Ethics Lab Context Booklet

on trauma survivors and birth.

December 2015
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Trauma

Sexual trauma

Sexual trauma is defined as any single event or series of events an individual may experience that elicits feelings of powerlessness, fear, injury, or threat of injury. An individual who has experienced rape, sexual assault, childhood sexual abuse, incest, sexual exploitation, or any form of coercive sexual experience has survived sexual trauma. Despite common misconceptions, a survivor’s experience of sexual trauma may not be violent or life threatening. Survivors of sexual trauma may experience a wide range of physical, cognitive, emotional, and behavioral responses, from memory loss to nausea. Some survivors experience suicidal thoughts, depression, and Post-Traumatic Stress Disorder (PTSD).

According to the Centers for Disease Control and Prevention’s 2010 National Intimate Partner and Sexual Violence Survey, 18.3% of women in the United States have experienced rape in her lifetime, and 13.0% and 27.2% of women have experienced sexual coercion or unwanted sexual contact, respectively. Women of color disproportionately experience sexual violence (22.0% of Black women, 33.5% of multiracial women, and 26.9% of American Indian or Alaska Native women have experienced rape, compared to the national figure of 18.3%).

Triggers and flashbacks

The term “trigger” is used to describe any explicit or implicit reminder of the traumatic event that causes the survivor to re-experience the trauma, called a “flashback”. These triggers are often sensory – a specific sound or smell that the survivor associates with the traumatic event, or the return of any particular feeling the survivor experienced prior to, during, or after the traumatic event (e.g.
the way a survivor is approached, spoken to, touched). A flashback may also be triggered by a different (non-traumatic) memory, or even an unrelated stressful or anxiety-inducing event. Likewise, certain dates (such as the anniversary of an attack) or hearing about another individual’s experience with sexual violence can be triggering.

Thus, it is unsurprising that routine obstetric care procedures and screenings can be triggering for survivors of sexual trauma. Common triggers for survivors of sexual trauma who are pregnant and receiving regular medical care include “speculum examinations... undressing, lying supine while the clinician is upright, inadequate draping, genital exposure, and intrusive touch.”¹ Further triggers may include any “gestures that may be perceived as overpowering” or “commands that accentuate powerlessness, such as ‘relax’”.¹

Notably, survivors may not be able to identify every possible trigger that may induce a flashback, while some triggers are unknowable to an individual, and therefore cannot be predicted or accommodated.
Pregnancy

Elements of a “good” experience

In “A Good Birth,” Anne Drapkin Lyerly, MD, draws from her landmark study, conducted through in-depth interviews of more than one hundred women regarding their childbirth, to identify key elements of women’s experiences that contributed to a positive birth. Lyerly’s central finding revolves around the notion of “control” in birth – “almost half the women my team and I interviewed spontaneously mentioned the word control in their discussions, and many more affirmed its importance when we asked them about it. They said that they felt out of control during birth; that they wanted more control; that they appreciated that a certain obstetrician or midwife let them take control; that holding on, in some way, to control as they understood it was ‘very important’ to a good birth.” The women interviewed defined “control” differently, but Lyerly and her team were able to identify five critical themes that influenced each woman’s understanding of being in control during the birth: agency, personal security, connectedness, respect, and knowledge. Some women identified decision-making power and ownership of their birth experience as control, while others felt that state of their own emotional safety during the birth contributed to their notion of control. Likewise, others found the amount of information they received, the level of support and connectedness to loved ones and caregivers, or even their own ability to sustain their own mental strength during pregnancy to be most essential to experiencing a “good” birth. Key to Dr. Lyerly’s findings is the influence of control—however defined—on a woman’s experience of birth.
Prenatal Care

Standard prenatal appointments

Weeks 4 – 28: Once every four weeks  
Weeks 28 – 36: Once every two weeks  
Weeks 36 – birth: Once every week

The first prenatal care visit, and subsequent first trimester appointments

The first prenatal appointment typically involves a conversation about personal and familial medical history with the physician, a physical exam (including a breast exam), a pelvic exam (consisting of a Pap smear and a bimanual internal exam), and a blood draw. This appointment is likely longer than future first trimester visits, which typically consist of weight and blood pressure checks, and a brief conversation about any symptoms or patient concerns.

