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# Education in Trauma-Informed Care in Maternity Settings Can Promote Mental Health During the COVID-19 Pandemic

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## ABSTRACT

Globally, the pandemic has adversely affected many people's mental health, including pregnant women and clinicians who provide maternity care, and threatens to develop into a mental health pandemic. Trauma-informed care is a framework that takes into account the effect that past trauma can have on current behavior and the ability to cope and can help to minimize retraumatization during health care encounters. The purpose of this article is to highlight the pressing need for perinatal clinicians, including nurses, midwives, physicians, doulas, nurse leaders, and nurse administrators, to be educated about the principles of trauma-informed care so that they can support the mental health of pregnant women, themselves, and members of the care team during the pandemic.

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The full physiologic impact of the SARS-CoV-2 virus and COVID-19 disease on pregnant women and their infants is not yet clear. However, evidence of the disproportionate effect of the virus is emerging. Pregnant women who are Black or Hispanic have higher seroprevalence rates than pregnant women who are White (Flannery et al., 2020). Pregnant women with the virus are more likely to be hospitalized and require intensive care treatment, including mechanical ventilation, than women who have the virus but are not pregnant (Ellington et al., 2020). Although pregnant women may worry about their own health and the health of their fetuses during pregnancy, strict public health measures that have been taken to reduce the spread of the virus, including social distancing and home isolation, have cut women off from some of their usual social supports (Thapa et al., 2020). Stress related to preparation for birth during the pandemic and worries about COVID-19 infection for themselves and their newborns can elevate women's risk of experiencing moderate or severe anxiety over and above sociodemographic, obstetric, and other relevant health factors.

Researchers suggested that the next inevitable pandemic in the United States will be a mental health pandemic (Brooks, 2020), including among pregnant women (Choi, Heilemann, et al., 2020). Concern about an impending mental health pandemic creates an imperative for perinatal clinicians to use trauma-informed care (TIC) to support the mental health of pregnant women. Using TIC may best be done by educating perinatal clinicians to assess and assist pregnant women with their psychosocial concerns in settings where they deliver perinatal care.

TIC as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) is a viable model with which to promote the mental health of people who receive medical care in settings where such care is delivered. Recently, researchers recommended the incorporation of TIC into maternity care during the pandemic (Choi, Heilemann, et al., 2020; Choi, Records, et al., 2020). However, the use of TIC in maternity care has not been thoroughly addressed in the nursing literature. Although Sperlich et al. (2017) detailed a framework for the adoption of TIC in maternity care practice, they also identified

a need for further education about the TIC model in maternity care settings. [Mosley and Lanning \(2020\)](#) described the evidence and guidelines for the incorporation of TIC in doula care. In a study of trauma care providers, [Bruce et al. \(2018\)](#) described a lack of education, time constraints, and worries about retraumatizing patients as barriers to the use of TIC. Education about TIC can increase clinicians' knowledge, attitudes, and confidence in providing psychosocial support ([Hall et al., 2019](#)), which may improve their job satisfaction and reduce their risk for burnout ([Schulman & Menschner, 2018](#)). In this article, we highlight the pressing need for perinatal clinicians, including nurses, midwives, physicians, doulas, nurse leaders, and nurse administrators, to be educated about the principles of TIC so that they can support the mental health of pregnant women, themselves, and members of the care team during the pandemic.

## How the COVID-19 Pandemic Has Affected Mental Health of the General Population

The COVID-19 pandemic has exacerbated existing stressors in many peoples' lives ([Table 1](#)), especially among people of color, racial and ethnic minority groups, disabled people, those with chronic illnesses, and the economically disadvantaged ([Centers for Disease Control and Prevention, 2020c](#)). COVID-19 has also illuminated the long-existing racial and socioeconomic disparities and inequities in the United States. In the United States, individuals who are Black are 2.8 times more likely than White individuals to die from COVID-19, Indigenous individuals are 2.6 times more likely, and Hispanic individuals are 2.8 times more likely. ([Centers for Disease Control and Prevention, 2020d](#)). Native American communities, with poor living conditions and limited access to health care, have been hit especially hard ([National Academies of Sciences, Engineering, and Medicine, 2017](#)). Increasing reports of a panoply of social problems suggest that a mental health crisis could be developing in the United States ([Table 2](#)).

