Universal precautions: the case for consistently trauma-informed reproductive healthcare

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In the United States, about 1 in 5 women have experienced childhood sexual abuse, and a similar proportion experience rape as adults. Childhood sexual abuse and other forms of trauma have serious impacts on our patients' reproductive health. The American College of Obstetricians and Gynecologists recommends universal screening for a history of sexual abuse and universal application of a trauma-informed approach to care. Despite these recommendations, universal screening is far from universally practiced, and trauma-informed care, despite being the standard of care, is far from standard. Given the high prevalence of trauma in the United States, its impact on perinatal outcomes, the sensitive nature of reproductive healthcare, and the likelihood that many patients may not disclose their trauma history, we advocate for trauma-informed reproductive healthcare as the standard of care.

Key words: adverse childhood experiences, intimate partner violence, medical trauma, reproductive healthcare, survivors, trauma-informed care

Introduction

In 1987, at the peak of the HIV epidemic, the Centers for Disease Control and Prevention introduced the practice of "universal precautions," which is the practice of treating all patients as potentially infectious.[1] This policy change occurred in response to an epidemic that involved approximately 0.02% of the US population at the time.[2] In contrast, 90% of adults have experienced a traumatic event[3] as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Trauma exposure can have long-term sequelae affecting mental and physical health, but trauma-informed care (TIC) is not universally practiced throughout reproductive healthcare. TIC responds to the high prevalence and sequelae of trauma by actively resisting retraumatizing in patients and acknowledging the impact that traumatic events have on patients' lives and health. We advocate treating all patients as survivors of trauma: TIC is beneficial for all patients.

In 2000, the American College of Obstetricians and Gynecologists (ACOG) published clinical guidelines for working with childhood sexual abuse survivors.[4] The universal provision of TIC was recommended for postpartum care in 2009.[5] In 2021, the ACOG released a recommendation advocating the implementation of a trauma-informed approach in all healthcare encounters.[6] Similar to the universal precautions for infectious diseases, applying trauma-informed universal precautions assumes that all patients may carry a history of trauma and merit the care that a survivor would be provided. Care that is trauma-informed recognizes the high prevalence of trauma and responds by treating all patients as possible survivors.

Clinicians providing reproductive healthcare across areas, whether in obstetrics and gynecology, pediatrics, or internal medicine, encounter patients across their lifespans. As such, all clinicians providing reproductive healthcare should have the training and tools to provide TIC. In this call to action, we define the term "trauma" and review its prevalence in the United States, discuss the impact of trauma on survivors' experiences and the outcomes of reproductive healthcare, define and discuss TIC, and offer concrete tools for clinicians seeking to make their care trauma-informed. We urge our colleagues and also challenge ourselves to use this knowledge and these tools to transform our individual practices and the systems in which we work and help provide TIC for all patients.

Trauma: types, sequelae, prevalence

Per DSM-5, trauma involves exposure to actual or threatened death, serious injury, or sexual violence—either by direct experience, witnessing the event, or learning that it occurred to a close contact.[7] The trauma may be sexual in nature but may also involve other adverse experiences such as emotional or physical abuse. Trauma may also involve community- and societal-level events such as civil unrest, structural racism, and natural disasters. Exposure to trauma in childhood, which is in itself an adverse event, is linked to adverse health outcomes and decreased life expectancy. There is a dose-response relationship

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between adverse childhood events (psychological, physical, and sexual abuse) and adverse health outcomes such as such as chronic pelvic pain, avoidance of reproductive healthcare, depression, and hypertension.[8–10]

Medical trauma encompasses a patient's responses to "pain, injury, serious illness, medical procedures, and frightening treatment experiences."[11] Although these responses come from pain related to an illness or an acute medical intervention in some cases, provider maltreatment can also lead to this trauma response.

Well-publicized examples of individual physicians' misconduct exist in addition to more systemic issues such as forced and coercive contraception and sterilization (eg, "Mississippi appendectomies"), eugenics, and hysterectomies performed without consent.[12] Although reproductive coercion is traditionally conceptualized as behavior by an intimate partner intended to interfere with contraceptive usage and pregnancy, clinicians can also interfere with patients' desires for intrauterine device removal and the ability to access permanent contraception.