Second trimester appointments

Second trimester visits typically include additional blood tests and ultrasounds. Ultrasounds can be performed abdominally or transvaginally (transvaginal ultrasounds are often used in the early stages of pregnancy). Appointments in the second trimester can also include amniocentesis or other diagnostic tests, such as chorionic villus sampling (CVS) to test for chromosomal abnormalities and other genetic defects. Typically, the procedure is transvaginal—a small catheter tube inserted through the patient’s vagina and into her cervix—though the procedure can also be performed transabdominally.
Third trimester appointments

In the third trimester, the physician will test the patient for group B streptococcus by swabbing the lower vaginal and anal area. Additional pelvic exams may be administered to determine the baby’s position in the uterus and to monitor changes in the cervix.
The American Context

A representative study of 2,400 first-time mothers who gave birth to a single child in a hospital setting between July 2011 and June 2012 was conducted to better assess the experience of pregnancy among women ages 18 to 45 in the United States.

Seeking prenatal care

Of all mothers surveyed, 78% reported receiving prenatal care from an obstetrician, while 9% and 8% of mothers received prenatal care from family physicians and midwives, respectively.

The average length reported for prenatal visits (excluding waiting room times) was 32 minutes. Notably, 20% of mothers surveyed reported that their provider “sometimes” or “never” spent enough time with them. One mother said, “I always felt like my OB had to rush to the next appointment, and she was booked pretty solid.”

Though 78% of women “always” or “almost always” saw the same caregiver for the duration of their prenatal care, 22% were seen by more two or more healthcare professionals during their pregnancy.

Giving birth

Of all mothers surveyed, 70% reported that an obstetrician was the primary caregiver during birth. Family physicians were the primary providers in 6% of births, while an additional 7% of mothers whose birth was attended by a physician were unsure of their caregiver’s medical specialty. Midwives were the
primary caregivers for 10% of births, with the remaining 5% and 1% of births attended by a nurse and a physician assistant, respectively.

Though the same health care professional provided both prenatal care and labor and delivery care for 64% of women, 12% of mothers surveyed had only met their primary caregiver for the birth once before briefly, and 21% of mothers surveyed had never met their primary caregiver for the birth.

Almost every woman (99%) surveyed received some form of support during birth from a partner, family member, or healthcare professional (nurse, physician, midwife, doula). While 77% of mothers received supportive care from a husband or partner, nearly 5% of mothers surveyed did not have a partner, family member, or friend attend the birth.

Approximately 3 in 10 mothers delivered via Cesarean section; 7 in 10 delivered via vaginal birth.
Organization and delivery of obstetric care (from the “Listening to Mothers III: Pregnancy and Birth” survey)

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<thead>
<tr>
<th>Prenatal care provider</th>
<th>%</th>
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<tbody>
<tr>
<td>Obstetrician-gynecologist</td>
<td>78%</td>
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<tr>
<td>Family physician</td>
<td>9%</td>
</tr>
<tr>
<td>Midwife</td>
<td>8%</td>
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<tr>
<td>Non-midwife nurse, physician assistant, other</td>
<td>5%</td>
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<th>Regularity of prenatal care provider</th>
<th>%</th>
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<td>Always or almost always saw the same provider</td>
<td>78%</td>
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<tr>
<td>Saw two or more providers</td>
<td>22%</td>
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<table>
<thead>
<tr>
<th>Primary birth attendant</th>
<th>%</th>
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<tbody>
<tr>
<td>Obstetrician-gynecologist</td>
<td>70%</td>
</tr>
<tr>
<td>Midwife</td>
<td>10%</td>
</tr>
<tr>
<td>Physician of unknown or unreported specialty</td>
<td>7%</td>
</tr>
<tr>
<td>Family physician</td>
<td>6%</td>
</tr>
<tr>
<td>Non-midwife nurse or physician assistant</td>
<td>6%</td>
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<tr>
<th>Familiarity of primary birth attendant</th>
<th>%</th>
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<tbody>
<tr>
<td>Primary birth attendant was also primary prenatal provider</td>
<td>64%</td>
</tr>
<tr>
<td>Had never met primary birth attendant</td>
<td>21%</td>
</tr>
<tr>
<td>Had met primary birth attendant briefly</td>
<td>12%</td>
</tr>
</tbody>
</table>
References


Rape, Abuse, and Incest National Network (RAINN). Effects of Sexual Assault. (2009). Available at:


