جنبه های روانشناختی تروما در بارداری

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- Women presenting for health care may have experienced trauma in the forms of
  - sexual or physical abuse (childhood or adult),
  - emotional abuse,
  - violence (including intimate partner violence),
  - neglect,
  - accidents,
  - disaster,
  - war,
  - death, and
  - medical events such as traumatic birth.
- These events may be directly experienced or witnessed

- 7% of pregnancies experience trauma

❖ Most common:

- Motor vehicle crashes (MVC)
- Falls
- Battering or physical abuse

- Non-accidental trauma, such as **domestic violence** and **suicide** are common in pregnancy.

Statistics are likely, grossly *underreported* by victims.

- Homicide rates of pregnant and post-partum women in New York City showed that homicide was the 2nd most common cause of death among **pregnant** and **post-partum women**.
- Further, **suicide** was responsible for **10%** of all maternal deaths

MECHANISM OF INJURY: INTIMATE PARTNER VIOLENCE (IPV) (DOMESTIC VIOLENCE)

- Risk Factors:
  - Young
  - Single
  - Non-Caucasian
  - ↓ Socioeconomic Status
- Frequently underreported

- No other time in a woman’s life, is she more likely to be battered by an intimate partner.

- Domestic violence is about power and control. Be mindful for signs of the following: coercive behavior, intimidation, emotional abuse, economic abuse, and isolating the patient from friends and family.
- The patient may present for falls or other home related accidents. Examine breasts, abdomen, back and genitals and look for injuries at different stages of healing.

- Pregnant women who are abused, suffer greater complications during their pregnancy.
- They tend to gain less weight and have a higher incidence of anemia, infections and bleeding.
- Also, rates of maternal depression, suicide, tobacco, alcohol and drug use are higher

Intimate Partner Violence Screening Tool

(performed in absence of patient partner)

1. Within the past year -- or since you have been pregnant -- have you been hit, slapped, kicked or otherwise physically hurt by someone?

2. Are you in a relationship with a person who threatens or physically hurts you?

3. Has anyone forced you to have sexual activities that made you feel uncomfortable?

(ACOG, 2012)

STN
SOCIETY OF TRAUMA NURSES

- Many victims of abuse are not ready to leave their abusers because of fear of **reprisal**; **economic dependence** on the abuser, especially if there are **children**; **no acceptable place** to go; **belief** that the **abuse will stop**; or belief that the **abuse is their fault**.
- Victims may believe expressions of remorse and promises that the abuser will change their behavior. Dropout rates from treatment programs are high

- Attempting to or leaving a relationship with a perpetrator often increases the risk of injury.
- Providers should not encourage their patients to leave a relationship .
- If patients come to their own decision to terminate a relationship, close attention should be paid to devising and implementing a safety plan and seeking assistance from hospital and community resources where available

- providers of health services must understand the impact of trauma (especially directly experienced physical or sexual trauma) and PTSD (or similar symptoms)

TRAUMA: DEFINITIONS

- The American Psychiatric Association defines trauma as "exposure to actual or threatened death, serious injury, or sexual violence in one or more ways".
- The traumatic event can be experienced directly, witnessed, experienced by a family member or close friend, or result from repetitive exposure to aversive details related to a traumatic event

ACUTE STRESS DISORDER (ASD)

- Acute stress disorder (ASD) is characterized by acute stress reactions that may occur in the initial month after a person is exposed to a traumatic event.
- The disorder includes symptoms of **intrusion**, **dissociation**, **negative mood**, **avoidance**, and **arousal**.
- Some patients who experience ASD go on to experience posttraumatic stress disorder (PTSD), which is diagnosed only after four weeks following exposure to trauma

- For patients with ASD and acute, intense anxiety, agitation, or sleep disturbance in the immediate period following the traumatic event, we suggest adjunctive treatment with a benzodiazepine rather than other medications
- Benzodiazepine treatment should be limited to two to four weeks.

PSYCHOSOCIAL INTERVENTIONS

- Psychosocial interventions that have been tested either to treat symptoms of acute stress disorder (ASD) and/or to prevent the development of posttraumatic stress disorder (PTSD) include:
- trauma-focused cognitive-behavioral therapy (CBT),
- exposure therapy,
- cognitive therapy,
- and psychological debriefing

APPROACH TO TREATMENT

- It’s suggested trauma-focused cognitive-behavioral therapy (CBT) as first-line treatment of patients with acute stress disorder (ASD) rather than other psychotherapies or medication

- a clinical trial randomly assigned 24 patients with ASD following civilian trauma to receive five sessions of either CBT or supportive counseling within two weeks of the traumatic event .
- At six months following their event, a ***smaller*** proportion of patients in the CBT group met diagnostic criteria for PTSD in the CBT group compared with the supportive counseling group (17 versus 67 percent).

