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

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

DEPARTMENT OF PSYCHIATRY, ADULT DIVISION, UNIVERSITY OF COLORADO, AURORA COLORADO

University of Colorado Anschutz Medical Campus

BACKGROUND

- Posttraumatic stress disorder (PTSD) in typical perinatal samples is estimated at 3.3% during pregnancy and 4.0% in postpartum[1].
- Maternal or fetal complications may increase risk, with PTSD among these cases estimated at 18.9% and 18.5% before and following birth, respectively[1].
- While women who are admitted for care 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 women.

PROGRAM ACTION

Goal: Program evaluation initiative to standardize screening.

Setting and Patients

- Antepartum unit at a major metro birthing hospital serving a wide geographic catchment area and diverse population.
- Women 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.

Screening and Assessment

- Semi-structured diagnostic interview and assessment.
- Standardized screening battery with the Posttraumatic Stress Disorder DSM-5 Checklist (PCL-5), the Generalized Anxiety Disorder 7 (GAD-7); and the Edinburgh Postnatal Depressive Scale (EPDS).

Interventions and Inpatient Care

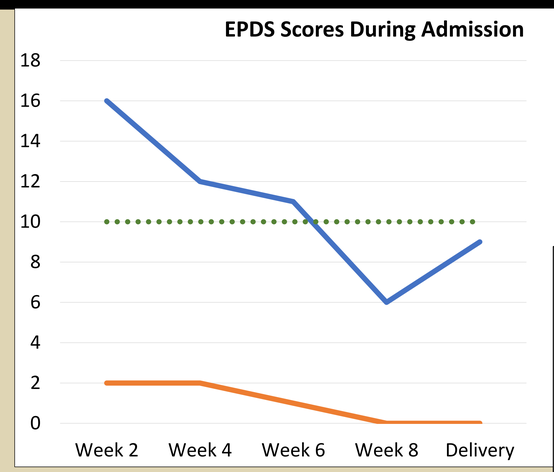
- *Health and behavior*: increasing activity, decreasing boredom, improving sleep, activating social supports; improving adherence to medical recommendations and reduce the stress of admission.
- *Psychotherapeutic approaches:* acceptance and commitment interventions to increase cognitive flexibility, tolerance of uncertainty, and engagement in values-based actions; cognitive behavioral interventions to reduce maladaptive cognitions and increase behavioral activation; dialectic behavioral interventions to increase distress tolerance skills and manage strong emotions to enhance decision making capacity.
- *Standard approaches:* dyadic interventions to enhance the prenatal bond; psychoeducation on the NICU environment; problem-solving; patient-team/patient-support system communication; medication management as needed.

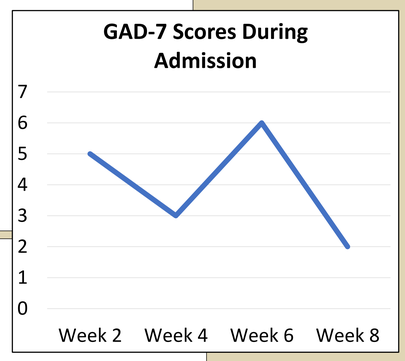
Follow-up Care

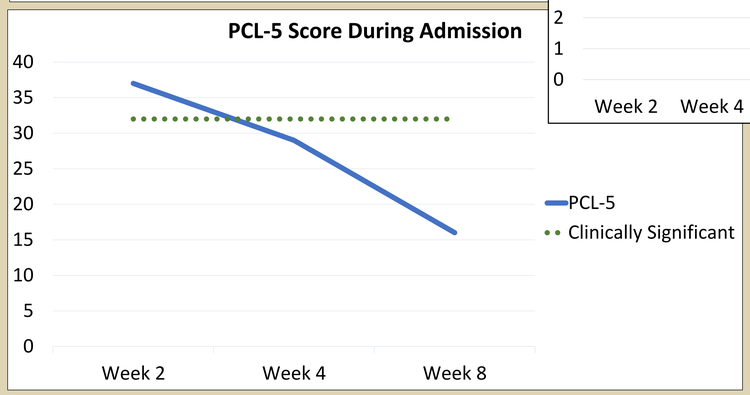
- Group therapy, individual therapy, psychiatry, and/or inpatient interventions throughout patient or baby's admission.
- Referrals are placed to internal and external resources.

