of trauma-informed care

TIC is highly effective in addressing the needs of patients, reducing ongoing traumatic stress, and improving post-traumatic symptoms. The four "R's" of TIC include:

(1) Recognizing the widespread effects of trauma.

(2) Recognizing trauma-related signs and symptoms in patients.

(3) Responding to re-traumatization as it occurs by adhering to key principles.

(4) Resisting re-traumatization through appropriate procedures and frameworks [3].

The principles of TIC are outlined in **Table 1**.

Table 1. Principles of trauma-informed care

Principle	Description
Safety	Ensure the physical and emotional safety of patients, clinicians, and staff.
Trustworthiness and transparency	Promote transparency in clinical and administrative processes while safeguarding confidentiality. Build trust with patients, supportive family members, and staff.
Peer support and mutual self-help	Encourage individuals with a history of trauma to connect with others who share similar experiences, fostering healing and resilience.
Collaboration and mutuality	Foster collaboration with patients and staff, emphasizing shared decision-making in all clinical interactions.
Empowerment, voice, and choice	Uphold patient autonomy by supporting their choices and control during all interactions and decisions. Promote empowerment in all aspects of care.
Combating structural violence	Address the traumatic impact of structural violence on both patients and staff. Advocate for policies and processes that are responsive to diverse racial, sociocultural, and gender needs.

To ensure a positive birth experience and minimize re-traumatization, the principles of TIC can serve as a foundation for developing a personalized care framework for perinatal women. This framework can be applied across all stages of the perinatal period, providing women with consistent support and fostering a safe environment for both their physical and psychological well-being.

3. Implementation of trauma-informed care in perinatal women

The specific implementation process of TIC for perinatal women has not yet been standardized. The following process is summarized based on a review of relevant literature [1,2,4].

(1) Prenatal

(a) Form an implementation team: Assemble a multidisciplinary team comprising clinicians, midwives, nurses, medical assistants, psychologists, psychiatrists, social workers, and peer support specialists. Involve clinical leadership and provide standardized training for all team members.

(b) Screen for universal trauma: Conduct trauma screening for all women during their first prenatal visit, ensuring family members are not present during the process. Based on the findings, facilitate access to psychological counseling and legal support if necessary.

(c) Fetal screening and early intervention: Emphasize the importance of timely fetal screening. Schedule additional tests promptly if abnormalities are detected and intervene early as needed.

(d) Foster trust and communication: Inform women of their rights, actively listen to their needs, and engage in clear, consistent, and friendly communication to establish trust.

(e) Personalized care planning: Inquire about personal experiences with labor and delivery, goals for care, concerns, and fears. Collaborate to create a care approach, birth plan, and preparations for potential emergencies.

(2) During labor

(a) Maintain control and autonomy: Support the woman's autonomy in deciding whether to undergo cervical examinations, the gender of the provider, and the location of delivery.

(b) Safe touch practices: Ensure the woman is in a comfortable position and consents before any physical contact.

(c) Trauma awareness: Take into account the woman's traumatic experiences and minimize the risk of re-traumatization during physical exams, labor, and birth interventions.

(3) Postpartum

(a) Contraceptive planning: Develop individualized, safe, and reliable contraceptive plans for women not wishing to become pregnant, reducing the risk of trauma from unintended pregnancies.

(b) Information sharing: Educate women about team communication, hospital policies, and effective ways to seek help.

(c) Feedback mechanisms: Encourage women to complete satisfaction surveys and feedback forms after discharge. Use this input to guide the development of TIC policies, training, and team education.

Throughout the perinatal period, holistic, patient-centered care is prioritized to strengthen collaboration between women, families, and healthcare providers.

Antje *et al.* [3] observed a lack of screening tools specifically designed to assess post-traumatic stress disorder

(PTSD) related to labor and delivery. Current questionnaires, primarily intended for other populations, often focus on psychosocial risk factors rather than trauma symptoms. Brooke *et al.* [1] highlighted the need for future research to develop assessments integrating mental health and perinatal care, as well as screening and intervention practices for survivors of perinatal sexual victimization. Additionally, they emphasized the importance of training healthcare providers in trauma-informed perinatal care.

A descriptive study exploring the experiences of Rwandan caregivers working with adolescent mothers underlined the importance of ongoing training in trauma- and violence-informed care. This approach ensures quality care for adolescent mothers, mitigates vicarious traumatization among caregivers and raises awareness of potential biases. However, findings from this study may not be generalizable to all cultural or regional contexts.

