Building a Model of Care for Prolonged Antepartum Admissions in a Birthing Hospital: *Provisioning Care through a Trauma-Informed Lens*

Danielle L. Cooke, PhD; Jessalyn Kelleher, PsyD; & Allison G. Dempsey, PhD

Disclosure Statement

Speaker: Danielle Cooke

Danielle Cooke and her coauthors have documented that they has nothing to disclose.

Emotional Setting

- Pregnancy is suddenly interrupted by news of complications:
  - Maternal: placenta previa/abruption; chronic hypertension; preterm labor
  - Fetal: fetal growth restriction; premature rupture of membranes
- Patients may be anxiously waiting to get to 20 weeks for hospitalization
- Patients may attend a routine appointment before being admitted or flown across the state
- Parents are asked to make decisions about care with limited information and ever changing guidelines
- Characterized by uncertainty and fear; hyper medicalization

Common Challenges

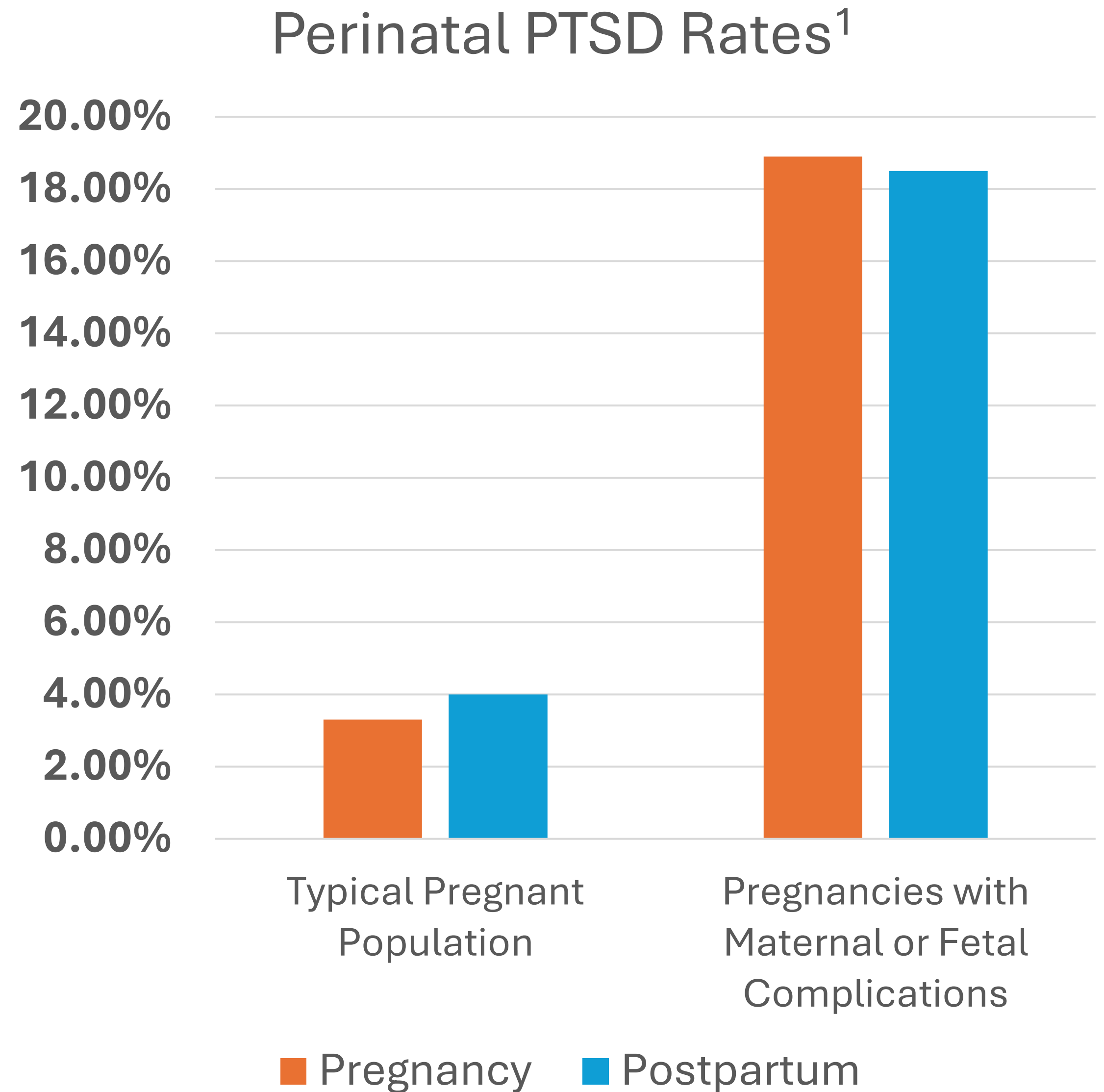
Hospital Setting

- Antepartum unit at a major metro birthing hospital
- 40% with Medicaid insurance
- Geographically diverse
- Diverse family racial/ethnic backgrounds and/or primary language spoken
- Admitted from 20-32 weeks for complications including fetal growth restriction, preeclampsia, placenta previa, among others

"Everyone told me this is where you go to save your baby"
Patient intake, 5/7/2024

Background

- Pregnant patients admitted for medical complications during pregnancy are at a higher risk of depression and anxiety[2]
- Few studies have extended this research into trauma despite the admission itself presenting as a traumatic event for many



Examples

Patient admits with PPROM since 18 weeks; admits at 22 weeks for monitoring and care from out of state.

Patient with new diagnosis of FGR at 29 weeks and partner in the process of moving the family out of state.

Patient with a substantial trauma history admitting for rapidly worsening pre-E with SF developing at 23 weeks.

Patient with new diagnosis of cancer necessitating preterm delivery in otherwise uncomplicated pregnancy.

Patients

Goal: Program evaluation initiative to standardize screening.

