NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY

Posttraumatic Stress Disorder and Trauma
Traumatic Delivery
Case Discussion
Facilitator's Guide

Contributors
Neeta Shenai, MD, University of Pittsburgh Medical Center, Western Psychiatric Institute and Clinic
Maureen Curley, PhD, University Hospitals, Connor Integrative Health Network

Pre-Assessment Learning

- Dekel S, Stuebe C, Dishy G. Childbirth Induced Posttraumatic Stress Syndrome: A Systematic Review of Prevalence and Risk Factors. *Frontiers in Psychology*. 2017;8:560. doi:10.3389/fpsyg.2017.00560.

- Shlomi Polachek I, Dulitzky M, Margolis-Dorfman L, Simchen MJ. A simple model for prediction postpartum PTSD in high-risk pregnancies. Arch Womens Ment Health. 2016 Jun;19(3):483-90. Epub 2015 Sep 23.

Additional Reading (Optional)

- Yildiz, P. D., Ayers, S., & Phillips, L. (2017). The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis. *Journal of Affective Disorders,208*, 634-645. doi:10.1016/j.jad.2016.10.009

- Haagen, J. F., Moerbeek, M., Olde, E., Hart, O. V., & Kleber, R. J. (2015). PTSD after childbirth: A predictive ethological model for symptom development. *Journal of Affective Disorders,185*, 135-143. doi:10.1016/j.jad.2015.06.049

- Montgomery E. Feeling safe: a metasynthesis of the maternity care needs of women who were sexually abused in childhood. Birth. 2013 Jun;40(2):88-95. doi: 10.1111/birt.12043.

- Delicate A, Ayers S, McMullen S. A systematic review and meta-synthesis of the impact of becoming parents on the couple relationship. Midwifery. 2018 Jun;61:88-96. doi: 10.1016/j.midw.2018.02.022. Epub 2018 Mar 6.

Session

- **Introduction to Session and Case Discussion [10 minutes]. Facilitators to review general background information below with group.**

1. Prevalence (Yildiz et al)
    a. As many as 1/3 of women rate their delivery as traumatic
    b. Significant minority met criteria for PP-PTSD (acute PP-PTSD 4.6-6.3%)
2. Risk Factors (Haagen et al)
    a. Predisposing factors
        i. Prior psychiatric history; previous trauma; high fear of delivery/pain; first delivery
    b. Aspects of delivery

i. Subjective distress during delivery; presence of dissociation; loss of control; emergency c-section; neonatal complications; perception of the care received as incompetent or uncaring (=biggest predictor)

c. Maintaining factors • _Negative appraisal of trauma; rumination/repetitive thinking; poor supports

3. Screening for traumatic deliveries and PP- PTSD
    a. Challenges: poor sleep/hypervigilance common in PP period
4. Clinical course and trajectories
    a. Prevalence decreased as postpartum period progressed (Study by Haagen J, 2015 and Kim WJ, 2015)
    b. Limitations of studies: did not control for prior PTSD, attrition of sample
5. Impact on maternal health (Delicate et al)
    a. Affects mother infant bonding and relationship with FOB
    b. Increased risk of comorbid psychiatric illness
    c. Avoidance of hospital settings/physicians
    d. Affects future reproductive decisions
6. Management of postpartum PTSD secondary to traumatic delivery
    a. Trauma informed care and physical exams
        i. Locus of control remains with patient
        ii. Explaining procedure
        iii. Modifications that can be made to promote comfort

- **Case Discussion and small group activity [40 minutes]**
  Break into groups of 3-4 with a facilitator in each group. If only one facilitator, review case as a large group. See below

- **Large Group Discussion: Take-Home Points [5 minutes]**
  1. Childbirth can be perceived as a traumatic event
  2. Postpartum PTSD affects mother- infant bonding, increases the risk of comorbid psychiatric illnesses, and affects future reproductive decisions

Learning Objectives

1. The learner will describe the prevalence and risk factors associated with postpartum PTSD secondary to traumatic deliveries.
2. The learner will formulate a postpartum case with a focus on management of PTSD.
3. The learner will appreciate the impact of postpartum PTSD on maternal health.

Case Scenario Part 1

Ms. A is a 26 yo G1P0 at 25 weeks gestation who presents to her OB office for routine prenatal care. Her pregnancy has been complicated by preeclampsia, for which she is being treated with nifedipine. During the evaluation, she reports high fear of labor and neonatal complications. She reports increase in anxiety as well as a history of previous trauma, which she does not wish to discuss further in detail.

What risk factors does Ms. A have for development of postpartum PTSD secondary to childbirth? What more information would you want to obtain? What risk factors does Ms. A for development of postpartum PTSD secondary to childbirth? What more information would you want to obtain?

FACILITATOR TO PAUSE FOR SMALL/LARGE-GROUP DISCUSSION [5 minutes]

Predisposing Factors	Aspects of Delivery	Maintaining Factors
• History of trauma • Medical complications during pregnancy • High fear of labor • Current symptoms of anxiety • First child	See Below	See Below

Case Scenario Part 2

Ms. A is agreeable to a psychiatric evaluation as she hopes to decrease her anxiety overall.

Ms. A reports that this pregnancy was unplanned and father of baby has limited involvement.

