

Trauma and the perinatal period: a guide for OB/GYN providers

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Learning Objectives:

- Define the incidence of trauma in reproductive-aged women
- Recognize risk and protective factors for trauma in a perinatal patient
- Understand the screening tools and diagnostic criteria for experiences of trauma and post-traumatic stress disorder (PTSD)
- Learn common clinical presentations and differential diagnoses of trauma disorders in a perinatal patient
- Understand the biological, psychological and social factors which contribute to the pathophysiology of PTSD
- Learn evidence-based recommendations of PTSD treatment, including pharmacologic, non-pharmacologic, and psychotherapeutic modalities



Outline:

- Introduction
- Epidemiology: rates/incidence, risk factors and screening
- Diagnostic Criteria
- Clinical Features: clinical presentation and course/prognosis
- Differential Diagnosis and Assessment
- Pathophysiology
- Treatment: psychopharmacology and non-pharmacology
- Case Study with questions
- Summary

Introduction:

- The Substance Use and Mental Health Services Administration (SAMHSA) defines trauma as an event, series of events, or set of circumstances that are experienced by an individual as physically or emotionally harmful or threatening, and that have lasting adverse effects on the individuals functioning and physical, social, emotional or spiritual well-being.
- Recognizing and responding to trauma is a critical component of obstetrical care as it can impact one's health, social functioning, and ability to engage in healthy behaviors. Pregnancy introduces special considerations around trauma and intimate partner violence.
- Patients who have experienced traumatic events are at risk for re-traumatization during health care encounters.

Introduction

Trauma comes in many forms, from circumscribed events to prolonged experiences. Examples include:

- **Early life trauma and adversity.** Recent data reported that >75% of individuals seeking obstetrical care in under-resourced communities had ACES >2 and 50% had ACES > 4.
- **Sexual assault.** Women are more likely to be victims of sexual assault than men. One in five women in the US have been raped at some point in their lives.
- **Intimate Partner Violence (IPV).** IPV is more common in pregnant patients than gestational diabetes, preeclampsia or neural tube defects.
- **Traumatic delivery.** As many as 1/3 of women rate their delivery experience as traumatic. Approximately 12–30% of women may experience Postpartum PTSD (PP-PTSD) following a reproductive loss or traumatic delivery. Most women with PP-PTSD have a prior history of PTSD: only 3% of women develop new onset of PTSD after a traumatic childbirth.

Epidemiology: Rates and Incidence

Approximately **half** of all women will be exposed to at least one traumatic event in their lifetime. Past trauma is a major contributor to risk for many different psychiatric illnesses, not just PTSD.

Posttraumatic Stress Disorder (PTSD): Women are **twice as likely** to develop PTSD after a traumatic event as compared to men, leading to a higher overall rate of PTSD among women (12% lifetime prevalence in women vs. 6% in men).



Epidemiology: Risk Factors



- PTSD
 - The development of PTSD is dependent on both the intensity and type of trauma experienced.
 - There are several risk factors that can predispose an individual to developing PTSD after exposure to trauma, including:
 - being female;
 - history of childhood trauma;
 - lower level of education;
 - exposure to interpersonal violence;
 - exposure to more than three traumatic events; and
 - premorbid psychiatric diagnoses.
 - Specifically, those who have a history of childhood abuse are at an increased risk of developing perinatal-onset PTSD



Epidemiology: Risk Factors

- IPV
 - Women of reproductive age have been reported to experience the highest rates of IPV
 - Risk factors for IPV include:
 - younger age;
 - low education level;
 - unemployment; and
 - low socioeconomic status
 - Populations who are at high risk for experiencing IPV include:
 - pregnant persons;
 - LGBTQ+ individuals;
 - those who are socially isolated;
 - those with controlling, angry, or hostile partners;
 - those with a history of abuse; and
 - those with partners who use substances.