### Mental Health of Women During Pregnancy and the Postpartum Period

Maintaining emotional well-being during pregnancy is important because it strongly predicts mental health outcomes during childbirth and the postpartum period. Maintaining emotional well-being may also affect a woman's ability to bond

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### Concern about an impending mental health pandemic creates an imperative for perinatal clinicians to use trauma-informed care to support the mental health of pregnant women.

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with her newborn, which correlates with healthy, short- and long-term neurobehavioral outcomes for the infant ([Cohen, 2020](#)). Some of the life stressors amplified during the current COVID-19 pandemic are risk factors for perinatal mood and anxiety disorders that could heighten risk for experiencing the birth process as traumatic ([Table 3](#)).

Perinatal mood and anxiety disorders are the number one complication of childbirth and the most underdiagnosed complication of pregnancy and the postpartum period ([Toohey, 2012](#)). In a study of 10,000 women who were screened for depression 4 to 6 weeks after birth, 14% had positive screens, and major depressive disorder was the most common diagnosis upon further evaluation ([Wisner et al., 2013](#)). Other disorders considered to be perinatal mood and anxiety disorders include postpartum anxiety, bipolar disorder, posttraumatic stress disorder (PTSD), and other less common conditions. When maternal mental health disorders are expanded to include substance use disorders, the prevalence increases to 1 in 5 women ([Maternal Mental Health Leadership Alliance, 2020](#)). Since the onset of this pandemic, perinatal clinicians have seen increasing numbers of pregnant women who present with anxiety that rises to a clinically significant level ([Lebel et al., 2020](#)). The pandemic may exacerbate preexisting psychiatric disorders among women ([Cohen, 2020](#)). Even before the COVID-19 pandemic, one third of women perceived their birth experiences as traumatic ([Reed et al., 2017](#)). As many as 20% to 48% of all women who give birth meet some diagnostic criteria for PTSD ([Alcorn et al, 2010](#)). The results of a recent review of 59 studies showed that the mean prevalence of PTSD related to childbirth was 4% in community samples and as high as 18% during pregnancy and the postpartum period in women who were considered high risk ([Yildiz et al., 2017](#)).

Screening women for mental health concerns can help clinicians determine the level of emotional support they need and can help guide family support from a strengths-based perspective, an

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**Table 1: Psychosocial Stressors Among the General Public During the Pandemic**

Work related

- Job loss, income loss (Brooks et al., 2020; Sarin, 2020)
- Working from home, loss of child care, and schooling from home (Patrick et al., 2020)
- Difficulties working from home due to limited or no internet connectivity, especially in rural areas or among people with smart phones as their only devices (Centers for Disease Control and Prevention [CDC], 2020a)
- Working as essential personnel, risking exposure to the virus (CDC, 2020b)
- Challenges with sick leave needs (Carino, 2020)

Access to health care

- Limited access due to loss of health insurance associated with layoffs (Stolberg, 2020)
- Limited access due to noncitizen status (East & Marcus, 2020)
- Difficulty accessing telehealth services due to limited or no Internet connectivity (Settles, 2020)
- Delay of nonacute medical services due to fear of exposure to virus (Luthra, 2020)

Social stressors

- Social isolation (Sarin, 2020)
- Lack of access to traditional social supports: friends, family members, faith communities (United Nations Sustainable Development Group, 2020)
- Homeschooling children (Williams, 2020)
- Inability to visit hospitalized loved ones (Hafner, 2020)
- Death of loved ones or co-workers due to COVID-19 (Pfefferbaum & North, 2020)
- Relationship strain due to quarantine (Chaker, 2020)
- Inability to celebrate at weddings and mourn at funerals (Lee, 2020)
- Loss of personal liberties due to quarantine (Pfefferbaum & North, 2020)
- 24/7 exposure to distressing news about the pandemic (Pfefferbaum & North, 2020)
- Poor diet and lack of exercise contributing to unwellness (Mattioli et al., 2020)
- Boredom and frustration (Brooks et al., 2020)