In addition to medical trauma, patients experience other forms of trauma through systemic disparities including structural racism, intergenerational trauma and disenfranchisement, and inconsistent access to basic needs such as potable water and shelter. Although individual clinicians may not be able to overcome systemic barriers and issues, they must cultivate awareness and incorporate that knowledge into their care of patients who are affected by systemic issues such as racism, targeted policing, unevenly applied immigration policies, and criminalization of substance use.[13,14]

Given the known health impacts of trauma, trauma-informed clinicians should be aware of groups that may have a higher prevalence of posttraumatic stress disorder (PTSD). Within the carceral system, the lifetime prevalence of PTSD ranges from 4% to 32% in men and 16% to 58% in women. Among women with a history of living homeless, as many as 56% have a history of PTSD.[15] Nearly 1 in 4 (23.6%) women who are military personnel or veterans report sexual assault while in service.[16] Among American adults, the lifetime prevalence of PTSD is higher among Blacks (8.7%) than Whites (7.4%), Hispanics (7%), and Asians (4%).[17] The prevalence of PTSD is also higher among lesbian, gay, bisexual, transgender, or queer people than cisgender and heterosexual people.[18] We will use gender-inclusive language in this article to describe patients seeking reproductive healthcare.

Trauma-informed care and trauma-specific services

Subsequently, we describe the key principles and concepts of trauma-informed practice and trauma-specific services. Trauma-informed care realizes the impact of trauma on health outcomes; recognizes the signs of trauma exposure; responds to patient and staff needs with a culture of physical, psychological, and emotional safety; and avoids retraumatizing survivors (Figure 1).[19] We believe that individual clinicians and systems should be universally trauma-informed. However, in addition to the universal precaution of TIC, clinicians must also have access to trauma-specific services.

The term "trauma-specific services" refers to evidence-based prevention, intervention, or treatment services addressing traumatic stress and the co-occurring trauma sequelae such as mental health concerns.[19] These services may include psychoeducation, peer support, and treatments that are often offered through social workers or other behavioral health professionals. Reproductive healthcare providers may be the professionals to whom survivors first present; therefore, it is our responsibility to efficiently link our patients to trauma-specific services. Trauma-specific services are necessary for survivor care but are not a substitute for all providers consistently practicing TIC with individual patients (Figure 2).

Survivors and reproductive healthcare

Within reproductive healthcare, a history of trauma is associated with higher rates of unintended pregnancy, sexually transmitted infections, chronic pelvic pain, early coitarche, and experience of sexual violence revictimization.[20–22] Survivors may avoid pelvic examinations because they trigger the reexperiencing of posttraumatic reactions. The lack of access to basic healthcare that results (eg, delayed entry to prenatal care and missed opportunities for sexually transmitted infection and cervical cancer screening)[20,23] further stratifies health outcomes for survivors.

Figure 3 offers vignettes of how trauma and trauma-informed care could affect patient care. As in Case A, healthcare experiences may or may not be triggers (ie, reminders of past trauma) that cause posttraumatic reactions.[24] Triggers are not limited to intrusive contact; power dynamics, sensations, emotions, and proprioception can be triggering or activating for a survivor. Another trauma manifestation that may alert a provider to a patient's trauma history is dissociation—a stress response that occurs when a patient is overwhelmed. They may not be responsive to verbal stimuli or may respond to stimuli that are not physically present and connect to traumatic memories triggered by an examination or procedure. Self-injury and substance use (Case B) can also present in trauma survivors as coping techniques. A delayed entry to prenatal care or a return for follow-up may also represent manifestations of trauma (Cases A and C). When a patient pursues clinical care with which the clinician is very uncomfortable, for example, in Case D's plan for home trial of labor after a cesarean delivery and declining recommendations on transfer to labor and delivery, we recommend that the care team acknowledge their strong feelings. Instead of asking what is "wrong" with a patient, be curious about what makes the patient think that their chosen care path is the most sensible for them. Recognizing behaviors or conditions as potential indicators of trauma and responding accordingly is an essential provider skill. Instead of focusing just on the physical or behavioral symptoms and eliminating them, explore the possible root causes and contexts with your patient.