Epidemiology: Risk Factors

- Traumatic Birth
 - Traumatic birth experiences include a wide range of experiences or set of experiences. Examples include:
 - A wide range of medical complications during labor and delivery
 - Neonatal complications
 - Poor communication from medical staff
 - Perception of care received as incompetent or uncaring
 - Feeling of loss of control during labor and delivery
 - Dissociation
 - Lack of privacy or dignity during birth experience
- **A woman's personal experience of the event is particularly salient in informing her risk of postpartum traumatic sequelae and may be informed by her history of earlier adversity or trauma.**



Screening



- The optimal approach to screening for trauma as a component of obstetrical care is an area of active research.
- If performed, screening for traumatic experiences and PTSD is a critical first step and should be followed by **evaluation** and **collaborative safety and treatment planning**.
- Disclosing traumatic experiences requires considerable courage. At the time of disclosure, it is important to highlight the patient's strengths, express a sense of hopefulness, and communicate knowledge of relevant resources.
- Additional considerations may be required for patients of minority backgrounds, including people who identify as a racial minority or LGBTQ+.



Screening

- PTSD
 - Several self-report screening measures for PTSD have been validated for clinical use. Commonly used screening tools include:
 - Primary Care PTSD Screen for DSM 5 (PC-PTSD-5)
 - 5-item screen that was designed to identify individuals with PTSD in a primary care setting.
 - PTSD Checklist for DSM 5 (PCL-5)
 - 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD.
- IPV
 - ACOG recommends screening for IPV at the first prenatal visit, once per trimester, and at postpartum
 - Commonly recommended screening tools include:
 - Humiliation, Afraid, Rape Kick (HARK)
 - 4 questions that assess emotional, physical and sexual IPV in the past year
 - Hurt/Insult/Threaten/Scream (HITS)
 - 4 items that assess the frequency of IPV
 - Woman Abuse Screening Tool (WAST)
 - 8 items that assess emotional, physical and sexual IPV

Screening

- Postpartum PTSD (PP-PTSD)
 - Relatively few resources exist for screening for PP-PTSD specifically within Ob-Gyn settings. Many clinicians, therefore, utilize screening measures for detecting PTSD more generally.
 - The City Birth Trauma Scale (CBTS) is a 29-item self-report questionnaire that assesses for DSM 5 diagnostic criteria for PTSD specifically in the context of traumatic childbirth.



Diagnostic Criteria: PTSD

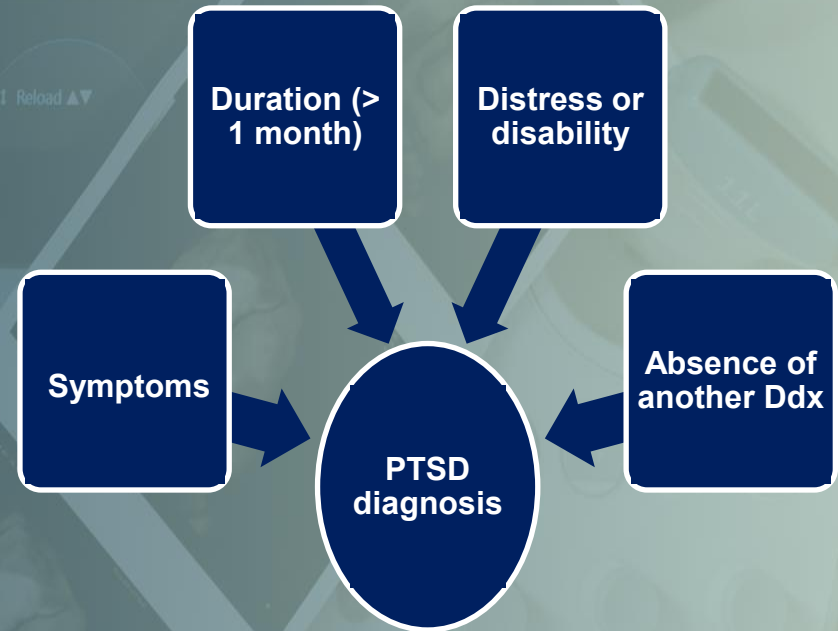
- Traumatic experiences may come in many forms, the DSM-5 specifically recognizes the following as “qualifying traumatic events” for a diagnosis of PTSD:
 - Actual or threatened death
 - Serious injury
 - Sexual violence
- 4 mechanisms of exposure:
 - Direct exposure
 - Witnessing
 - Trauma to a close loved one
 - Repeated extreme exposure to aversive details

NOTE that perinatal (or other medical) events may be perceived on than by their care team. For example a crash cesarean may be perceived by a birthing person as threatened death to themselves or infant, while the care team may not have considered this a critical event.

