NOTICE: This document contains correspondence generated during peer review and subsequent revisions but before transmittal to production for composition and copyediting:

- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*

**The corresponding author has opted to make this information publicly available.*

Personal or nonessential information may be redacted at the editor's discretion.

Questions about these materials may be directed to the *Obstetrics & Gynecology* editorial office: obgyn@greenjournal.org.

Date: 10/21/2022
To: "Elliott Main" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-22-1610

RE: Manuscript Number ONG-22-1610

Addressing Adverse Childhood and Adult Experiences: Initial Approaches and Recommendations for Prenatal Care

Dear Dr. Main:

Thank you for sending us your work for consideration for publication in Obstetrics & Gynecology. Your manuscript has been reviewed by the Editorial Board and by special expert referees. The Editors would like to invite you to submit a revised version for further consideration.

If you wish to revise your manuscript, please read the following comments submitted by the reviewers and Editors. Each point raised requires a response, by either revising your manuscript or making a clear argument as to why no revision is needed in the cover letter.

To facilitate our review, we prefer that the cover letter you submit with your revised manuscript include each reviewer and Editor comment below, followed by your response. That is, a point-by-point response is required to each of the EDITOR COMMENTS (if applicable), REVIEWER COMMENTS, and STATISTICAL EDITOR COMMENTS (if applicable) below.

The revised manuscript should indicate the position of all changes made. Please use the "track changes" feature in your document (do not use strike-through or underline formatting).

Your submission will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by 11/11/2022, we will assume you wish to withdraw the manuscript from further consideration.

*** Please note the following:

* Help us reduce the number of queries we add to your manuscript after it is revised by reading the Revision Checklist at https://journals.lww.com/greenjournal/Documents/RevisionChecklist_Authors.pdf and making the applicable edits to your manuscript.

* Figures 1-2: Please confirm that these are original to the manuscript.

EDITOR COMMENTS:

1. Rather than saying “This article offers…” in the precis, try to make a general summary statement about points of emphasis (for example: Screening for adverse childhood and adult experiences in prenatal care allows clinicians to address past and present adversity and trauma with a goal of improving perinatal outcomes.)

2. Avoid duplication between text and the tables and figures (simply refer to the table, box, or figure).

3. Much of the "call to action" section seems repetitive with the remainder of the document. Please be sure to remove repetitive content, and combine the call to action and conclusion sections.

4. Remove case studies (Box 2). Could be supplemental material if you would like to keep it.

5. Agree with reviewer 3 that there is a need to pare down the content--especially in the background section to make this more accessible to a busy clinician.

REVIEWER COMMENTS:

Reviewer #1:

Fantastic article. Outstanding review and recommendations regarding approach to trauma informed care. Should be required reading for all prenatal providers. I have no recommended substantive changes (although on line 376 the authors use the term IPT but don't define it until line 392).

Reviewer #2:

This Clinical Expert Series article is written with the objective to provide consensus recommendations for clinicians to address adverse childhood and adult experiences during prenatal care.

This is a well-written and thorough manuscript on a topic that is pertinent to routine obstetric practice. I think it will be of interest to this journal's readers.

1. I generally recommend that the authors acknowledge the dearth of evidence to guide recommendations for addressing childhood/adult adverse experiences. While it is easy to agree that addressing adverse experiences is ethically appropriate and will positively affect the individual patient experience, it is not as obvious to me that there should be an expectation for objective, measurable improvements in perinatal outcomes (or even what outcomes should be assessed for improvement). Specifically:

Line 94 - "Adverse experiences can lead to poor health outcomes" - recommend acknowledging the lack of data in this area by stating "….are associated with…" instead of "can lead to".

Lines 190-193 - Can the authors provide some evidence-based reference to support these statements? These concepts are central to the premise of the manuscript (that acknowledgment of adverse experiences during prenatal care can affect individual patient outcomes) and so I think it is essential to provide readers with the evidence basis for this.

Line 251 - I request that the authors cite some evidence to support the effect of trauma-informed care on perinatal outcomes. The cited reference to an ACOG statement on racism is relevant to the first part of sentence (that "addressing racism….is a priority in obstetrics"), but not the premise that trauma-informed care has a direct effect on perinatal outcomes.