- CBT for ASD patients should typically be provided by a trained clinician over **six weekly sessions of 60 to 90 minutes**; additional sessions can be added if necessary.
- The intervention is typically delivered at least **two weeks after trauma** exposure. This allows the individual additional time for transient symptoms to abate and for post-trauma stressors to ease
- The commencement of therapy should be timed with respect for other stressful events stemming from the trauma. The patient may find it difficult to focus attention on therapy if distracted by trauma-related events or experiences, such as pain, surgery, legal proceedings, relocation, or other stressors.

TRAUMA-FOCUSED CBT

- Trauma-focused CBT for ASD typically includes:

1. patient education,
2. cognitive restructuring,
3. and exposure

PATIENT EDUCATION

- Patients are educated about:
- stressful reactions to trauma,
- trauma-related disorders,
- and treatment options

EDUCATING PATIENTS ABOUT STRESSFUL REACTIONS TO TRAUMA SHOULD AIM:

- Normalize the stress response
- Heighten expectancy of recovery
- Explain the stress responses in terms of conditioning models that require the patient to learn that reminders are no longer dangerous

COGNITIVE RESTRUCTURING

- Cognitive restructuring is used to address maladaptive or unrealistic appraisals the patient may have about the *trauma*, his or her *response to the event*, and *fears of potential future harm.*

EXPOSURE

- Exposure therapy assists patients in confronting their feared memories and situations in a **therapeutic manner**
- Re-experiencing the trauma through exposure allows it to be emotionally processed so that it can become less painful
- includes both imaginal exposure and in vivo exposure

DELAY EXPOSURE THERAPY

- For some patients with ASD, it is necessary to delay exposure therapy for several months into the PTSD phase for others, including patients with:

●**Extreme avoidance** or **dissociative responses**, because these presentations may indicate extreme stress responses that may be complicated by exposure.

●A primary response of **anger**, because anger often does not respond optimally to exposure exercises and may respond better to cognitive therapy.

DELAY EXPOSURE THERAPY

- **An acute grief response**, because exposure therapy may complicate normal grieving.

- **Borderline or psychotic features**, because these people require containment and exposure may complicate their presentation.

- **Significant suicidal risk**, because these patients require suicide management.

- Persisting PTSD responses to childhood trauma, because addressing childhood trauma weeks after a recent trauma may be excessively difficult.

- Exposure, a component of trauma-focused CBT, has been found to be more effective when provided as monotherapy than cognitive restructuring in patients with ASD

- A clinical trial found that an early exposure-based intervention delivered in the emergency department to persons recently exposed to a traumatic event was successful in preventing PTSD

PSYCHOLOGICAL DEBRIEFING

- intervention involves recollecting, articulating, and reworking of the traumatic event, typically in a group format.
- psychological debriefing (also known as "critical incident stress debriefing") **has not been found to be effective** in reducing PTSD symptoms among individuals experiencing a traumatic event
- Meta-analyses of numerous clinical trials found no evidence of effectiveness for either the initial, single-session intervention or for subsequent, multiple-session versions.

PTSD

- PTSD is a diagnosis that is applied when the traumatic event or events result in a constellation of symptoms:
- negative changes in cognition and mood,
- intrusion (unwanted memories or thoughts),
- avoidance,
- and a state of hyperarousal. Not all survivors of trauma have a memory of the traumatic event, though they may manifest symptoms and signs of trauma with or without PTSD.

IDENTIFICATION

- The clinician should be sensitive to the possibility that the patient may continue to be a victim **of ongoing trauma**, such as with intimate partner violence or trafficking, but unwilling to disclose for fear of the abuser.
- Since a trauma history may not be disclosed at the first visit, we inquire about possible exposure to physical or sexual trauma at subsequent visits.
- An environment of trust, safety, and confidentiality is essential in helping patients to feel comfortable disclosing