Diagnostic Criteria: PTSD

To meet the diagnostic criteria for PTSD, an individual must:

- Be experiencing a constellation of **symptoms** (see next slide for more details)
 - Symptoms that occur after a stressor but do not include all described symptom clusters, an “Adjustment Disorder” may be a salient diagnosis.
- Symptoms must be present for greater than **1 month**
 - If present for < 1 month, this is termed “Acute Stress Disorder” and is not PTSD
- Symptoms must be causing **distress or disability** – meaning it is causing work/educational or social or personal impairment
- Symptoms cannot be explained by an alternative differential diagnosis (another medical condition, a traumatic brain injury, substance use disorder, another mood or anxiety disorder)



Diagnostic Criteria: PTSD

1 stressor:

1 *Criterion A:*
Presence of a qualifying traumatic event



4 major symptom clusters:

2 *Criterion B:*
Intrusion
(at least 1 required)

3 *Criterion C:*
Avoidance
(at least 1 required)

4 *Criterion D:*
Negative alteration in cognition and mood
(at least 2 required)

5 *Criterion E:*
Alterations in arousal and reactivity
(at least 2 required)

These 2 clusters of symptoms may either (1) Begin or (2) Worsen in response to the traumatic event

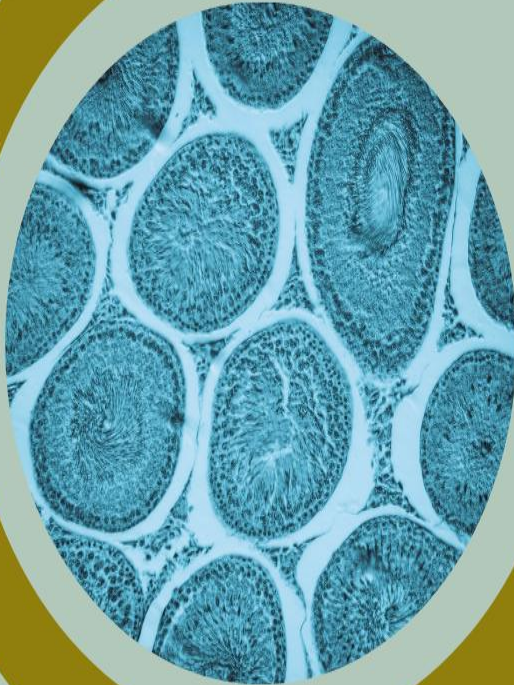


Diagnostic Considerations: PP-PTSD

- Posttraumatic stress disorder (PTSD) is a well-defined mental health disorder which specifically develops in relation to an experience of trauma.
- Postpartum-PTSD (PP-PTSD) is not a distinct diagnosis in the DSM-5. Diagnostic criteria for PTSD in general should be considered in the context of the traumatic delivery as the identified stressor.



Diagnostic Considerations



- In addition to PTSD, those who experience traumatic events are at increased risk for a myriad of other primary mental health disorders such as:
 - Depressive disorders
 - Anxiety disorders
 - Personality disorders
 - Substance use disorders
- Traumatic sequelae may also include symptoms that do not meet criteria for a mental health disorder however may impact health behaviors and/or ability to engage in healthcare. Examples include:
 - Distrust
 - Non-adherence to prenatal care visits
 - Interpersonal sensitivity
 - Dissociation during painful or emotionally intense experiences
 - Passive interactional style





Frank IPV may be preceded by escalating use of power and control (graphic from thehotline.org)