- Patients with fetal/maternal complications anticipated to be admitted for one week or longer.
- Patients identified via chart review and/or discussion with the medical team.
- All patients seen as a part of this did identify as women in the chart

Screening and Assessment

- Semi-structured diagnostic interview and assessment
- Standardized screening battery in English and Spanish:
  - Posttraumatic Stress Disorder DSM-5 Checklist (PCL-5)
  - Generalized Anxiety Disorder 7 (GAD-7)
  - Edinburgh Postnatal Depressive Scale (EPDS)

Screening Approach

- All patients with anticipated admission <1 week approached for semi-structured assessment
- Patients who speak English and Spanish also provided with screening battery.
  - Generalized anxiety disorder 7 (GAD-7) for anxiety; Edinburgh Postnatal Depression Scale (EPDS) for depression; and Posttraumatic Stress Disorder CheckList for DSM-5 (PCL-5)
- Purpose and goal of screening is outlined
  - Prophylactic explanation of how it will be used is provided

Screening for psychological distress

Positive screen

- Additional psychiatry consult if needed/requested
- Patients seen weekly to every other week
- Safety planning/suicide severity assessment if needed
- Rescreening to monitor progress if indicated

Negative Screen: standard care

- Development of treatment and intervention plans
- Patients seen as needed
- Connection to other supports – "Boredom Busters," spiritual care, social work
- Dyadic interventions to enhance coping/normalizing temporary disruption

Interventions

Health and behavior

- increasing activity
- decreasing boredom
- improving sleep
- activating social supports
- improving adherence to medical recommendations
- reduce the stress of admission.

Psychotherapeutic approaches

- ACT: increase cognitive flexibility and engagement in valued activities
- CBT: increase behavioral activation, cognitive reframing
- DBT: increase distress tolerance, coping skills

Standard approaches

- dyadic interventions
- psychoeducation on the NICU environment
- problem-solving
- patient-team/patient-support system communication
- medication management as needed.