FIGURE 1
Trauma and trauma-informed care: key concepts and their implications for care

Concept	Key Aspects	Implications for Care
Trauma has individual impacts	➢ Event(s) ➢ Experience of event(s) ➢ Effect of event(s)	• *Understand that people with similar experiences may have different sequelae, ranging from none to PTSD.*
Prerequisites for trauma-informed care	➢ Realization ➢ Recognition ➢ Response ➢ Resisting re-traumatization	• *Be aware of the prevalence and impact of trauma.* • *Recognize the signs of trauma in patients and colleagues.* • *Integrate knowledge and awareness with action to make clinical services safe for survivors of trauma, whether patients or staff.* • *Identify and ameliorate policies and practices that could re-traumatize patients or staff.*
Principles of trauma-informed care	➢ Safety ➢ Trustworthiness and Transparency ➢ Peer Support ➢ Collaboration and Mutuality ➢ Empowerment, Voice and Choice ➢ Cultural, Historical, and Gender Issues	• *Prioritize safety of patients and staff.* • *Make systems transparent so patients and staff can trust in and feel safe in their workplace.* • *Link survivors to others with shared experience.* • *Minimize administrative hierarchy and create a culture of shared decision-making between patients and clinicians.* • *Ensure patients, clinicians, and other staff feel free to speak and seek their needs without fear of repercussion.* • *Educate clinicians and staff on pertinent past and present systemic injustices so everyone has a shared mental model of different potential sources of trauma patients and colleagues may experience.*

The Substance Abuse and Mental Health Services Administration outlines key concepts that clinicians and systems should adapt as part of trauma-informed care.[17].

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Tools for providers: screening and strategies

Given the high prevalence of exposure to traumatic events—sexual and otherwise—we advocate universal screening for trauma and also recommend treating all patients with a trauma-informed approach. Subsequently, we offer the screening tools and examination strategies to assist clinicians with this care.

Universal screening tells survivors that we are aware of the prevalence and impact of trauma, that we acknowledge the impact of trauma on health, and that we are allies.[25] When patients disclose a history of trauma, we recommend empathetic listening and inquiry regarding the type and degree of support the patient desires (Figure 4). Screening in this way facilitates collaborative provider-patient conversations to strategize for an examination. It is important to emphasize that disclosure is never mandatory, and that a patient has the right to choose the level of detail they would like to provide. Stay focused on the present—ask if their history affects their well-being during an examination and if there is anything you can do that would help.

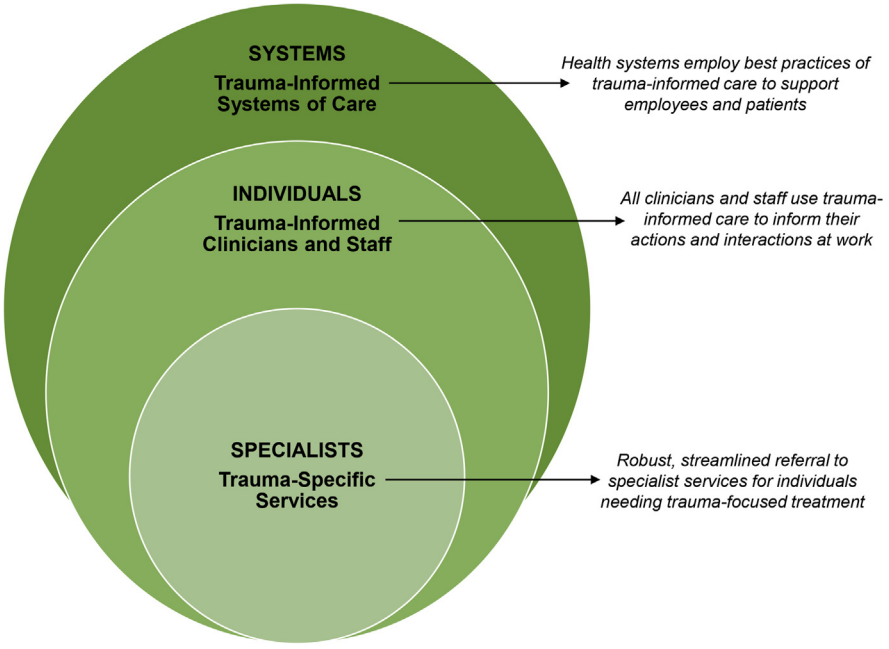
Displaying visible signals that your clinical setting welcomes disclosure shows patients that you are ready to respond with tailored practices and resources. Having local resource cards in restrooms or informational flyers about the prevalence and health impacts of trauma in examination rooms gives patients resources and an insight into how their choice to disclose trauma may be handled.