Clinical Presentation: PTSD due to IPV

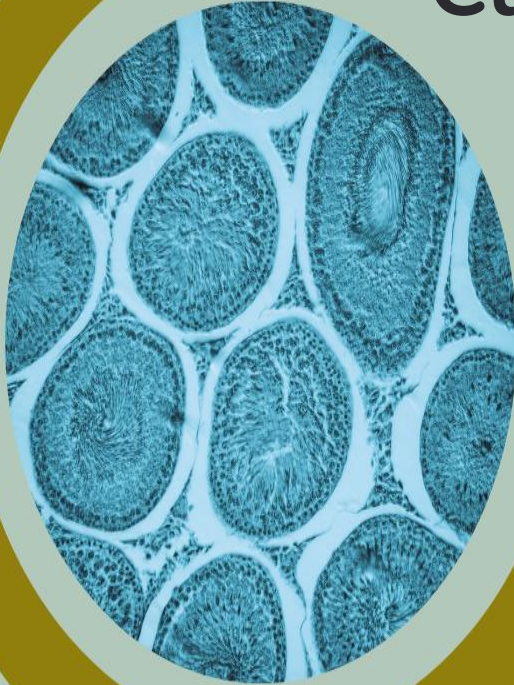
- PTSD experienced as a result of IPV commonly includes:
 - negative cognitive appraisals: self-blame, alienation, fear
 - dissociation and numbing
 - avoidance of intimacy OR hypersexuality
 - difficulty trusting others
 - maladaptive relationship behaviors
 - self-injurious behaviors
- IPV can also result in chronic health conditions (e.g., chronic pain, fibromyalgia, headaches, TBIs, STIs)

Clinical Presentation: PP-PTSD

- Presentation of Postpartum PTSD may include:
 - Re-experiencing: Intrusive thoughts, images, nightmares of delivery
 - Avoidance: may be centered on medical care; of hospitals, physicians, medical staff, outpatient clinics, procedures, pelvic examinations
 - Persistent avoidance ☒ not wanting future pregnancies **or** requesting cesarean sections in future pregnancies
 - Negative cognitions:
 - Themes of guilt/shame surrounding motherhood or ability to care for baby
 - Fears about potential for sickness and death in baby



Clinical Presentation: PP-PTSD



- Chronic PTSD secondary to childbirth has pervasive adverse effects on health including:
 - Impaired mother–infant bonding
 - Reduced quality of relationship with significant other
 - Decreased quality of life
 - Increased risk of comorbid psychiatric illnesses
 - Increased risk of obstetrical complications in future pregnancies



Clinical Presentation: Course

- Trauma may manifest on a spectrum of severity ranging from adjustment disorders to PTSD/other trauma-related disorders
- Trauma symptoms after perinatal adverse events can emerge as delayed or chronic at any point ☒ can be after 12 months
- Trauma from IPV is typically ongoing and repetitive. The course of IPV is influenced by the extent of harm to the victim as well as the risks to others in the family, such as children.
- Over the long-term, sequelae of trauma may present as comorbid conditions, physical pain conditions or sexual dysfunction.



Clinical Presentation: Prognosis

- Prolonging/complicating factors relevant to PTSD:
 - Premorbid or comorbid disorders
 - Previous traumatic events
 - Repetitive trauma (such as recurrent pregnancy losses or IPV)
- Prolonging/complicating factors relevant to PP-PTSD
 - Twin/multiple gestation pregnancies
 - Medical complications during the pregnancy, labor, or delivery
 - NICU admission for baby
 - Delayed or inadequate prenatal care and providing childcare to other young children in the home



Differential Diagnosis:

In general, the distinguishing characteristic of PTSD from other overlapping disorders includes:

- The relationship between the **onset of symptoms with a traumatic event or prolonged experience of trauma.**
- The **cluster of symptoms** which span intrusion, avoidance, hypervigilance and negative alterations of mood/cognition.



Differential Diagnosis: Overlapping Symptoms

Differential Diagnoses for PTSD in the Perinatal Period	Overlapping Symptoms
Bipolar disorder	Irritability, distractibility, mood lability
Depressive disorders	Appetite changes, Anhedonia, Avolition, Insomnia
Generalized anxiety disorder	Irritability, Fear, Nightmares, Feeling “on edge,” Worry
Substance use	Mood swings, erratic behavior, Avoidance, Paranoia
Obsessive Compulsive Disorder	Recurrent, intrusive thoughts; presence of compulsions as reaction to obsessions