Stressors related to race

- Racial and economic disparities brought to light by much higher rates among people of color of contracting COVID-19 and dying from it (CDC, 2020d)
- Increased exposure to the virus among pregnant Black and Hispanic women compared with White women (Flannery et al., 2020)
- Experiences of xenophobic harassment, especially among Asian Americans (Donaghue, 2020)

approach to mental health services that builds on the strengths and resources rather than deficits of a person or family (Xie, 2013). Professional organizations that represent perinatal care providers have widely endorsed universal mandatory screening of all women for depression and anxiety at least once in the perinatal period (pregnancy through 12 months after birth). Some researchers suggested screening pregnant women for histories of trauma because those with such histories were more likely to also have histories of depression (Blackmore et al., 2016). Recently, health care teams have focused on refining newly implemented infectious disease protocols during the pandemic, but the need to return attention to mental health concerns, including screening pregnant women, is more important now than ever (Thapa et al., 2020); the

Edinburgh Postnatal Depression Scale is the most commonly used instrument (American College of Obstetricians and Gynecologists, 2018). A positive screen of 10 or greater for either parent indicates concern and that an appropriate referral should be made (Carlberg et al., 2018). Researchers suggested that the screening cutoff for the Edinburgh Scale could be 2 to 3 points lower (>7 or 8) for women who are Black or Hispanic because they may be less likely to express feelings of depression or anxiety than White women (Chaudron et al., 2010).

Rates of postpartum depression were higher among Black and Hispanic women compared with White women in a study of 3,732 women from New York City (Liu & Tronick, 2013). In a separate study of women who received Medicaid in New Jersey,

**Table 2: Social Problems That Increased During the COVID-19 Pandemic**

- Anxiety and panic (Sarin, 2020)
- New prescriptions for antidepressant, anti-anxiety, and anti-insomnia medications (Express Scripts, 2020)
- Alcohol use (Panchal et al., 2020)
- Other substance use or misuse, including drug overdoses (Panchal et al., 2020)
- Intimate partner violence (Humphreys et al., 2020)
- Child abuse (Humphreys et al., 2020)
- Homelessness (Sarin, 2020)
- Poverty (Williams, 2020)
- Food insecurity (DeParle, 2020)
- Impending increase in suicide (Panchal et al., 2020; Sarin, 2020)
- Weight gain (Zeigler et al., 2020)

Kozhimannil et al. (2011) found that 75% of all participants who were screened and found to be at risk for postpartum depression did not receive treatment, especially Black and Hispanic women. These women were also less likely to seek treatment for perinatal mood and anxiety disorders, to engage in treatment after first displaying symptoms, to follow up with treatment, and to refill prescriptions than White women (Kozhimannil et al., 2011). Barriers to seeking treatment may include transportation issues, child care needs, and nonflexible employment (Keefe et al., 2016). Each of these challenges may be exacerbated by the circumstances of the pandemic. A systematic review and meta-analysis showed that members of many minority communities express more stigma associated with seeking mental health support than members of majority communities (Eylem et al., 2020). When combined

with other social adversities, stigma may make minority women even less likely to seek help.

Telemental health services are behavioral health services that are delivered by phone, video, or other Web-based technologies; they extend the reach of conventional mental health services, especially into isolated communities (Langarizadeh et al., 2017). Such services have become more prevalent during the pandemic and provide more options for women who need referral after a positive screen for depression. However, those from disadvantaged groups (Black, Hispanic, and those with lower income and less education) and those who live in rural communities are less likely to have broadband Internet access at home and therefore have limited access to these services (Dent et al., 2018).