2. Recommend consideration of how clinicians in a variety of practice settings might realistically implement the recommendations from this document and what our clinical field should be addressing on a systemic level to improve our care of this patient population. Specifically:

- Some additional background information on evidence-based risk factors for childhood/adult adverse experiences would be helpful. Many clinicians will not have readily available resources to implement the full scope of recommendations given in this document. Are there any specific patient populations who the authors think warrant targeted screening, or do they recommend that all clinicians attempt a universal approach to implementing these recommendations?

- It is clear from this manuscript that there is a significant need for clinical research in this area. If space permits, can the authors address some of the barriers to research that are specific to this patient population? Can a general obstetric provider expect to ever have strong evidence to guide care for these patients?

3. Minor edits/suggestions:

Line 158 - recommend shifting the reference to Table 2 to the end of the paragraph.

The manuscript acknowledges secondary trauma and clinician burnout as important considerations during the provision of trauma-informed care. Consider adding specific recommendations for addressing clinician preparation to address patient adverse experiences, for example at lines 220-222 and/or 307-308.

Line 244-245 - the suggested tools are specific to the response to adverse childhood experiences. Are there any suggested resources for information relevant to people with adverse adult experiences and reproductive trauma?

Line 254, 423 - consider "birthing BIPOC" instead of "BIPOC birthing people" to avoid redundancy within the term.

Line 304 - It would be helpful to have some illustrative examples of the "headline" approach that the authors suggest. This is one of the most easily implemented recommendations in this document and so a simple list of recommended wording/terms could be very helpful to readers.

Lines 341, 342 - replace "baby" with "infant/fetus"

Line 376/392 - definition of IPT should be with the first use of the term

Line 440 - Box 2 does not appear to have a reference within the text.

Table 3 - For the references support programs, perhaps the information about the Birthing Project could be generalized to reflect the benefit of doula services. It is unclear to me what a "sister friend" is and how this is different from a doula.

Table 4 - Missing "the" in question 5.

Attention to formatting of references. For example, reference 113 (lines 821-823) does not have the last names of the authors.

Reviewer #3:

The authors set out to create a summary of recommendations for obstetricians and gynecologists to integrate trauma-informed care into their practice.

The content is highly valuable, but difficult to digest given the length of the document. Additionally, there is no assessment or evaluation metrics offered.

1. Abstract: Not well organized. The overall impression is that these recommendations seemed aimed more at a health practice or system and less so at the individual clinician.

Introduction:
2. The study aim is introduced at the end of the first paragraph (lines 46-48). The authors contend that they provide recommendations tailored to the clinician about how to respond to ACE's and AAE's. However many recommendations are aimed at leadership and systems change. Please clarify the objective and aims to match the content.

3. The gap in clinician training is missing. There is no data presented on whether obstetrician gynecologists need this training or these recommendations. There is an assumption in line 57-60 that OB/GYNs do not "typically" provide trauma-specific services. This should be qualified. Much of what OB/GYNs do is trauma-specific care. Either cite lack of screening or lack of trauma-informed approach noted in other literature to qualify this.

4. Consider ending the introduction with the objectives/aims of the study.

Methodology
5. There is one paragraph briefly and generically detailing how these recommendations were derived. This seems very inadequate. How many stakeholders and patients were engaged for this work? What "other organizations were involved (line 67).

6. Did the scoping review (line 79) inform this work?

7. Following the "methodology" section are 5 pages of additional background information that should be summarize and added to the introduction or clarify these as ''basic principles" of implementation devised by the group (pages 6-10). Either way this information is very onerous to read through and points could be made more to the point.
"How to prepare your prenatal practice"

8. This section seems more geared toward a practice or health system as opposed to the stated objective of targeting the OB/GYN clinician.

9. Consider citing references that show the successful implementation of a champion model. There are several (line 210).

10. Under initiate education (line 233), authors only provide one resource. are there others that the authors came across that can be recommended? Is this resource free? Should education be asynchronous or synchronous?

11. The example resource sheet is very helpful.

12. The link in line 245 does not work.

13. List the 4 c's in the text (line 307).

14. Would suggest framing this review as a roadmap to successful implementation and highlight that many levels of stakeholders are needed. This is not just for the obstetric provider. A multidisciplinary team is required for the work laid out. As systems approach is required for implementation.