Pathophysiology



BIOLOGICAL
FACTORS



PSYCHOLOGICAL
FACTORS

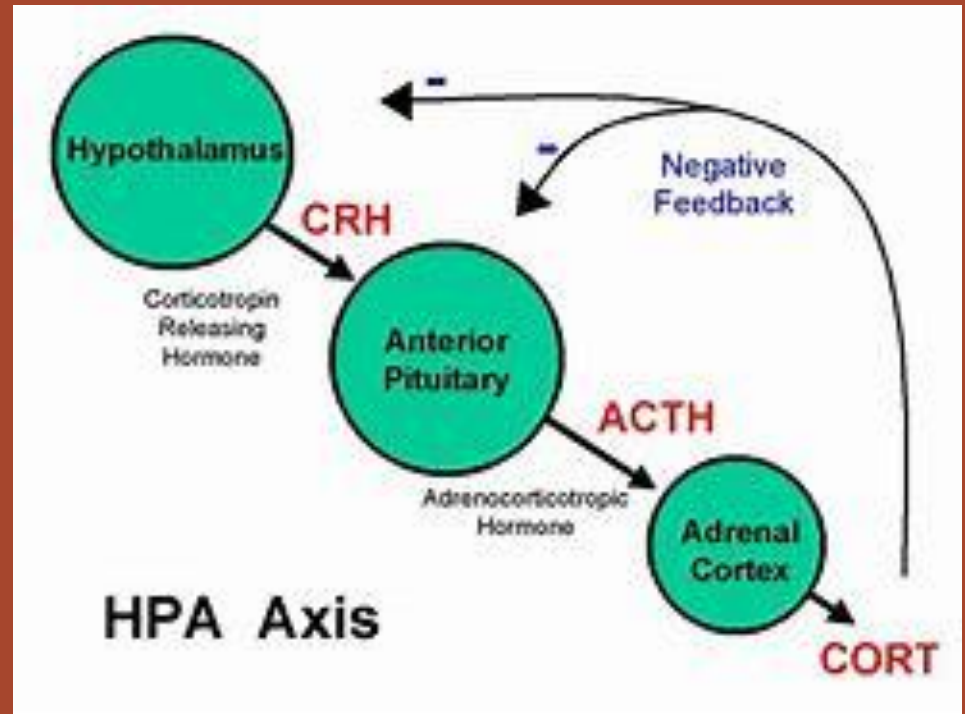


SOCIAL
VULNERABILITIES



Biological Factors

- HPA axis dysfunction
- Neurobiological structural changes
- Gene associations
- Proinflammatory state



Hutner et al., 2021.

Psychological Factors

Pre-existing psychiatric illness

Prior trauma exposure

Family history of psychiatric illness

Coping skills

Social Vulnerabilities

Racial differences in trauma exposure.

Although PTSD risk is elevated in Black individuals, race alone is unlikely to be the role mediator. Black women are at higher risk for being a victim of a violent crime and have repeated exposure to racism. Black women also have higher rates of pregnancy complications, putting them at a theoretically higher risk for PP-PTSD.

LGBT+ individuals are at greater risk for chronic stress and structural stigma in health care systems.



General principles of treatment

- The importance of treating those who have experienced trauma, PTSD, intimate partner violence, reproductive loss or traumatic birth experience should be underscored.
- Ideally treatment should be a multidisciplinary approach.
- The aim of treatment is to reduce levels of distress and improve function and quality of life with minimal adverse effects.
- Most evidence is drawn from studies on treatment efficacy in patients with non-childbirth-related PTSD, however it is suggested many of these non-childbirth related modalities may also be used effectively for PP-PTSD



Treatment: Psychotherapy

- The 2017 Veterans Health Administration/Department of Defense (VHA/DOD) Clinical Practice Guideline for PTSD recommends trauma focused psychotherapy as the 1st line treatment for PTSD over pharmacotherapy
- Psychotherapeutic modalities include:
 - Cognitive Behavioral Therapy (CBT)
 - Prolonged Exposure (PE)
 - Cognitive Processing Therapy (CPT)
 - Eye movement desensitization and reprocessing (EMDR)
 - Interpersonal Psychotherapy (IPT)
 - Written Exposure Therapy (WET)
- Other Talk Therapies include:
 - social problem solving
 - listening visits
 - supportive therapy
 - psycho-education