**Table 3: Pandemic-Specific Concerns That Could Elevate Childbearing Women's Risks for Perinatal Mood and Anxiety Disorders**

- Abrupt changes in relationships with clinicians
  - Wearing of masks and personal protective equipment
  - Inability to read provider's facial expressions
  - Difficulty understanding speech without the aid of lip reading
  - Difficulty breathing or feeling claustrophobic while wearing a mask
  - Transition to telemedicine visits (Thapa et al., 2020)
- Social isolation during pregnancy, at delivery, and during the postpartum period (Thapa et al., 2020)
  - Loss of usual support systems
  - Restrictions on labor room visitors
- Fear that they or their infants could contract the virus (Zeng et al., 2020)
- Fear that they could be separated from their infants (Rich, 2020)
- Reduced options when choosing birth preferences, leading to feelings of powerlessness (Rich, 2020)
- Shorter hospital stays, which may leave some women both physically and emotionally unprepared for the challenges that lie ahead
- General sense of malaise of navigating pregnancy during a pandemic

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**Education about the principles of trauma-informed care enables clinicians to increase the emotional support they provide to women and minimize their own risk of burnout.**

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### Mental Health of Clinicians

An increased incidence of psychological distress and emotional exhaustion has been documented among clinicians during the pandemic, including anxiety, depression, PTSD, and insomnia (Lai et al., 2020). Moderate to high levels of burnout were reported by half of the nurses who worked in areas with high numbers of COVID-19-positive patients (Hu et al., 2020). Particular high-risk factors for emotional distress and mental health symptoms in clinicians during epidemics or pandemics include the following: being a female, nurse, or other direct health care provider (Lai et al., 2020) and, as determined in a meta-analysis by Kisely et al. (2020), being young, having more recently entered the health care field, being the parent of a dependent child, having an infected family member or colleague, or experiencing stigma. Clinicians who provide direct patient care have a threefold higher risk of acquiring COVID-19 than the general public (Nguyen et al., 2020). All these factors put health care clinicians at even greater risk for depression, anxiety disorders, PTSD, substance misuse, burnout, and suicide than they were before the pandemic. None of the studies noted previously focused specifically on perinatal clinicians, although it is reasonable to assume that they might be similarly affected.

### Foundations of TIC

SAMHSA (2014) noted that individual trauma could result “from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, and spiritual well-being” (p. 11). Adverse childhood experiences are incidents that can be perceived as traumatic. As originally described by Felitti et al. (1998), adverse childhood experiences can include all types of abuse and neglect and a variety of household/family dysfunction. Persistent or recurrent exposure to such events or to severe events, such as witnessing a murder, among those who feel that circumstances are beyond their control and who have inadequate social support may cause them to become overwhelmed with negative emotions and to

unknowingly adopt maladaptive coping patterns.

Some potential adverse effects of trauma as described in a report by SAMHSA (2014) include decreased stress tolerance, heightened emotional or behavioral responses, hyperarousal or numbing, dissociation, impaired trust, and distorted thinking or perceptions. In addition, this report describes how current events and medical services can reawaken past traumas, how people with previous trauma are more likely to respond to new traumas in a heightened manner, and how people can bring coping mechanisms from early trauma to current health care situations in which they are seemingly out of proportion and no longer adaptive.

TIC is based on four key assumptions and six guiding principles (SAMHSA, 2014). The four assumptions are that clinicians show sensitivity when they realize and normalize survivors’ experiences of past trauma, recognize survivors’ behaviors as coping mechanisms, respond by creating a safer environment, and seek to avoid retraumatization. The six principles of a trauma-informed approach include safety, trustworthiness, collaboration, peer support, empowerment, and cultural sensitivity. A main goal of TIC is to use relationship-based care to foster reciprocal social connection among patients, their families, and staff. Such social connection creates a critical buffer to mitigate stress, promote resilience, and ultimately improve health outcomes.

### Trauma-Informed Universal Precautions

Clinicians use universal precautions such as hand hygiene and gloves with every patient to prevent transmission of infectious diseases regardless of whether the patient has a known history of infection. Similarly, clinicians should use TIC with all pregnant women regardless of whether the women have known histories of trauma. The use of TIC can help to promote mental health and ensure that women who receive care experience interactions that are respectful and supportive instead of abusive, offensive, or retraumatizing (Raja et al., 2015). Perinatal clinicians can routinely make accommodations in three areas to improve the comfort of pregnant women: verbal (always ask before touching and explain procedures to the level desired by the woman), nonverbal (make eye contact as appropriate and sit down when talking with women whenever possible), and environmental (use soft lights and soothing sounds).