What we do with the patients' reports of trauma history shows how prepared we are to provide TIC. Responding to patients' disclosures with sensitivity, considering reflections of their resilience, and having an awareness of how their past affects their reproductive healthcare experience is critical.[26] Optimally, our trauma-informed reproductive healthcare will meet patients' care needs and provide a linkage to trauma-specific services.

In addition to universal screening and provision of resources, structure visits in such a way as to place clinicians and patients on an equal footing. For a patient to be sitting on a paper-lined examination table in a clinic-issued garment to meet a potentially new clinician can feel intimidating. To minimize hierarchy and improve patient comfort, clinicians and patients should meet and discuss the plan for the visit before the patient changes into clinic-issued attire.

Having already inquired about trauma and having discussed its impact on the patient's health to the extent they desire, elicit the patient's goals and make a plan for the visit. Inquire about what aspects of the examination may be activating for a patient, because they are the expert on

FIGURE 2
Trauma-informed approach for all with specialist services as needed



All patients merit the care that a survivor would be provided. For some patients, specialist services and treatment are needed. A version of this figure is included in a work by J.S. that is pending publication; it is adapted from Frieden's pyramid framework.[38]

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their triggers and trauma responses. Do not assume that a patient would be amenable to a sensitive examination during their first appointment with you.

Attempt to be on an equal footing with the patient by sitting at an equal level and making eye contact. Ideally, examination rooms should be large enough to accommodate a support person, with a table inclined in such a way that a patient can watch the examination if they prefer.

Review the steps of the planned examination and ask the patient which aspects of the examination may be particularly challenging for them. Are there particular words that they find activating? Patients should have a clear opportunity to provide input regarding what will improve their experience—having a support person or chaperone present, choosing the sex of their provider, and having the explicit ability to stop the examination. Assure them that they are always in control of the examination and its pace.

During the examination itself, describe the steps to the extent the patient desires. Obtain continual consent throughout the process and be attuned to nonverbal cues discordant from verbal consent. Keep the patient covered, exposing areas only when necessary and then redraping them. Watch for visible and invisible fight, flight, and freeze reactions, and be willing to postpone the examination to another visit.[23,27] Although a patient may have given consent to a breast or pelvic examination earlier in the visit, a clenched jaw or rigid lower body is a sign to adjust the plan of care. Use grounding techniques to reorient the patient to the care setting—make eye contact and direct the patient to their physical senses through a drink of water or a cool washcloth for their head. Elicit direct verbal interaction and consent before resuming an examination.

Offer using the foot of the examination table as opposed to the footrests, because the latter offer the patient less control. When using the foot of the examination table, a patient can either place their feet flat on the pull-out foot of the table or place the soles of their feet together. Reconsider how you describe the surface on which you perform pelvic examinations—a table, not a bed. Think about word choices and how they may land for a patient who has heard them in other, traumatic contexts. Avoid phrases such as "open your legs" or "relax and it won't hurt as much."[28] Asking patients to let their knees fall to the sides as much as is comfortable for them keeps them in control and acknowledges differing mobility. Offer self-insertion of a speculum or vaginal ultrasound probe, self-swabbing for vaginal testing, or a mirror for patients to observe the examination.