CASE STUDY

- Patient "Juliana" was a young white Hispanic female who was seen due to length of admission and patient threatening to leave AMA.
- Interview revealed an extensive psychiatric history, including a history of childhood trauma and frequent suicide attempts.
- Therapeutic interventions focused on coping skills and distress tolerance.
- At each administration, results of screening were reviewed. Julia was surprised initially to see that the skills "actually worked" and started applying them regularly.
- **Week 2:** screening batteries revealed high rates of depression, mild anxiety, and significant trauma. Questionnaires were administered biweekly for GAD-7 and EPDS, and monthly for PCL-5.
- **Week 4:** trauma scores were beneath cutoffs and continued to decrease. Depression decreased from severe to mild.
- **Week 6:** delivery appeared imminent, and Julia engaged in shared decision making after reviewing the results to decide that she was ready to talk about her baby's NICU admission with the neonatology team, something she was previously not able to engage in.
- **Week 8**, for the first time in years, she reported not having suicidal ideation. The patient reported that she was willing to try therapy again after her admission and was connected to outpatient services.

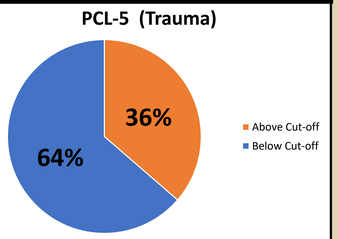


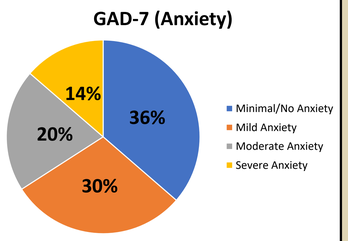


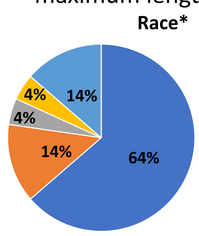


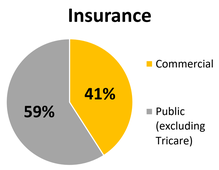
RESULTS

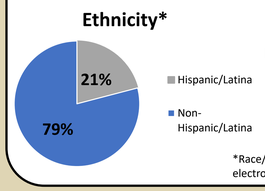
- 44 patients received all screeners.
- 16 patients (36.36%) screened above cut off for trauma (31 or greater).
- 28 patients (63.63%) screened above cutoffs for anxiety (5 or greater).
- 26 patients (59.09%) screened above cutoffs for depression (10 or greater).
- Average length of stay was 23.95 days, with a minimum length of 3 days and a maximum length of 76 days.

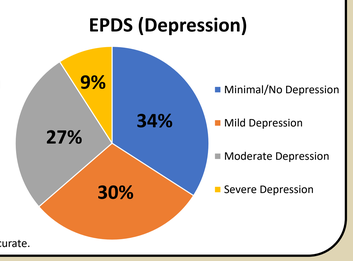












*Race/Ethnicity is presented as recorded in the electronic medical record and thus may not be accurate.

DISCUSSION

Lessons Learned

- Psychiatric symptoms are common and elevated during antepartum admission.
- Continued standardized screening is essential to provision of care.
- Future work should focus on increasing medical team and staff's awareness of trauma informed care.

Implications for Practice

- Trauma symptoms among women admitted during the antenatal period are common and can decrease over the course of treatment for some patient with appropriate care, as evidenced by patient report.
- As hospitalizations and medical complications can be traumatic, beginning care is essential to enhancing psychological and medical outcomes.

REFERENCES

1. Yildiz, Ayers, & Phillips (2017). "Prevalence of PTSD in pregnancy." *J. Affect. Disord.*
2. Peterson, Koelper, & Srinivas (2020). "Assessment of Anxiety and Depression." *Obstet Gynecol*.