Follow up Care

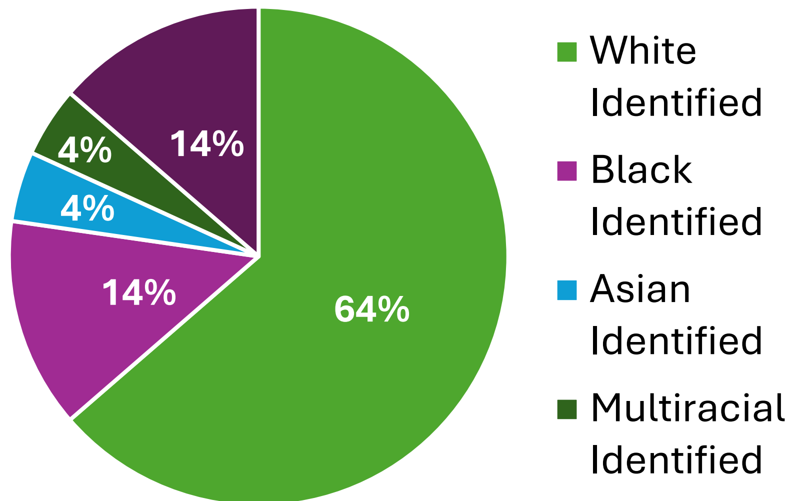
- Inpatient interventions throughout NICU admission.
- Referrals to group therapy, individual therapy, and/or psychiatry.

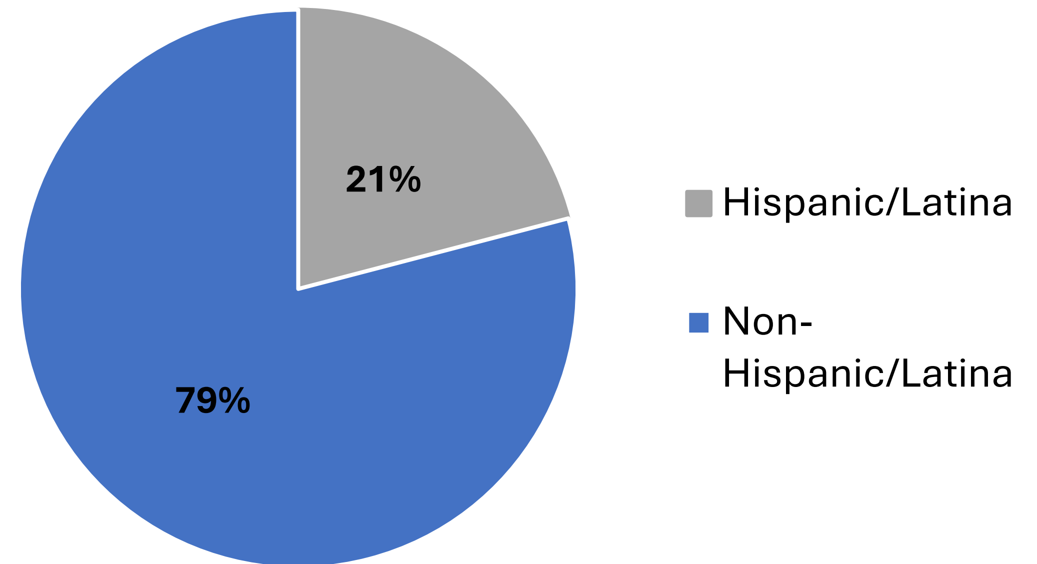
Interventions: Trauma informed care

- Enhancing sleep - minimizing sleep disruption, working with the team to determine how and when to wake patients
- Center patient as a team member and encouraging active participation in meetings
- Encourage clarity in setting of expectations and plan
- Preparation for meetings with team members
- Encouraging patients to ask their questions first
- Enhancing privacy
- Reassessments of needs and sense of safety as patient transitions from patient to parent roles