After the examination, step out while the patient dresses. Debrief—discuss what went well and what could be improved. Just as one might note whether a Graves or a Pederson speculum worked better for a patient, noting patients' preferences in the chart will improve future examinations. Survivors may have feelings of being abnormal or dirty, so discussing both normal and abnormal findings and what evaluation they require is important. Make a plan for the next steps. Particularly for trauma survivors whose experiences of abuse may have denied them bodily autonomy, a collaborative relationship that emphasizes clear expectations and concrete next steps is essential in them regaining control.[28] For more resources on trauma-informed care during examinations, including videos and educational materials for learners, readers can access a slide deck or video depending on their preferred medium.[29,30] Just as there is no checklist for TIC, no resource is infallible; we encourage readers to review multiple sources.

The state of TIC in reproductive healthcare

Although the above strategies for TIC in reproductive healthcare are well-established in literature, clinicians endorse barriers to providing TIC. These barriers may be on individual or system levels. Clinicians report a lack of proficiency and training in TIC; they feel

FIGURE 3
Vignettes demonstrating trauma-informed care

	Presenting Concern	Patient Experience	Clinician Observation	Clinician Actions	Trauma-Informed Additions
Case A	• 29yo G1P0 for new OB visit at 16 weeks • Reports dyspareunia • Does not disclose abuse or trauma history	• Guilt and fear leading to delaying new OB visit • Dissociation during pelvic examination	Patient very quiet during pelvic examination	• Screen for trauma and safety • Share examination findings • Begin sharing resources around pregnancy support and birth planning	• Make a plan for visit prior to changing for examination • Offer grounding strategies during dissociation • Make plans for coping with physical changes of pregnancy
Case B	• 40yo with opioid use disorder, chronic pelvic pain • Discloses a history of childhood sexual abuse	• Afraid pelvic pain means something is wrong with her • Avoids reproductive healthcare given discomfort with examinations	Patient late for appointment and short with staff	• Screen for trauma and safety • Establish mutual expectations for roles and responsibilities • Ensure patient has access to behavioral services for opioid use disorder	• Inquire about patient's fears regarding pain and examination • Note patient's presentation for sensitive care represents resilience from her trauma • Ask patient preferences for documenting abuse history in her chart
Case C	• 35yo with postcoital bleeding • History of excision for severe cervical dysplasia with difficulty following up with office visits afterward	• Dread of multiple visits and examinations • Fear of general anesthesia for recommended cold knife cone	• Fungating, friable cervical mass on examination • Record demonstrates multiple attempts to reach patient, including certified letter, to schedule cold knife cone 2 years earlier	• Screen for trauma and safety • Discuss suspected diagnosis and next steps	• Elicit patient fears and beliefs around disease and treatment • Offer linkage to peer support groups for cervical cancer • Refer to trauma-specific services as needed for coping strategies
Case D	• 28yo G2P1 presenting as homebirth transfer after prolonged labor in the setting of prior cesarean birth • Sought homebirth midwifery care this pregnancy secondary to traumatic hospital birth experience	• Felt unheard during first labor and experienced unscheduled cesarean birth as extremely traumatic • Returning to hospital evokes flashbacks and panic from prior birth experience	• Patient declining multiple aspects of recommended care • Patient appears anxious, jittery, and diaphoretic	• Screen for trauma and safety • Utilize shared decision-making around evaluation and management of labor	• Acknowledge prior experience as traumatic and impactful for present experience • Center patient's autonomy and share information with objectivity, avoiding coercive language or what may be perceived as threats about baby's safety • Acknowledge patient's bravery in returning to a site of past trauma

These cases illustrate how trauma-informed care and linkages to trauma-specific services can improve patients' experiences and create a collaborative provider-patient relationship.