15. Overall consider some bullet points of key takeaways and less text for the broad content of the manuscript.
Discussion

16. Evaluation and measurement of impact are lacking. This is a huge gap and must be addressed before asking clinicians to implement this work.

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Sincerely,

Torri D. Metz, MD, MS
Associate Editor, Obstetrics

The Editors of Obstetrics & Gynecology

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RE: Manuscript Number ONG-22-1610

Addressing Adverse Childhood and Adult Experiences: Initial Approaches and Recommendations for Prenatal Care

Dear Dr. Metz,

We would like to thank the reviewers for their positive feedback on our original submission and we thank Obstetrics and Gynecology for the opportunity to submit a revision. We have carefully gone through every reviewers' comments and made revisions accordingly. We feel that it is a much improved paper.

Beginning on the next page, reviewers' comments are presented in italics followed by our responses in plain font. We provide both a clean version of our revised manuscript and a version showing all tracked changes.

We appreciate the opportunity to work with you and the Editorial Board with this submission. Let me know if there are any further changes you would like us to make.

Thank you very much for your consideration of our revised manuscript.

Sincerely,

Elliott Main, MD

** Figures 1-2: Please confirm that these are original to the manuscript.*

These figures are original to the manuscript.

EDITOR COMMENTS:

1. Rather than saying "This article offers…" in the precis, try to make a general summary statement about points of emphasis (for example: Screening for adverse childhood and adult experiences in prenatal care allows clinicians to address past and present adversity and trauma, with a goal of improving perinatal outcomes.)

We have changed the precis to reflect this suggestion (lines 9-10).

2. Avoid duplication between text and the tables and figures (simply refer to the table, box, or figure).

We have edited the figure legends to avoid duplication with text (lines 502-504).

3. Much of the "call to action" section seems repetitive with the remainder of the document. Please be sure to remove repetitive content, and combine the call to action and conclusion sections.

We have attempted to remove repetitive content throughout the document, and combined the call to action and conclusion sections.

4. Remove case studies (Box 2). Could be supplemental material if you would like to keep it.

We have moved the case studies to supplementary material.

5. Agree with reviewer 3 that there is a need to pare down the content--especially in the background section to make this more accessible to a busy clinician.

We have pared down the content throughout the document, with particular attention to the background section, which has gone from 5 paragraphs to 3.

REVIEWER COMMENTS:

Reviewer #1:

Fantastic article. Outstanding review and recommendations regarding approach to trauma informed care. Should be required reading for all prenatal providers. I have no recommended substantive changes (although on line 376 the authors use the term IPT but don't define it until line 392).

We now define it point of first use.

Reviewer #2:

This Clinical Expert Series article is written with the objective to provide consensus recommendations for clinicians to address adverse childhood and adult experiences during prenatal care.

This is a well-written and thorough manuscript on a topic that is pertinent to routine obstetric practice. I think it will be of interest to this journal's readers.

1. I generally recommend that the authors acknowledge the dearth of evidence to guide recommendations for addressing childhood/adult adverse experiences. While it is easy to agree that addressing adverse experiences is ethically appropriate and will positively affect the individual patient experience, it is not as obvious to me that there should be an expectation for objective, measurable improvements in perinatal outcomes (or even what outcomes should be assessed for improvement). Specifically:

We have added a statement to the introduction acknowledging the dearth of evidence to guide screening as an important impetus for our paper (line 80-82).

Line 94 - "Adverse experiences can lead to poor health outcomes" - recommend acknowledging the lack of data in this area by stating "….are associated with…" instead of "can lead to".

We agree with the reviewer that “associated with” is most appropriate. This particular sentence was deleted during this round of editing; where we otherwise refer to this connection, we have used the term “associated with.” (Line 121)

Lines 190-193 - Can the authors provide some evidence-based reference to support these statements? These concepts are central to the premise of the manuscript (that acknowledgment of adverse experiences during prenatal care can affect individual patient outcomes) and so I think it is essential to provide readers with the evidence basis for this.

These lines have been deleted as part of the paring-down of the document. We do provide references documenting effects of screening for childhood adversity on the clinician-patient relationship(71-72), patient preference for addressing adversity and trauma with clinicians(lines 191-193), and the benefits of trauma-

informed care (lines 67-69; 74-77).

