Reducing psychological trauma in women undergoing urgent or emergency cesarean section: A qualitative study of stressors & possible solutions related to *obstetric* care

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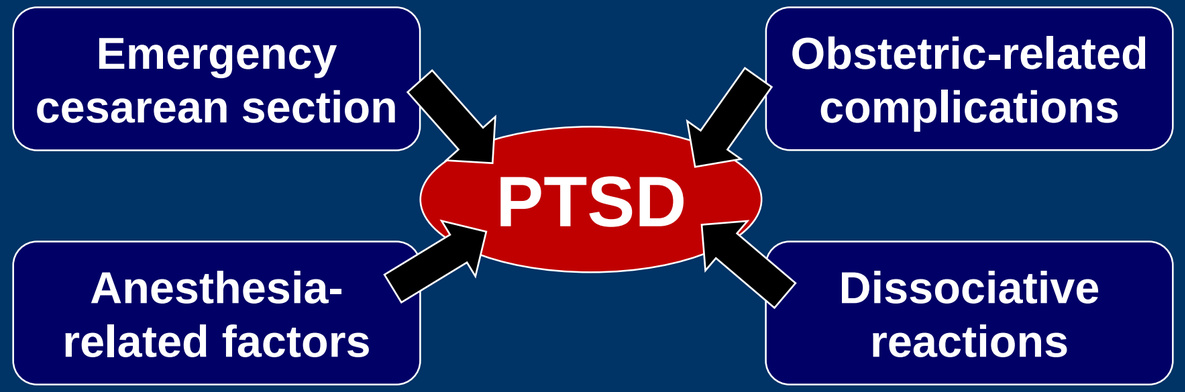
Background and Hypothesis

- Childbirth-related PTSD effects 3-6% of all postpartum women with highest rates (~20%) after preterm & other high-risk births
- Risk factors include:

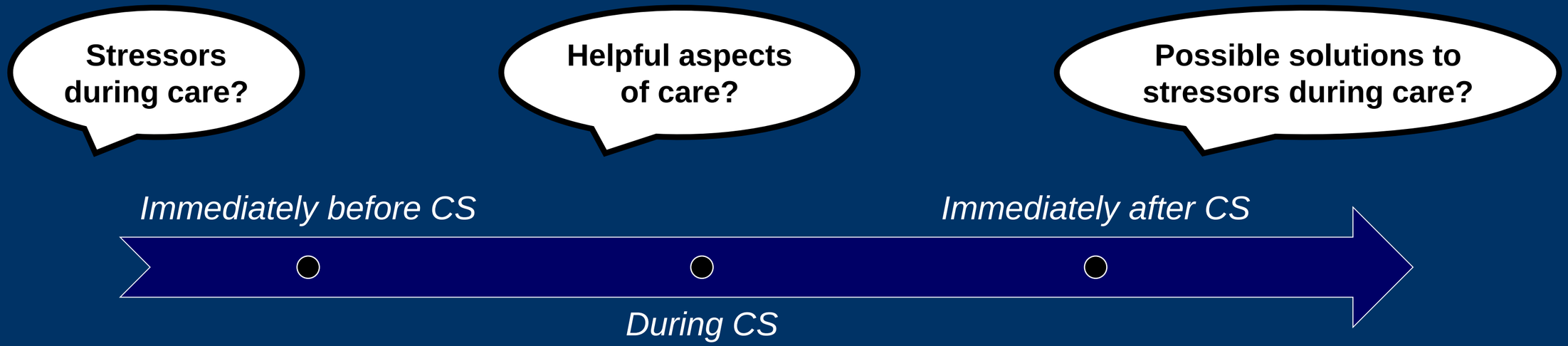


- ***Hypothesis:*** *Improved supportive care by health care providers (HCPs) during urgent or emergent cesarean section (UE CS) will reduce PTSD risk; this should be guided by an understanding of women's perspectives/experiences*
- This research is developing an Interdisciplinary Patient Support Tool to guide HCPs
- We report Phase 1 qualitative findings describing women's stressors & actionable solutions related to OBSTETRICAL care

Study Design & Methods

Research Team

- Phase 1: Qualitative, exploratory descriptive study
- Thirty-six women of mixed parity, ≥ 24 wks gestation, representing a broad spectrum of UE CS experiences, recruited ≤ 72 hrs of delivery
- In-depth, face-to-face interviews explored women's experiences of their interdisciplinary care during UE CS using open-ended questions supported by use of a semi-structured interview guide