Treatment: Pharmacologic therapies

- First-Line Medications
 - Sertraline 50-200mg daily (FDA approved for PTSD)
 - Paroxetine 20-50mg daily (FDA approved for PTSD)
 - Fluoxetine 20-80mg (Evidence supports off-label use)
 - Venlafaxine 75-225mg daily (Evidence supports off-label use)
- Other Medication
 - Prazosin 3-15mg hs (divided doses (afternoon and hs) above 5mg) (evidence to support off-label use for PTSD related nightmares)



Treatment: Alternative and complementary medicine therapies

- Yoga
- Mindfulness
- Massage
- Acupuncture
- Light therapy
- Omega 3 fatty acids



Treatment of PP-PTSD

- Evidence remains limited for PP-PTSD-specific treatments, but includes:
 - Individual trauma-focused psychotherapy
 - Eye movement desensitization and reprocessing (EMDR)
 - Trauma-focused cognitive behavioral therapy (CBT)
 - Immediate debriefing interventions and non-trauma-focused psychotherapy have not been shown to be helpful



Trauma-Informed Care

Irrespective trauma history, many women report feeling they are treated “like objects,” with “lack of explanation” and “lack of empathy” during obstetric care

Using TIC principles can help

- transparency
 - tell her what is happening
- choice
 - when possible
- control
 - adjust the environment, discuss treatment plan
- collaboration
 - you’re on the same team!



TABLE 5. Applying TIC Principles in the Perinatal Setting

Clinical scenario	Non-TIC response	TIC response	TIC principle at play
<p>“This patient is being very difficult” The patient in active labor has an anxiety attack each time a team member attempts a clinically necessary cervical exam</p>	<p>The team gets frustrated, tells her she is putting her baby’s safety at risk (shame and blame), and calls psychiatry without informing the patient (punitive and paternalistic)</p>	<p>Ask the patient what is causing her distress, offer her safe alternative labor and examination approach, and offer medications, support, and psychiatry consult as tools to aid her labor and birth experience</p>	<p>Safety and transparency</p>
<p>“I cannot go through it again” A patient in her third trimester presents to prenatal appointment disclosing fear of labor due to prior traumatic birth experience. Asks for elective cesarean to avoid vaginal delivery</p>	<p>Decline elective cesarean and refer to psychiatry</p>	<p>Develop a trauma-responsive birth plan; engage in self-care, mindfulness, and childbirth education in preparation for labor and compassionate and transparent conversation about emergency scenarios and indications for cesarean</p>	<p>Trustworthiness and transparency, empowerment, and choice</p>
<p>“I am a bad mother” A patient presents at 3 weeks postpartum to psychiatry with anxiety and sadness and states that she feels like a “bad mother”</p>	<p>Give her a diagnosis of postpartum depression and a sertraline script.</p>	<p>Assess safety of the patient and baby; increase social and parenting supports; and offer a range of treatments to choose from, including therapy, medication, and group therapy</p>	<p>Peer support, safety, and empowerment</p>
<p>“This patient is drug seeking” Patient who is 28 weeks pregnant is admitted to an inpatient psychiatric unit for psychosis. Her urine drug screen is negative. The patient is increasingly agitated and pacing.</p>	<p>Physical restraint and labeling drug seeking</p>	<p>Redirection, offering medication, and offering obstetric team assessment for evaluation and reassurance and engage the patient in discussion of triggers and coping strategies</p>	<p>Collaboration and mutuality</p>

From Sachdeva et al.:



Case study

- 29 year old G2P1001 woman presents for prenatal care at 8 weeks by LMP. Pregnancy unplanned but desired.
- Delivered son 20 months ago, that pregnancy was complicated by gestational diabetes
 - Obstetrician recommended primary C-section for macrosomia, patient chose trial of labor.
 - Had emergency C-section for NRFHRT during labor which was complicated by postpartum hemorrhage from uterine atony, required massive transfusion protocol and ICU admission. Infants APGARs were 5 and 8, he is now a healthy toddler meeting developmental milestones.
- In the office today, VSS and physical exam normal.
- Bedside USN showed IUP with cardiac activity consistent with LMP dating
- You review her medication list:
 - Sertraline 200 mg daily
 - Prazosin 2 mg qHS
 - Clonazepam 0.5 mg BID PRN anxiety
 - Prenatal vitamin
- Patient reports she stopped all her psychiatric medications 3 weeks ago with a + home UPT