Demographics

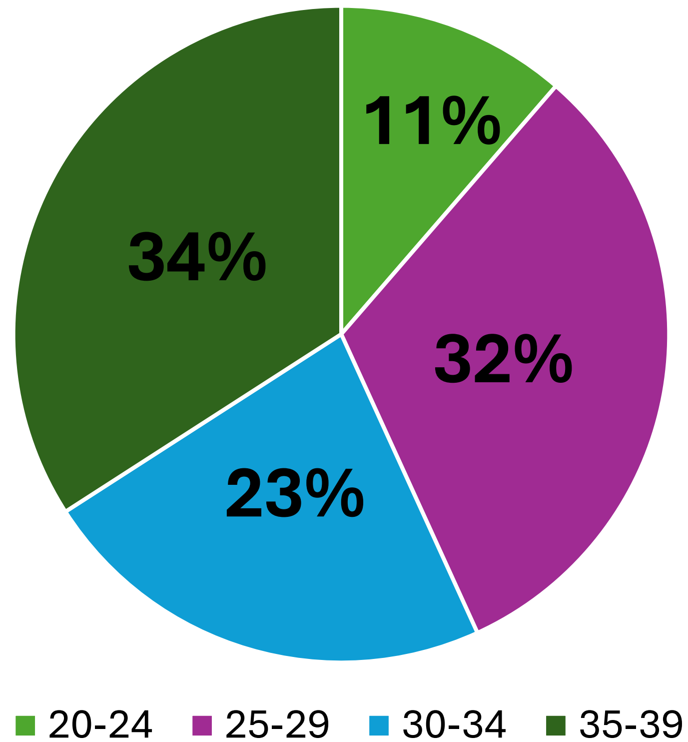
- 44 patients received all screeners
- Average length of stay was 23.95 days
  - Range 3 days - 76 days

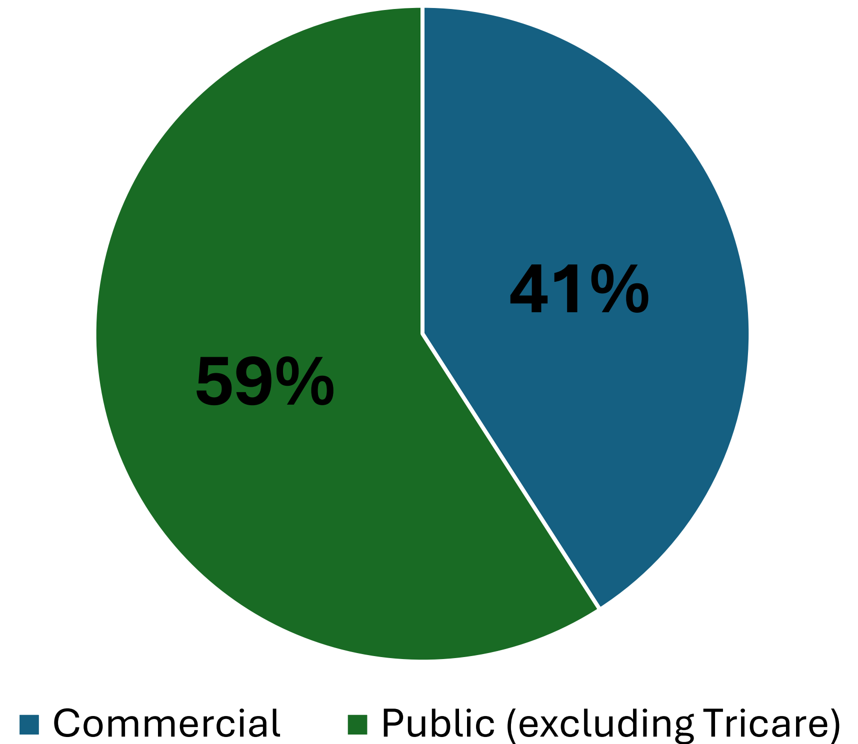




*Race/Ethnicity is presented as self-reported in the electronic medical record.