Line 251 - I request that the authors cite some evidence to support the effect of trauma-informed care on perinatal outcomes. The cited reference to an ACOG statement on racism is relevant to the first part of sentence (that "addressing racism….is a priority in obstetrics"), but not the premise that trauma-informed care has a direct effect on perinatal outcomes.

The statement in the paper is intended to convey that addressing racism is an integral part of a trauma-informed approach. We have added an additional citation to support this and removed the words perinatal outcomes (lines 263-265).

2. Recommend consideration of how clinicians in a variety of practice settings might realistically implement the recommendations from this document and what our clinical field should be addressing on a systemic level to improve our care of this patient population. Specifically:

- Some additional background information on evidence-based risk factors for childhood/adult adverse experiences would be helpful. Many clinicians will not have readily available resources to implement the full scope of recommendations given in this document. Are there any specific patient populations who the authors think warrant targeted screening, or do they recommend that all clinicians attempt a universal approach to implementing these recommendations?

We recommend universal screening. This is consistent with ACOG Committee Opinion #825, which recommends that all clinicians adopt universal screening for current trauma and a history of trauma. We have amended introductory paragraph to highlight the recommendation for universal screening (lines 44-45).

We have also added a statistic documenting the high prevalence of lifetime traumatic events, which we believe supports the position of universal screening (lines 48-49).

To enhance useability to all clinicians, we have added two psychoeducation resources to the resource list that any clinician can use regardless of their referral options (line 485 section on "Online and Apps").

- It is clear from this manuscript that there is a significant need for clinical research in this area. If space permits, can the authors address some of the barriers to research that are specific to this patient population? Can a general obstetric provider expect to ever have strong evidence to guide care for these patients?

We are encouraged by the large number of studies examining associations between adversity trauma and perinatal outcomes (for example, our scoping review has identified 130 studies), as well as the increase in inquiry about trauma and efforts to develop trauma-specific interventions in the perinatal period, that there will be forthcoming evidence to guide care. We hope this area of research will become an NICHD priority, which will further strengthen our understanding. We have added a statement that we can expect more evidence given large initiatives to adopt screening (lines 451-452). While we agree that there are significant barriers to research in perinatal populations, we have not addressed this in the manuscript given the focus on practical considerations for clinicians.

3. Minor edits/suggestions:

Line 158 - recommend shifting the reference to Table 2 to the end of the paragraph.

This has been done (line 170).

The manuscript acknowledges secondary trauma and clinician burnout as important considerations during the provision of trauma-informed care. Consider adding specific recommendations for addressing clinician preparation to address patient adverse experiences, for example at lines 220-222 and/or 307-308.

We added brief section on clinician and staff wellbeing (lines 242-252).

Line 244-245 - the suggested tools are specific to the response to adverse childhood experiences. Are there any suggested resources for information relevant to people with adverse adult experiences and reproductive trauma?

We have added an additional links to resources addressing practice change in a variety of settings (lines 225-230). We are not aware of specific toolkits for practice change to address reproductive trauma. However, we feel the resources provided are applicable beyond their specific clinical areas of focus because they address general strategies for practice transformation, for example engaging leadership and planning for sustainability, which can be applied more broadly.

Line 254, 423 - consider "birthing BIPOC" instead of "BIPOC birthing people" to avoid redundancy within the term.

We have replaced the term "BIPOC birthing people" with "birthing BIPOC" (lines 412 and 267).

Line 304 - It would be helpful to have some illustrative examples of the "headline" approach that the authors suggest. This is one of the most easily implemented recommendations in this document and so a simple list of recommended wording/terms could be very helpful to readers.

We inserted a sample script (line 492 under "Contain the interaction").

Lines 341, 342 - replace "baby" with "infant/fetus"

These lines were deleted as part of paring down the content.

Line 376/392 - definition of IPT should be with the first use of the term

We have added the definition with the first use of the term (line 386).

Line 440 - Box 2 does not appear to have a reference within the text.

We have added a reference within the text and moved the material to the Supplementary Materials section (line 367).

Table 3 – For the references support programs, perhaps the information about the Birthing Project could be generalized to reflect the benefit of doula services. It is unclear to me what a "sister friend" is and how this is different from a doula.