Case study (continued)

- Patient reports experiencing a panic attack when she had a positive pregnancy test and felt “like it was happening all over again.”
- Since stopping meds, experiencing:
 - Persistent difficulty falling asleep
 - Increased irritability
 - Persistent feelings of guilt and shame
 - Intrusive and distressing thoughts, most often memories of her son’s birth
 - Waking up from nightmares about her delivery leaves her exhausted during the day
 - Hard to concentrate at work (as an accountant) and she is concerned about the quality of her work
- Did not attend postpartum visits after her son was born; had to take clonazepam before her appointment today because of severe anxiety about being “in an OB place”
- Reports feeling terrified this pregnancy will have the same outcome as her last one, or that she or the baby may end up dying this time.



What is the differential diagnosis for this patient based off this information? What is the most likely diagnosis and why?

- a) Posttraumatic Stress Disorder (PTSD)
- b) Adjustment disorder
- c) Acute Stress Disorder
- d) Major depressive disorder
- e) Generalized Anxiety Disorder

What other information might be useful to know for diagnosis and clinical decision-making?



What is the differential diagnosis for this patient based off this information? What is the most likely diagnosis and why? PTSD

Intrusion	Intrusive and distressing thoughts, most often memories of her son's birth Waking up from nightmares about her delivery leaves her exhausted during the day
Avoidance	Did not attend postpartum visits after her son was born; had to take clonazepam before her appointment today because of severe anxiety about being "in an OB place"
Negative alteration in cognition or mood	Persistent feelings of guilt and shame
Hyperarousal	Persistent difficulty falling asleep Increased irritability Hard to concentrate at work



Case Presentation Differential Dx

Adjustment disorder has onset within 3 months of stressor and does not persist beyond 6 months after a stressful event has occurred. This diagnosis does not include intrusion and avoidance symptoms and is a diagnosis of exclusion (disturbance does not meet criteria for another mental health disorder).

Acute Stress Disorder occurs at least 3 days and up to 1 month after a traumatic event.

Major depressive disorder includes symptoms which may overlap with PTSD (excessive guilt, changes in sleep, problems with concentration) however does not typically include intrusion and avoidance symptoms.

Generalized Anxiety Disorder includes symptoms which may overlap with PTSD (difficulty with sleep and concentration) however are centered around the experience of excessive worry



What other information might be useful to know for diagnosis and clinical decision-making?

- Past psychiatric history—specifically what happened after the delivery, what psychiatric symptoms were present
- Co-morbid psychiatric symptoms: depression, anxiety, mania, psychosis
- Medication history: number of medication trials, how long she has been on medications, what other medications she has tried
- Previous experiences with therapy/counseling
- Lethality—SI and HI, access to firearms
- Who prescribed the psychiatric medications and were they consulted about cessation?
- Family history, son's health, and development
- Substance use, PDMP, clonazepam usage



What are the risks of abrupt discontinuation of SSRIs?

- Discontinuation syndrome, especially at high doses of SSRI
 - Flu-like symptoms, shock-like sensations, insomnia, vivid dreaming, irritability, crying spells, dizziness exacerbated by movement are most common
 - Movement disorders, impairment in concentration in memory less common
 - Paroxetine and venlafaxine are biggest offenders
- Relapse/recurrence of symptoms being treated



Case Study (continued)

- You ask about the postpartum period following her son's delivery
- About 2-3 weeks postpartum, patient began to experience recurrent nightmares about delivery, as well as intrusive thoughts and reminders throughout the day
- Developed persistent sleep disturbances, depressed mood, anhedonia. Also experienced intense guilt and horror over the event, feeling as though she was at fault for what occurred.
- Though son is healthy and meeting developmental milestones, she is convinced that he would never growth up normally or be healthy and that the C-section "had ruined him for life."
- Felt extremely anxious that something terrible would happen to him and refused to be separated from him. This delayed her return to work once her parental leave ended.
- Her husband reported he would often have to take the baby monitor away from her because she would watch and listen to it obsessively to make sure her son was well
- She would have extreme irritability, often directed towards her husband or other family members
- These symptoms persisted for several months