## Clinical Practice Implications of TIC

Education about the six principles of TIC enables perinatal clinicians to increase the emotional support they provide to women and minimize their own risk of burnout. Ensuring the well-being of clinicians is “essential to better control infectious diseases,” which makes it of paramount concern during the pandemic (Chen et al., 2020, p. e15). The clinical practice implications of the principles of TIC are outlined in Table 4. Incorporating these principles and practices through education can help perinatal clinicians and nurse leaders to promote the mental health of women, themselves, and the members of the health care team.

### Principles of TIC

**Safety.** Everyone in the health care environment has a need and a right to feel physically and psychologically safe. Although maternity units are not the primary locations at which patients with COVID-19 receive treatment, perinatal clinicians need to be fully prepared to address the concerns of women in their care about how their safety will be maintained. While doing so, clinicians need more support than just to follow the usual advice to reduce their own stress by meditating, taking brief breaks, and focusing on self-care. Clinicians need the full support of the hospital administration to perform their job responsibilities in ways that will best ensure their safety from the virus.

**Trustworthiness.** Whether between clinicians and women or between nurse leaders and clinicians, trust is created and maintained through frequent, transparent, and bidirectional communication. While clinicians communicate with women throughout pregnancy about changes in care practices due to the pandemic, administrators should offer parallel communication with clinicians about changes in policies and procedures.

**Collaboration.** One purpose of a trauma-informed approach is to reduce power differentials between individuals and improve collaboration through partnerships. The physical state of a woman during labor and birth (e.g., lying down, exposed in a hospital gown, often in pain, tethered to an intravenous pole, and dependent) artificially creates a power differential between her and the clinicians who care for her (e.g., standing, fully clothed, not in pain, free to move,

and in control). Although women may be afforded fewer choices for how their care is managed during the pandemic, they should be asked what matters to them to promote their involvement as partners in making care plans that are agreeable to them. In the same vein, administrators and nurse leaders should involve clinicians in decision making about the implementation of needed changes in care practices and protocols related to the pandemic.

**Peer support.** Peer support is one way to enhance feelings of safety, trust, and collaboration. Individuals who have lived through challenging experiences and who have been trained to provide peer support can help women cope with and recover from their own experiences (Blanch et al., 2012). The concept of peer support takes on added importance during the pandemic because requirements for isolating, quarantining, and social distancing can lead to diminished interactions between women and their support systems. In addition, pairing a more experienced clinician with a less experienced peer during the pandemic is one way that administrators can help to ease the anxieties of those with less experience in the health care workforce.

**Empowerment.** Recognizing and building on individuals' strengths enhances their resilience and empowers them to heal from trauma and function at the highest level possible. Sharing decision making and contributing their voices are additional ways for people to feel empowered, whether they are receivers or providers of health care.

Women are entitled to be treated with respect at all times. Unfortunately, a significant number of women in the United States and other countries have reported disrespectful treatment during pregnancy and childbirth (Beck, 2018); nurses and doulas have similarly reported witnessing disrespectful treatment (Morton et al., 2018). Lessening or eliminating power differentials between women and their perinatal clinicians can lead to greater self-advocacy and involvement of women in determining their care plans. Women and perinatal clinicians can be further empowered to maintain their mental and emotional well-being by ensuring they are aware of the mental health resources available to them.

**Cultural sensitivity.** Cultural stereotypes and biases can adversely affect peoples' engagement with health care and health care outcomes.