Current symptoms: Ms. A reports feeling overwhelmed with multiple worries including fear of delivery, stress related to the health of her baby, worry surrounding finances, and limited support. These worries are associated with difficulty falling asleep, "butterflies in my stomach" feelings, and almost daily headaches.

Past psychiatric history: Ms. A states she has a history of sexual assault when she was 16 years old, but has never been in treatment with a therapist or psychiatrist. In the past, she has used cannabis to cope, which she stopped after she discovered she was pregnant. During her pregnancy, she has noted an increase in nightmares, re-experiencing, and anxiety with pelvic examinations.

Management: You discuss options for treatment with Ms. A including pharmacological treatment with an SSRI; her preference is to start therapy first for symptom control, citing concerns about taking a medication during pregnancy.

Case Scenario Part 3

Two weeks later, Ms. A has delivered following emergency C-section at approximately 27 weeks gestation. She presents to you for follow up five weeks postpartum and shares her daughter continues to receive medical care in the NICU. She tells you that during her C-section, she felt the staff disregarded her completely and would not explain what was going on.

How would you screen for postpartum PTSD secondary to child birth trauma?

FACILITATOR TO PAUSE FOR SMALL/LARGE-GROUP DISCUSSION [5 minutes]

Facilitator elicits the following:
Broad Screening Questions:
- How was your delivery?
- During delivery, did you feel your life or your baby's life was in danger?
- How did your delivery differ from what you expected to happen?
- How did you feel about how you were treated during your delivery?
- How well supported did you feel during delivery and postpartum from hospital staff, family, and friends?

Specific Symptom Screening:
- Have you noticed you avoid things that remind you of your delivery (for example, physicians and/or hospitals)?
- Do you find yourself trying not to think about your delivery, as it causes stress or negative emotions?
- Have you or others noticed that you have been checking on your baby more frequently, as you worry something bad will happen?
- Are there extra measures you have taken to ensure that your baby and/or you are safe?
- How do you feel about going to your Ob-Gyn for your postpartum care?

Ms. A shares that she thought her baby was going to die during delivery and she describes a high level of distress that persisted postpartum. Prior to C-section, she experienced a high level of pain and following delivery, she required further monitoring for 4 days as she experienced acute kidney injury from complications of preeclampsia. As her baby was born prematurely, she was in the NICU for approximately a week and half for further monitoring and treatment.

She reports the following symptoms of PTSD:

- Re-experiencing: nightmares 3-4x/week
- Avoidance: did not attend the scheduled postpartum visit with her OB/GYN because the practice is located within the hospital she delivered; is considering avoiding future pregnancies due to her delivery experience
- Negative thoughts or feelings: feels something bad will happen to her baby, which has resulted in difficulty bonding and pervasive low mood
- Arousal/reactivity: frequently checks to make sure baby is safe, to the point that she is waking multiple times during the night, even when baby does not need to feed, as she is worried baby is not okay.

Describe the risk factors Ms. A has for development of persistent postpartum PTSD.

FACILITATOR TO PAUSE FOR SMALL/LARGE-GROUP DISCUSSION [5 minutes]

Predisposing Factors	**Aspects of Delivery**	**Maintaining Factors**
• History of trauma • Medical complications during pregnancy • High fear of labor • Current symptoms of anxiety • First child	• Emergency C-section • NICU admission • Presence of obstetrical emergency • High subjective distress • Dissociation during delivery • High pain • Sense of loss of control	• Poor supports • Negative appraisal of trauma • Thought suppression • Rumination/repetitive negative thinking

What would you recommend for treatment?

FACILITATOR TO PAUSE FOR SMALL/LARGE-GROUP DISCUSSION [5 minutes]

Pharmacologic treatment:

- SSRIs:
  - Breastfeeding: All SSRIs pass into breastmilk at relative infant dose of <10% (considered safe)
    - Sertraline: 0.54-2.2%
    - Paroxetine: 0.34- 3%
    - Citalopram 0.2 – 5.9%
    - Escitalopram 4.5 -6.4%
    - Fluoxetine 0.54-6.8%
    - Fluvoxamine 0.2-1.58%
- Prazosin:
  - Alpha-1 adrenergic receptor blocker
  - Improves nightmares and can help with sleep disturbance, total sleep time, and sleep quality
  - 2 studies showed improves hyperarousal symptoms
  - No carryover effects; soon after discontinuing prazosin, disrupted sleep pattern re-emerges

- Breastfeeding: little data is available on the use in breastfeeding
    - Maternal levels: manufacturer reports that one mother was studied and excreted at most 3% of the dose into her breastmilk
    - Infant levels: no relevant published information

Non-pharmacologic interventions:

- Support groups: specifically, for traumatic deliveries
- Individual therapy
    - Discuss woman's needs, impact on her ideal family constellation, sexual relationship with her partner
- NEST: nutrition, exercise, sleep, time to self (support)
- Trauma informed care (including physical exams)
    - Trauma informed care is universal precautions for all patients to minimize medical traumatization and avoid triggering to those with trauma history
    - They are trauma specific interventions for patients with a known trauma history to optimize safety and support recovery, which include:
        - Locus of control remains with patient
            - Consent to exam
            - Empowering patient to communicate preferences (ex. Stop the exam)
        - Explain the procedure
            - Offer an overview of what will happen
        - Discuss modifications that can be made to promote comfort