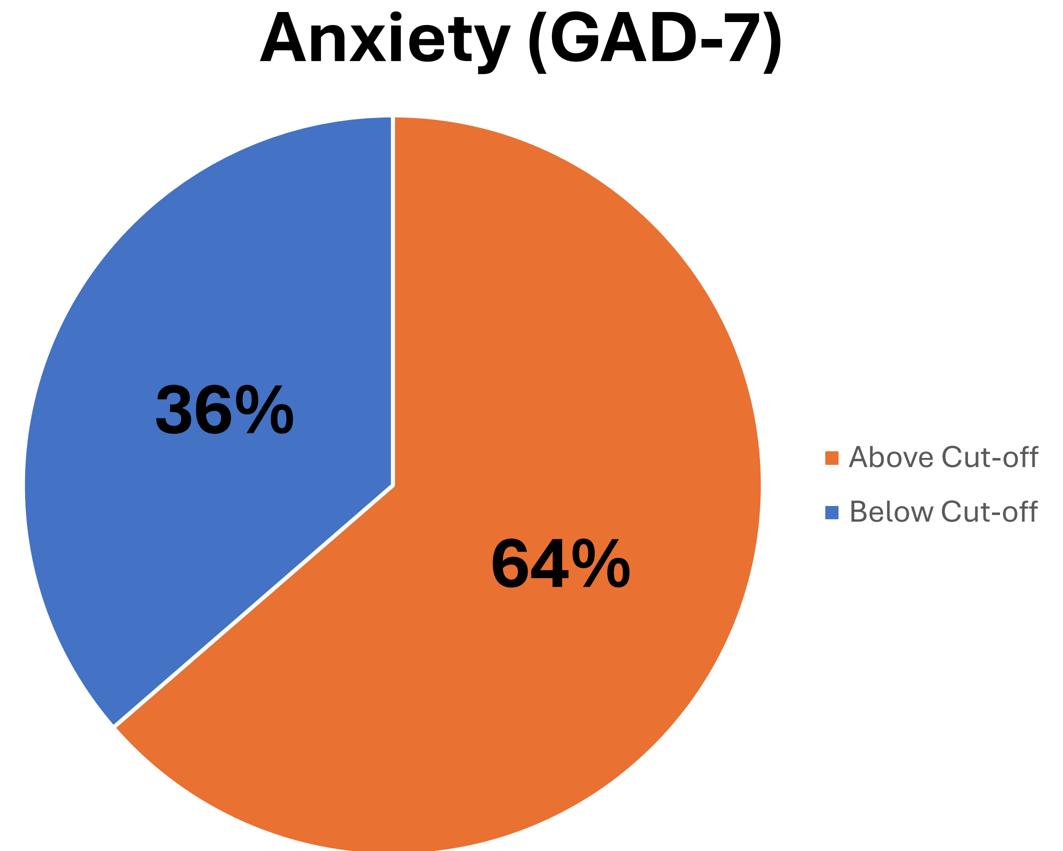
Demographics Continued





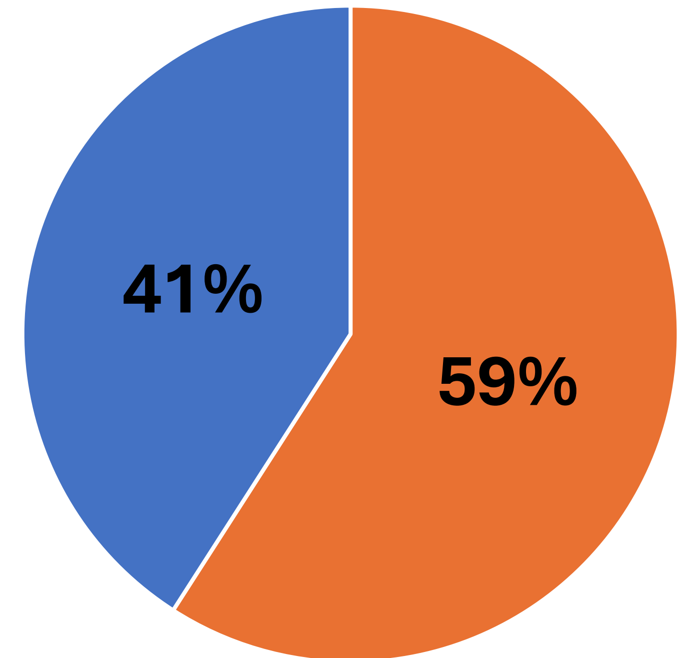
Results: Anxiety (N=44)

