NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY

Posttraumatic Stress Disorder and Trauma Reproductive Loss

Clinical Vignette

Trainee Guide

Contributors

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Pre-Assessment Learning

- Hamana, L, Rauch, S., Sperlich, M., et al (2010) Previous experience of spontaneous or elective abortion and risk for posttraumatic stress and depression during subsequent pregnancies. *Depression and Anxiety* August, 27 (8) 699-707. Doi; 10.1002/da.20714.

- Farren, J. Jaimbrant, Ameye, L., Karen, J. , et al (2016) Post traumatic stress, anxiety, and depression following miscarriage or ectopic pregnancy: A prospective cohort study. *BMJ Open* 2016:6: e011864/ doi;10.1136/bmjopen

- Daugirdate, V. van der Akken,O. et al (2015). Post-traumatic stress and post-traumatic stress disorder after termination of pregnancy and reproductive loss: Review Article. *Journal of Pregnancy,* Vol. 15; doi; 10.1155/2015

Additional Reading (optional)

- Gold KJ, Leon I, Boggs ME, Sen A. Depression and Posttraumatic Stress Symptoms After Perinatal Loss in a Population-Based Sample. J Womens Health (Larchmt). 2016 Mar;25(3): 263-9.

- Gravensteen IK, Jacobsen EM, Sandset PM, Helgadottir LB, Rådestad I, Sandvik L, Ekeberg Anxiety, depression and relationship satisfaction in the pregnancy following stillbirth and after the birth of a live-born baby: a prospective study. *BMC Pregnancy Childbirth.* 2018 Jan 24;18(1):41.

Session

This module focuses on the spectrum of stress and trauma disorders which women can experience surrounding perinatal mortality and morbidity, including Adjustment Disorders and Posttraumatic Stress Disorder (PTSD - Acute, Chronic, and Complex and Delayed), as well as sub-syndromal trauma responses. Perinatal mortality includes reproductive loss from spontaneous abortion (SAB), elective abortion (EAB), and stillbirth, including both wanted and unwanted pregnancies. Perinatal morbidity includes babies born with fetal anomalies, or adverse birth outcomes.

Learning Objectives

1. The learner will evaluate the incidence, risk and protective factors among women who are vulnerable to developing PTSD surrounding perinatal morbidity and mortality including SA, EAB, Stillbirth, and fetal anomalies
2. The learner will appreciate that PTSD and its variants can result from all types of reproductive losses, and adverse birth outcomes for both wanted and unwanted pregnancies. .
3. The learner will apply sensitive, compassionate, and culturally appropriate communication skills to women who have experienced loss and adverse birth outcomes
4. The learner will competently evaluate, diagnose, and treat PTSD and stress related responses among women who have experienced loss or adverse birth outcomes.

5. The learner will analyze the short- and long-term impact of untreated PTSD across the life span of the woman, her partner, children and subsequent pregnancies.

Clinical Vignette

Ms. J is a 31 yo G1P0 married white female who is self-referred for transfer of care to a new psychiatric provider. She has a history of newly diagnosed Bipolar Disorder and was started on Cariprazine by another provider at the beginning of April. In May, she was excited to learn that she was 6 weeks pregnant, informed family and friends, and stopped taking her Cariprazine. One week later, experienced cramping, went to her local emergency department, and was informed that the fetus had no heartbeat. She was referred to the obstetrics/gynecology (OB/GYN) team for complete SAB. On initial interview with the psychiatric provider, she reported after the SAB, she felt like she was on a "a roller coaster," including mood swings, lability, angry outbursts, yelling, screaming, irritability, and argumentativeness with husband. She would become severely depressed, had panic symptoms 2x/week, and took several days to recover. She resumed Vralyor 3mg in August.

Visit 1

She presented for her first visit to a perinatal mental health clinic in distress after pregnancy loss, concerned about whether medications may have contributed to SAB. She hopes to conceive again as soon as possible, as "my biological clock is ticking."

History of Presenting Illness

Ms. J reports that when on Cariprazine, her mood was more regulated, but she still felt quite depressed, had residual irritability, and frequent crying episodes. She experienced intermittent suicidal ideation, feeling, "What is the point?" She had no plan/intent to act on her suicidal thoughts. Her symptoms would worsen around exposure to babies and pregnant women. Edinburg Post Natal Depression Scale was 24. This is a gold standard screening tool for postpartum depression. Scores of 13 and above indicate a positive screen, and indicate further evaluation is needed. She scored "sometimes' on # 10, which asks about thoughts of suicide. Patient also scored a positive screen on the Generalized Anxiety Scale of 17. A score above 8 is considered a positive screen.

Review of Systems

- Sleeping less than 5 hours
- Disrupted energy
- Varied appetite: most recently increased appetite with 10 pound weight gain. Restless, pacing, fidgety, cannot sit still, which suggests a side effect of the medication
- She has had no other psychotropic medication trials

Medical History

History of cyst of ovary, unspecified laterality
History of migraine headaches

Discussion Questions

1. Analyze Ms. J's biological, psychological and obstetrical risk factors for adverse outcomes, as well as protective factors.

2. What 3 screening questions would you ask to determine whether Ms. J meets criteria for PTSD?

3. Propose short and long treatment interventions, including any adjustments to medication.

Visit 2

Ms. J has been psychiatrically stable on a new medication for the past 6 months. Since she was last seen, she never followed up with the recommended treatment plan, other than to change to a new mood stabilizer (one she had previously taken), which she feels is effective.

Visit 3

On visit number 3 she states she learned she was pregnant again w/ EDC in December 2018. She states that she is trying to be more cautious, informing only a few people. Unfortunately, at her 12-week ultrasound, no heartbeat was detected. She had Dilatation and Curettage Spontaneous Abortion # 2. She presents as subdued, depressed. No SI/HI/SIB or hopelessness. She now feels more urgency to become pregnant and states she and husband want "to do everything possible to conceive." She is wondering about discontinuing her psychiatric medication.

Other than Bipolar Disorder, she has no new medical problems, and takes no new medications.

4. What changes in treatment, approach would you consider if any?

5. Would you consider trial off of mood stabilizer? Alternative? Provide rationale. If so what type of alternative treatment would you recommend?

6. What elements need to be include in any informed consent?

Take Home Points

1. Women can experience a range of stress and trauma disorders after *all types of pregnancy losses.*
2. Recognizing and treating PTSS/PTSD after reproductive loss *reduces overall psychiatric morbidity*
3. Recognizing and treating PTSS/PTSD *improves outcomes of subsequent pregnancies*
4. Women can experience PTSS/PTSD *after wanted as well as unwanted* reproductive losses
5. Women can experience reproductive loss as a *real death experience, regardless of gestational age* of the baby.