WARNING SIGNS OF POSSIBLE PRIOR TRAUMA AND/OR PTSD

- Physiologic reaction of distress, such as a startle response to loud sounds
- Negative alterations in cognition and mood, such as flat or angry affect, that can arise unpredictably or with subtle triggers
- Somatic symptoms including headache, insomnia, weight loss, abdominal pain, and sexual dysfunction
- Avoidance behavior of any sensory reminders of the traumatic event
- Hyperarousability, hypervigilance, and/or increased anxiety
- Dissociation
- Extreme distrust or dislike of the provider or others in positions of power

DISSOCIATION

- Dissociation is an alteration in the usually integrated functions of consciousness, memory, identity, or awareness of body, self, or environment.
- the patient becomes mentally removed from the immediate reality and begins to relive the previous traumatic experiences or becomes flooded with feelings about this event.
- the patient's voice may change and revert to the voice she had at the time of the trauma
- decreased responsiveness to external stimuli ("shutting down"),
- impaired memory (ie, dissociative amnesia),
- and disturbances of identity and awareness (eg, depersonalization and derealization).

MANAGING PATIENT DISSOCIATION

- we stop and reorient the patient to the present time and place by using language such as the following: "I am Dr. (Name). You are in my office. It is (date and year), and you are completely safe. Can you hear me?"
- We repeat this information as necessary until the patient is grounded in the present.
- After such an event, the patient may need some time alone, or with her support person, before she is comfortable enough to either continue the visit or leave the office.

IF A HISTORY OF TRAUMA IS DISCLOSED, WE ASK THE FOLLOWING:

- Does the patient currently feel safe?
- Do they have anyone in their life that they have talked to about this, or would they like behavioral health resources?
- Would the patient feel more comfortable deferring an examination or procedures to a future appointment?
- Does the patient have any known triggers that we can actively work to avoid?
- Does the patient have any specific request(s) pertaining to the examination or future visits?

- An example can illustrate the use of cognitive therapy for PTSD.
- A woman raped by a home intruder wrongly blamed herself.
- The therapist led the woman through a series of questions about the event, establishing through her answers that her actions were reasonable, that she had not done anything to bring on the event, and that she could not have prevented it.
- She was then asked, if her sister or her daughter behaved in the same way under the same circumstances, would she think they were to blame?
- Allowing the woman to generate the information in this discussion and then to re-evaluate her perceptions was successful in changing her self-blaming beliefs.

EXPOSURE THERAPY PROGRAMS FOR PTSD

Exposure therapy is an effective treatment for PTSD

- Imaginal exposure
- In vivo exposure
- Virtual reality exposure — A more recently developed method for providing exposure therapy is through virtual reality, which is well suited to recreate traumatic experiences that cannot typically be encountered feasibly and safely for therapeutic purposes, such as combat, catastrophic disasters, or severe motor vehicle accidents .Virtual reality exposure therapy uses a head-mounted computer display to present the PTSD patient with visual, auditory, tactile, and other sensory material that stimulate traumatic memories and affective response (picture 1) [12

EXPOSURE THERAPY PROGRAMS FOR PTSD

- Exposure therapies differ in the number and types of included components, including the number and frequency of exposure sessions.
- Exposure therapy programs often include homework exercises making use of imaginal exposure.
- In one common approach, a tape recording is made during a session of the patient describing the traumatic event aloud. Between sessions, the patient practices exposure at home, listening to the tape and further processing the traumatic material.

- cognitive processing therapy, a widely used therapy for PTSD, is principally a cognitive therapy, though it includes exposure to memories of the trauma.
- The exposure component consists of writing a detailed account of the trauma and reading it in the presence of the therapist and at home.
- Cognitive processing therapy examines thoughts and feelings that emerge during the exposure exercise and provides training to challenge problematic beliefs about *safety*, *trust, power, control, esteem, and intimacy*.
- Individuals are taught to challenge faulty assumptions and self-statements and to modify maladaptive thoughts and over-generalized beliefs.

COPING SKILLS TRAINING

- these interventions do not focus on the patient's trauma
- Role playing
- Assertiveness training
- Stress management
- Relaxation exercises
- Biofeedback (eg, using electromyography, heart rate, or respiration rate)
- Teaching sleep hygiene
- Recommending exercise

EYE MOVEMENT DESENSITIZATION AND REPROCESSING(EMDR)

- The technique involves the patient imagining a scene from the trauma, focusing on the accompanying cognition and arousal, while the therapist moves two fingers across the patient's visual field and instructs the patient to track the fingers.
- The sequence is repeated until anxiety decreases, at which point the patient is instructed to generate a more adaptive thought.
- An example of a thought initially associated with the traumatic image might include, “I’m going to die,” while the more adaptive thought might end up as, “I made it through. It’s in the past.”