- Generalized Anxiety Disorder 7 (GAD-7)
- Cut-off of 5 or above for anxiety
- 28 patients above cut-off
- 16 below cut-off of 5



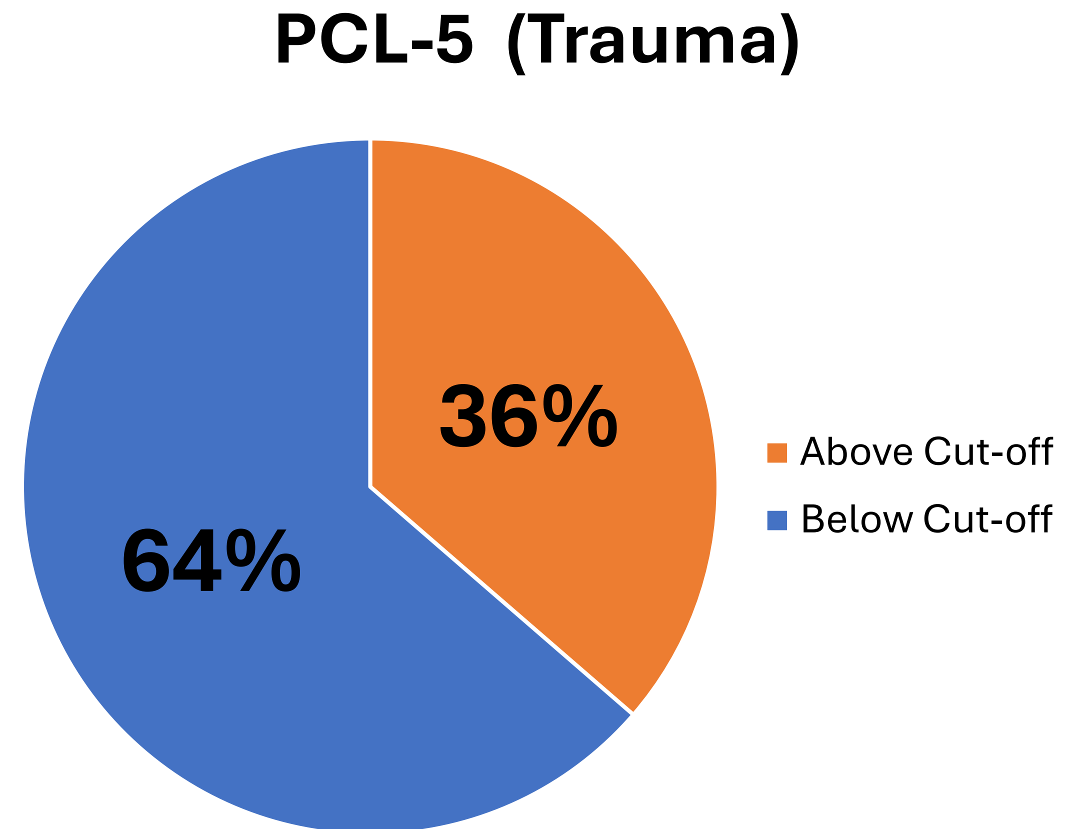
Results: Depression (N=44)

- Edinburgh Postnatal Depression Scale (EPDS)
- Cut-off of 10 or above; or any endorsement of question 10 ("the thought of harming myself has occurred to me")
- 26 patients above cut-off
- 18 below cut-off of 10



Results: Trauma (N=44)

- Posttraumatic CheckList for DSM-5 (PCL-5)
- Cut-off of 31 or above
- 16 patients above cut-off
- 28 below cut-off of 31



Lessons Learned

- Hospitalizations and medical complications can be traumatic
- Psychiatric symptoms are common and elevated during antepartum admission.
- Anxiety, depression and trauma symptoms can be identified via screening.
- Screening can identify those in need of increased support and/or intervention
- Future work should focus on increasing medical team and staff’s awareness of trauma informed care to enhance care for all patients.