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uncomfortable addressing trauma.[31] Providers report having an inadequate general knowledge of sexual trauma.[32] Some find developing trusting relationships with survivors to be more difficult than with the general population, which impedes their ability to provide quality care.[31,33]

In addition to these provider-level barriers, there are profound systems-level barriers to TIC provision, such as lack of training, short appointment times, and inadequate resources. On-the-job training is not an adequate replacement for a structured educational intervention, even among the most practiced providers.[34] Inadequate time allotted per patient prevents clinicians from opening the "Pandora's box" of trauma inquiry.[31,33] In addition, providers often lack a streamlined referral process to trauma-specific services.[31,32] Despite our best intentions, we are working within a healthcare system that has historically devalued consent: for Henrietta Lacks to willingly donate her cells for research, for women who are immigrants to undergo hysterectomy, and for people living in poverty to receive long-acting or permanent contraception, among other issues.[35–38] Until we recognize our role in perpetuating medical trauma and even as we work to reduce the harm we and our system cause patients, we, as clinicians, may continue contributing to the trauma inherent in our healthcare systems.

The prevalence of traumatizing events in our society and our healthcare system necessitates a universal precautions framework regarding TIC. If all patients were treated as survivors, and the systems of education and clinical care were changed accordingly, the pressure placed on individual providers would be alleviated, leading to decreased provider discomfort and elevated care for patients with and without trauma.

Call to action: TIC for all

Trauma caused by factors ranging from childhood sexual abuse to racism and medical trauma is highly prevalent and deeply impactful for our patients. By adopting TIC as a universal precaution, we can avoid retraumatization and provide excellent reproductive healthcare. Just as universal precautions became the standard of care in response to the HIV epidemic,[39] TIC needs to be the standard of care in response to the high prevalence of trauma. Given the disproportionate burden of trauma in marginalized communities, TIC implementation is an opportunity to decrease disparities in healthcare and health outcomes. Coles and Jones[5] advocated for universally trauma-informed perinatal care in 2009, Tillman[40] declared TIC the standard of

FIGURE 4
Sample scripts to screen for trauma and respond to disclosures

Screening	Responding to a Disclosure
Verbal Option	▪ Thank you for sharing that with me.
"Do you feel as though certain events in your life have impacted your health? What would you want me to know about that?"[43]	▪ I'm so sorry that happened to you.
Verbal or Written (Self-Administered) Option	▪ You did not deserve that.
"Have you ever experienced an unusually or especially frightening or traumatic event?"	▪ Would you like some resources that have been helpful for others experiencing events like that, or did you want me to just be aware of your experience?
If NO: stop screen	▪ Would you like me to know anything else about that experience given the plan we are making for our visit today?
If YES: "In the past month, have you…" ▪ Had nightmares about the event(s) or thought about the event(s) when you did not want to? ▪ Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? ▪ Been constantly on guard, watchful, or easily startled? ▪ Felt numb or detached from people, activities, or your surroundings? ▪ Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? *3/5 is a reasonable cut point to minimize false negative responses*[42]	▪ Would you like me to document anything about that in your chart, and if so, what wording would be comfortable for you?

Universal screening for trauma can take the form of a short, broad question or a validated questionnaire such as the Primary Care PTSD screen.[42,43] The aim of screening is not disclosure but to convey the impactful nature of trauma and open the door to whatever support a patient may desire.

PTSD, posttraumatic stress disorder.

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care for all healthcare in 2020, and the ACOG endorsed this approach in 2021. However, this approach has not yet become standard throughout reproductive healthcare.[5,40] Providers need more tools for trauma screening, trauma-informed communication, and recognizing trauma and its sequelae.[41] Lectures, journal clubs, and articles like this one highlight opportunities for improvement in care. However, for lasting change to take hold, longitudinal provider training needs to emerge in concert with institutional commitments to TIC principles.

In this article, we outlined provider tips for trauma-informed reproductive healthcare. Although individual clinicians' actions are necessary, systemic changes are also critical. With improved organizational culture and education, clinicians can gain confidence that trying new conversations and adaptations cocreated with trauma survivors will improve the effectiveness of reproductive healthcare. Regardless of the subspecialty, it is time for all reproductive health clinicians to practice trauma-informed care. ■

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