We changed the reference to doula services (line 485, under "Support Programs").

Table 4 - Missing "the" in question 5.

We inserted "the" into question 5 (line 491).

Attention to formatting of references. For example, reference 113 (lines 821-823) does not have the last names of the authors.

We have scrutinized the references for errors. The previous reference 113 was an error and was deleted.

Reviewer #3:

The authors set out to create a summary of recommendations for obstetricians and gynecologists to integrate trauma-informed care into their practice.

The content is highly valuable, but difficult to digest given the length of the document. Additionally, there is no assessment or evaluation metrics offered.

1. Abstract: Not well organized. The overall impression is that these recommendations seemed aimed more at a health practice or system and less so at the individual clinician.

We have edited the abstract for organization and clarity.

Introduction:
2. The study aim is introduced at the end of the first paragraph (lines 46-48). The authors contend that they provide recommendations tailored to the clinician about how to respond to ACE's and AAE's. However many

recommendations are aimed at leadership and systems change. Please clarify the objective and aims to match the content.

We have broadened the statement of purpose to include clinicians and prenatal care practices (line 84).

3. The gap in clinician training is missing. There is no data presented on whether obstetrician gynecologists need this training or these recommendations. There is an assumption in line 57-60 that OB/GYNs do not "typically" provide trauma-specific services. This should be qualified. Much of what OB/GYNs do is trauma-specific care. Either cite lack of screening or lack of trauma-informed approach noted in other literature to qualify this.
We added a statement in the introduction to address the gap in clinician training (lines 73-74).
We removed the statement "obstetric clinicians do not typically provide trauma-specific services".

4. Consider ending the introduction with the objectives/aims of the study.

We changed the introduction so that it ends with the objectives statement (lines 81-85).

Methodology
5. There is one paragraph briefly and generically detailing how these recommendations were derived. This seems very inadequate. How many stakeholders and patients were engaged for this work? What "other organizations were involved (line 67).

We have amended the methodology section to include more specific information about the process, including the number of stakeholders (line 90), and other organizations (lines 91-94) involved.

6. Did the scoping review (line 79) inform this work?

The scoping review did inform the work. The results of the scoping review will be published separately.

7. Following the "methodology" section are 5 pages of additional background information that should be summarize and added to the introduction or clarify these as ''basic principles" of implementation devised by the group (pages 6-10). Either way this information is very onerous to read through and points could be made more to the point.

We have pared down and consolidated this information.

"How to prepare your prenatal practice"

8. This section seems more geared toward a practice or health system as opposed to the stated objective of targeting the OB/GYN clinician.

We have re-framed the purpose of this paper to reflect this as an objective (lines 81-85).

9. Consider citing references that show the successful implementation of a champion model. There are several (line 210).

We have added references to the use of a champion model for implementation (line 207).

10. Under initiate education (line 233), authors only provide one resource. are there others that the authors came across that can be recommended? Is this resource free? Should education be asynchronous or synchronous?

We have added a reference to a freely available didactic module and role play for ob-gyn residents to learn to take pregnant patients' trauma histories (lines 235-237).

11. The example resource sheet is very helpful.

12. The link in line 245 does not work.

We have updated this to a working link (line 241).

13. List the 4 c's in the text (line 307).

We added the 4 c's in the text (line 321).

14. Would suggest framing this review as a roadmap to successful implementation and highlight that many levels of stakeholders are needed. This is not just for the obstetric provider. A multidisciplinary team is required for the work laid out. As systems approach is required for implementation.

We have amended the purpose statement to include practices as well as clinicians (line 84), and emphasized the importance of a multidisciplinary team, many levels of stakeholders, and a systems approach in the conclusion section (lines 464-467).

15. Overall consider some bullet points of key takeaways and less text for the broad content of the manuscript.

We have included bullet points in the conclusion section (Box 2, line 497) and pared down content the paper to make it more digestible to readers.

Discussion

16. Evaluation and measurement of impact are lacking. This is a huge gap and must be addressed before asking clinicians to implement this work.

The "Recommendations for Researchers" box (line 497) includes recommendation to study trauma informed care interventions' effects on perinatal outcome measures. We have added an additional sentence suggesting possible areas for evaluation and measurement of impact that could be applied to the perinatal period based on research from primary care (lines 448-449).