**Table 4: Six Key Principles of a Trauma-Informed Approach for Maternity Care Settings During the COVID-19 Pandemic**

Principle	Clinical Practice Implications for Maternity Care	Clinical Practice Implications for Perinatal Clinicians
1. Safety (physical and psychological)	<ul style="list-style-type: none"> <li>• Support women's rights to bodily integrity.</li> <li>• Devise ways to introduce oneself that overcome the barrier that personal protective equipment (PPE) presents (such as attaching a personal photo or writing your name on your protective hospital gown).</li> <li>• Explain what will be done to keep women as safe as possible from the virus during care.</li> <li>• Change prenatal visits to telehealth visits as possible to minimize women's exposure to the virus (Fryer et al., 2020).</li> <li>• Inform childbearing women about hospital policies relating to the presence of support people during labor and delivery; reassure them that at least one support person will be allowed to be present.</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure adequate supplies of PPE and education about how to use PPE appropriately to help clinicians feel safe (Shanafelt et al., 2020).</li> <li>• Consider minimizing assignments of those at higher risk of contracting COVID-19 (Black, Asian, or those with other ethnic or minority backgrounds) with women who are known to be positive for COVID-19 (Nguyen et al., 2020).</li> </ul>
2. Trustworthiness	<ul style="list-style-type: none"> <li>• Communicate transparently about what changes to care practices can be expected due to the pandemic, including practices around care of the childbearing woman and her newborn in the event that she is positive for COVID-19.</li> <li>• Acknowledge women's personal histories, especially around events that might cause heightened anxiety in the hospital or birth setting.</li> <li>• Encourage families to make plans early to get their support systems in place for when they bring their newborns home.</li> <li>• Refrain from pressuring women who have given birth to be discharged early; provide follow-up resources for care during the postpartum period, including for breastfeeding.</li> </ul>	<ul style="list-style-type: none"> <li>• Address clinicians' specific anxieties and fears about their vulnerability and loss of control (Shanafelt et al., 2020).</li> <li>• Provide frequent, timely, transparent, and bidirectional communications with clinicians when policies, procedures, and recommendations change in response to local and national data (Wang et al., 2020).</li> </ul>
3. Collaboration	<ul style="list-style-type: none"> <li>• Mutually create plans with women who have heightened anxiety to lessen their concerns.</li> <li>• Involve women as partners in decision making about their own care, giving them choices when possible (as the pandemic has taken away some choices).</li> <li>• Offer telehealth resources including medically reliable apps and/or Web sites that women can use to enhance their understanding of their pregnancy.</li> </ul>	<ul style="list-style-type: none"> <li>• Collaborate with clinicians when making decisions about policies and procedures, ensuring that their voices and expertise are included and respected.</li> <li>• Increase the availability of support staff such as social workers and encourage their collaboration with perinatal clinicians to help nurses and midwives cope with challenging women and situations (Chen et al., 2020).</li> </ul>

(Continued)



**Table 4: Continued**

Principle	Clinical Practice Implications for Maternity Care	Clinical Practice Implications for Perinatal Clinicians
4. Peer support	<ul style="list-style-type: none"> <li>• Offer opportunities to women with high-risk pregnancies and to those whose infants are anticipated to need admission to a neonatal intensive care unit to connect with peer mentors.</li> <li>• Be proactive about providing outreach and peer support to people of color and others from disadvantaged communities because they may not readily ask for help.</li> </ul>	<ul style="list-style-type: none"> <li>• Create a buddy system to partner inexperienced clinicians with their more experienced colleagues to reduce anxiety among those with less experience.</li> </ul>
5. Empowerment	<ul style="list-style-type: none"> <li>• Provide respectful care to all women.</li> <li>• Affirm with women that they can make good decisions; offer meaningful opportunities to make decisions to give women a sense of control that may otherwise be lacking during the pandemic.</li> <li>• Empower women to use mental health services during pregnancy and the postpartum period, including telemental health, if they are ready to do so.</li> <li>• Strive to destigmatize women's use of mental health supports by normalizing that pregnancy and parenting during COVID-19 are particularly challenging experiences.</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain awareness of and offer support to clinicians who are at increased risk for social problems as outlined in Table 2 or who are experiencing trauma or grief; empower them to access mental health and psychosocial support services, including a psychological assistance hotline and employee assistance programs.</li> <li>• Hold debriefing sessions (including virtually), which may help clinicians resolve their emotions after difficult clinical situations have occurred and/or after co-workers or their family members have been affected by COVID-19 (Foreman, 2014).</li> <li>• Institute Schwartz Rounds to provide a regular, structured time and safe place for clinicians to meet to share the emotional, psychological and social challenges of working in health care (Leamy et al., 2019).</li> <li>• Empower clinicians by engaging them in online education programs on psychological skill development (Chen et al., 2020).</li> </ul>
6. Cultural sensitivity	<ul style="list-style-type: none"> <li>• Provide culturally effective care to all.</li> <li>• Examine how one's biases, both explicit and implicit, may affect care; endeavor to eliminate biases.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide full support to clinicians who are stigmatized due to their race or ethnicity (Shanafelt et al., 2020).</li> <li>• Understand the disproportionate effect of the pandemic on families of color and give clinicians of color permission to take care of themselves and their families as needed.</li> </ul>