INTERPERSONAL THERAPY

- which focuses on disorder-specific symptoms and impairment in the context of current interpersonal relationships, has demonstrated efficacy for PTSD in a clinical trial

MINDFULNESS-BASED STRESS REDUCTION

- which teaches patients to attend to the present moment in a nonjudgmental, accepting manner, led to modest reduction of PTSD symptoms in a clinical trial

OTHER PSYCHOTHERAPIES

- Acceptance and commitment therapy (ACT)
- Psychodynamic psychotherapy
- Eclectic psychotherapy

PREVENTING POST-TRAUMATIC STRESS DISORDER FOLLOWING CHILDBIRTH AND TRAUMATIC BIRTH EXPERIENCES: A SYSTEMATIC REVIEW

- According to a recent systematic review, risk factors for traumatic birth experience and/or developing PTSD symptoms include :
- a history of psychopathology,
- pregnancy-related pathology,
- operative births and
- several types of negative feelings concerning birth

PREVENTING POST-TRAUMATIC STRESS DISORDER FOLLOWING CHILDBIRTH AND TRAUMATIC BIRTH EXPERIENCES: A SYSTEMATIC REVIEW

- When women evaluate their delivery, four factors predominate in the rating of this birth experience:
- the availability of support from caregivers,
- the quality of relationships with caregivers,
- being involved in decision-making,
- and having high expectations or having experiences that exceed expectations

- maternal PTSD leads to a lower birthweight and lower rates of breastfeeding

- All 13 included articles investigated secondary prevention. No relevant articles were found concerning the question on primary prevention.

PREVENTING POST-TRAUMATIC STRESS DISORDER FOLLOWING CHILDBIRTH AND TRAUMATIC BIRTH EXPERIENCES: A SYSTEMATIC REVIEW

- All evaluated secondary prevention, and none primary prevention
- Interventions included debriefing, structured psychological interventions, expressive writing interventions, encouraging skin-to-skin contact with healthy newborns immediately postpartum and holding or seeing the newborn after stillbirth.
- The large heterogeneity of study characteristics precluded pooling of data.
- The writing interventions to express feelings appeared to be effective in prevention.
- A psychological intervention including elements of exposure and psycho-education seemed to lead to fewer post-traumatic stress disorder symptoms in women who delivered via emergency cesarean section.

- Continuous support during delivery was found to have a significantly positive effect on the birth experience.
- women attribute their traumatic childbirth experience to:

✓ a lack or loss of control,

✓ to suboptimal communication with health practitioners,

✓ and to too little practical and emotional support.

➢ Consequently, awareness of these factors among health practitioners could lead to a different role during labor and consequently to fewer traumatic events.

- an active approach to prevent or treat PTSD and PTSD symptoms at an early stage could perhaps also lead to fewer or less severe cases of PTSD.
- This can primarily be done by identifying women who had a traumatic birth experience.
- Because a seemingly uncomplicated childbirth can lead to PTSD symptoms, the first step in recognizing a traumatic birth experience is openly to ask each postpartum woman about her feelings and thoughts concerning the delivery.

QUESTIONNAIRES

- Wijma Delivery Expectancy/Experience Questionnaire (version B)
- the Delivery Satisfaction Scale

Table 5. Maternal satisfaction scale for caesarean section

Each question is followed by a Likert scale as below.

☐ ☐ ☐ ☐ ☐ ☐ ☐

Strongly disagree Strongly agree

ANAESTHETIC

1. I was pain free during my caesarean section.
2. I felt the anaesthetic I received was safe for me.
3. I felt the anaesthetic I received was safe for my baby.

INSERTION OF NEEDLE IN THE BACK

4. I had no pain when the needle was put into my back.
5. The needle was put easily into my back.
6. I was in a comfortable position when the needle was put into my back.

SIDE-EFFECTS

During the caesarean section, I did NOT experience the following:

7. Shivering
8. Dry lips/mouth
9. Dry throat
10. A change in mood

After the caesarean section, I did NOT experience:

11. Back Problems
12. Itchiness

ATMOSPHERE

In the operating room, during the surgery, I was able to:

13. Interact with my partner
14. Bond with the baby
15. Have a sense of control
16. Communicate with the staff
17. See the baby after delivery
18. Hold the baby after delivery
19. I knew what the staff were doing during the operation.
20. I found the atmosphere in the operating room comfortable.
21. I was able to nurse my baby after delivery