- Interviews: Audio-taped, transcribed verbatim & analyzed using thematic content analysis (NVIVO 12 Plus)
- Findings: Also reviewed by interdisciplinary team & program leaders

Results: Five Major Stressors and Corresponding Solutions

	1) Feeling Unprepared for UE CS	2) Fear of the Operating Room	3) Uncertain Trust in HCP
Stressors	• *"It's hard to go into something tough [like an UE CS, when] you don't know exactly how it's gonna go and no one really warns you ahead of time about everything"* • *"I had meetings with my OB, I went to prenatal classes… nothing much about a CS was discussed which led to a lot of information at the last minute"* • *"It felt like such a big disconnect… Everyone's like… you're doing great during labor and then this [OB] I just met two minutes ago comes out of nowhere he's like, 'Oh, you need a CS'"*	• *"I asked, 'am I gonna die'– because the [OB] resident made me sign something but I didn't get to read it.... it was like signing my life away"* • *"They took my husband away… I knew he was panicked as well"* • *"You're seeing all of the instruments laid out that… they can possibly be using on you… it can… be overwhelming"* • *"I thought I would feel them cut me open"*	• *"They probably… should have made the call [for a CS] sooner…"* • *"I mean like I felt like I had control but I didn't necessarily feel like somebody was walking me through the detailed options, no"* • *"I wasn't sure if the OB resident was doing [the CS] and… I didn't really like that… it's good to help the resident but I also don't want to be the guinea pig"*
Solutions	Prenatal education & anticipatory guidance • Baseline CS risk: 20-25% low risk pregnancies • What a CS involves • How an UE CS Birth differs from vaginal birth • Timely feedback about changing CS risk over time • QR code links to information about peripartum CS care	• Anticipatory guidance/continuous support in the operating room (before the surgery starts, during CS, at the end of the CS) • Intraoperative communication and feedback	• Establish a clinical relationship early/in labor. Continuity of care is helpful • Timely feedback as changing CS risk, discuss issues, answer questions • Brief before CS starts • Debrief at the end of CS in the operating room, PACU & postpartum

Results: Five Major Stressors and Corresponding Solutions

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4) Loss of Expected Birth Experience

Stressors

- *" I know that [skin-to-skin and having the father cut the umbilical cord at the birth] is normal at this hospital… but they never said, 'Oh, because you have [an emergency CS you can't do this]'. If they [had told us earlier] it would have been better"*
- *"I thought that… I would be able to see my baby right away. I knew that I couldn't but I was really down about it. I think that seeing her even once in real life [after her CS birth] would have reassured me and allowed me to wait to see her again with patience… I was just kind of like I need to see her I want to see her and sad that I could not see her. The staff made up for it by bringing her to my room later but it was a lot later and I felt really empty" (Pre-eclamptic, preterm, NICU)*

Solutions

- Preserve: "CS Birth experience" when safely possible in operating room
- Drop the drape so mother (masked) can see the baby at delivery, provide birth time and birth weight. Keeping informed about baby care
- Allow cheek-to-cheek or supported holding, photos, etc.
- Drive by viewing of the baby if in the resuscitation room. Ensure timely follow-up contact between parents and NICU

5) Inconsistent Patient-centered Care

Stressors

- *"I just feel like… in that moment… I'm young… and it's my first kid… so I feel like… somebody should've specifically stayed beside me, and walked me through what all the other doctors were doing around me. I had – doctors holding my feet down, or I had nurses hold tie my arms up, and no one was telling me anything"*
- *"There just seems to be a lack of postpartum care for the mom… you go to the hospital, you have your baby and then you literally don't talk or see anyone for six weeks… From a proactive perspective that just feels like you went through this huge traumatic experience and then no one checks in"*

Solutions

- Anticipatory guidance/continuous support
- Continuity of patient's HCP during CS whenever possible
- Timely access to medical records preop
- PTSD screening/timely access/referral to Mental health supports after delivery

Conclusion & Discussion

- Supportive care involves a "wrap-around" approach from all interdisciplinary HCPs. Actionable solutions identified extend beyond time-points included in the study. Supportive care does not replace the need for high quality clinical care. Research in both areas is required.