Note. Adapted from "SAMHSA's Concept of Trauma And Guidance For a Trauma-Informed Approach" by Substance Abuse and Mental Health Services Administration, 2014. [https://ncsacw.samhsa.gov/userfiles/files/SAMHSA\\_Trauma.pdf](https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf).

Institutional leaders and clinicians should promote policies and processes that respond to the cultural needs of the people served and staff. Families of color often have a multitude of justifiable reasons to mistrust the medical system. One example is the Tuskegee Syphilis Study in which African American men were the subjects of experimentation to determine the natural history

of syphilis between 1932 and 1972 (Gamble, 1997). The pandemic and the concurrent Black Lives Matter movement have raised awareness about long-standing racial inequities in the United States, including maternity outcomes. Among a diverse group of 1,369 people surveyed (men and women; Black, White, and Hispanic) to determine their reasons for avoiding medical

**While recognizing current institutional constraints and barriers of time and financial resources, it is nevertheless critical to advocate for education in trauma-informed care.**

care, 33% indicated unfavorable evaluations of the process or outcome of seeking medical care, including physician factors (Taber et al., 2015).

Pregnant women of color described stressful interactions with all levels of health care staff, unmet informational needs, and inconsistent social support that led them to believe that their experiences of discrimination, racism, and disrespect in health care encounters affect both their health and that of their infants (McLemore et al., 2018). Pregnant women who report racist experiences have three times the likelihood of adverse birth outcomes, including giving birth to low-birth-weight or preterm newborns (Weinstein, 2019). Exposure to personal and institutional racism likely contributes to the current poor outcome statistics among pregnant Black women compared with White women; Black women are twice as likely to suffer from severe complications during pregnancy, more likely to have traumatic births, and three times more likely to die from pregnancy-related causes (Petersen et al., 2019).

Racial discrimination can result from biases, either explicit (known to us) or implicit (unconscious, uncontrollable thoughts, judgments, and stereotypes). The levels of implicit bias among clinicians in the health care field were similar to the frequency of bias in the general population in a review of 42 articles on this topic (FitzGerald & Hurst, 2017). However, clinicians' biases may influence how they diagnose and treat patients. In a review of 15 studies, Hall et al. (2015) found that providers appeared to have positive implicit attitudes toward White people compared with people of color; these were more often significantly related to patient-provider interactions and health outcomes than treatment processes. Even as clinicians endeavor to recognize and reduce their own biases while providing care, some may also be the recipients of harmful, racially motivated slurs and actions within or outside the work environment. During this pandemic, these actions have been directed primarily at Asian Americans since the virus first emerged in China (Donaghue, 2020).

**Conclusion**

In summary, the COVID-19 pandemic will likely be a part of life in the United States for the

foreseeable future. Using TIC techniques can help all perinatal clinicians, including nurses, midwives, doulas, and physicians, to better support women during pregnancy and the postpartum period and to promote their mental health during this time of heightened anxiety. At the same time, having these skills increases clinicians' confidence during the provision of maternity care. The principles of TIC can be used to further inform policy development regarding interactions between clinicians and pregnant women and practices to support clinicians. While recognizing current institutional constraints and barriers of time and financial resources, it is nevertheless critical to advocate for education in TIC. Such an educational program has been developed by the National Perinatal Association in collaboration with the NICU Parent Network and is available online (Hall et al., 2020). A series of relevant educational Webinars, although neither specific to perinatal clinicians nor to the pandemic, is also available (Trauma-Informed Care Implementation Resource Center, 2018). Health educators in hospitals may also choose to develop their own educational resources.

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