Maggie *et al.* [5] emphasized the significance of training healthcare providers to address obstetric violence, promote women's autonomy, avoid over-medicalization, and ensure informed consent or refusal for all interactions. Similarly, Madeleine *et al.* [6] recommended incorporating TIC education into midwifery training programs to drive sustainable change and improve care quality over the long term.

Perinatal TIC encompasses diverse strategies and holds great potential for addressing implicit bias, obstetric violence, and vicarious traumatization while fostering safe, supportive environments for both women and healthcare professionals. However, the limited availability of applied research on TIC intervention programs for perinatal women and the small sample sizes of some cross-sectional studies highlight the need for further investigation to strengthen evidence-based practices.

4. Effectiveness of trauma-informed care application in perinatal women

4.1. Reducing the risk of trauma to mother and child while promoting safety and comfort

Perinatal trauma increases the risk of preterm birth, low birth weight, and maternal and infant mortality. Ashby *et al.* [7] studied the impact of TIC by comparing two groups: a control group of 429 adolescent mothers who received standard care in 2007–2008 and an intervention group of 415 adolescent mothers who received TIC at the same facility in 2012–2013. The intervention group demonstrated a significant increase in the number of prenatal visits. While there was no significant difference in the rate of preterm births between the two groups, the intervention group showed a notable reduction in the rate of low birth weight and a significant decrease in infant mortality.

Shadow *et al.* [8] conducted seven semi-structured individual interviews using convenience and snowball sampling with six to eight Karen-speaking women in Melbourne who were 18 years or older and had received perinatal care within the preceding 24 months. The study concluded that trauma- and violence-informed approaches, including care design and accessibility, facilitation of choice and control, and trauma-informed interpreting services, contributed to a sense of safety and well-being during the perinatal period.

These findings suggest that applying TIC to perinatal care can help prevent re-traumatization, mitigate the effects of trauma, and promote safety and comfort for women during this critical period.

4.2. Enhancing resilience and empowerment

Resilience and empowerment are closely linked processes that play a pivotal role in motherhood. Resilience refers to a dynamic process involving self-awareness, focus, action, reflection, and maintenance. It represents an individual's ability to adapt, withstand, and overcome environmental stresses and risks, tending toward introspection. Empowerment, in contrast, involves a transformative experience of power derived from interactions

within the social world, often characterized by extroversion.

Amina *et al.* [9] propose that incorporating TIC prevention measures, such as thoughtfully and unbiasedly discussing clinical variables and achievable goals at appropriate times, can foster resilience and self-efficacy. This approach significantly enhances the likelihood of positive future health outcomes. Postpartum visitors who patiently listen to women's self-reports of their birth experiences, emphasize their subjective agency during childbirth and affirm their bravery contribute to the development of resilience and post-traumatic growth.

These findings highlight the unique and essential role of family and social support throughout a woman's perinatal journey, reinforcing the importance of empowering women and nurturing their resilience during this transformative period.

5. Conclusion

Women are particularly vulnerable to gender-related trauma, and the perinatal period presents numerous risk factors for re-traumatization and trauma formation. Trauma and its sequelae significantly impact maternal and infant health, family relationships, and social development. While many scholars have highlighted the importance of TIC for perinatal women through descriptive studies and have proposed specific implementation methods, the small sample sizes of these studies and the racial and geographic variability limit the direct replication of interventions across different regions.

Furthermore, research on the practical application of TIC for perinatal women remains limited, with most studies focusing on program development rather than implementation. Challenges in TIC implementation include the lack of standardized tools for screening risk factors and trauma symptoms, as well as the insufficient availability of interpreters to address the needs of women from specific cultural backgrounds. Obstetric violence remains a critical concern in maternal healthcare, and the vicarious traumatization of nurses and midwives has emerged as a new area of research.

Future priorities should include the development of integrated mental health and perinatal care assessments, the implementation of screening and intervention practices for survivors of perinatal sexual victimization, and the provision of trauma-informed perinatal care training. Emphasis should also be placed on multidisciplinary collaborative team training and the integration of TIC education for midwives and midwifery students to ensure sustainable improvements in care quality.

Funding

2024 Zhejiang Provincial Education Science Planning Project "A Study of the Mediating Effect of Spiritual Health on the Sense of Meaning in Life and Death Coping Skills Among Undergraduate Nursing Students" (Project No. 2024SCG410)

Disclosure statement

The authors declare no conflict of interest.

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