Case Study (continued)

- At 10 months postpartum (about 1 year ago), she saw a psychiatrist at the insistence of her husband
- Was first prescribed fluoxetine. This was chosen because her sister had done well on it for treatment of anxiety/depression
- After 2 months at a dose of 60 mg daily, she was switched to sertraline due to lack of response.
- About 4 months ago, she was referred to a therapist and began attending weekly visits
- She last saw her psychiatrist 3 months ago at which time sertraline was increased to 200 mg daily due to only partial relief of her symptoms at a lower dose. She was also started on PRN clonazepam for anxiety and reports using 1-3 times per week.
- Review of the prescription monitoring database results in no concern for misuse or abuse
- Currently denies symptoms consistent with mania, psychosis, or OCD now or in her past
- Drinks one glass of wine about 2-3 times per week until + home UPT when she completely stopped
- Denies passive death wish, SI, or HI. No thoughts or desires to harm the pregnancy. No access to any firearms.



What are the potential risks of untreated PTSD in pregnancy? What are the potential risks of untreated PTSD regardless of pregnancy status?

- Risks of PTSD in pregnancy—mixed from studies but most consistently have shown LBW, reduced rates of breastfeeding; evidence on association and/or impact on preterm birth, fetal growth, head circumference, mother–infant interaction are contradictory¹
- General risks of PTSD—Increased risk of SI/suicide attempts, substance use, increased rates of depression and anxiety, poor interpersonal and occupational functioning.

What are the recommended treatments for PTSD?

- First-line medications: sertraline, paroxetine, fluoxetine and venlafaxine.
- Trauma-focused psychotherapy alone often recommended for first-time treatment of PTSD in adults though access and availability might be a limiting factor
- In general, concurrent psychotherapy and medications are often superior to either alone
- If no response to first SSRI, may consider switch to different SSRI or venlafaxine
 - When switching antidepressant medication, most experts recommend a cross-titration over 2-4 weeks (depending on starting dose)
- Prazosin often adjunct for treatment of nightmares, hyperarousal
- VA clinical guidelines do not recommend benzodiazepines or cannabis for treatment of PTSD. In some states (PA included), PTSD is on the list of approved conditions for medical marijuana treatment.

What are your thoughts on the length of the patient's medication trial for PTSD? What is the recommended length of treatment for PTSD? What is a therapeutic trial of medication?

- 200 mg of sertraline appeared to achieve symptom resolution (considered a robust response), but she was only on it for 3 months. Evidence indicates patients should be on maintenance medication for at least 6 months to prevent relapse.
- Therapeutic trial is considered 8–10 weeks at **maximum tolerated dose** within therapeutic range (varies for different meds). Very important to consider when deciding to switch or augment medications and determining if a medication was truly trialed.



Case Study (continued)

- The patient reports she did not consult her psychiatrist before stopping all medications. This is partly because the psychiatrist left the practice and she hasn't been able to find another psychiatrist
- She is concerned the being on medication while pregnant will harm the baby or lead to miscarriage
- She feels bad enough that she took a clonazepam in order to get to this appointment
- At the same time, she does not want to experience the same symptoms she had following the birth of her son.
- She tearfully asks you what you recommend for her...



How would you address this patient's concerns? What approach would be best in this situation?

- Validation, empathy
- Review risks of untreated PTSD in pregnancy and, in general, impact on quality of life
 - Risks of untreated PTSD in pregnancy
 - Associated with low birth weight and reduced rates of breastfeeding
 - Contradictory or inconclusive data on association with preterm birth, fetal growth, head circumference, mother-infant interactions, child development
 - Untreated PTSD in general carries increased risk of comorbid depression, anxiety, substance use disorder, suicidality, impaired occupational and social functioning
- Risk/risk discussion regarding SSRI in pregnancy

Which SSRI would you recommend for this patient?

- Patient did well on sertraline so this would be first consideration though it was not explicitly stated if she had any side effects, which would be worth exploring.



What are the potential side effects of benzodiazepines and prazosin? What are the potential risks to a developing baby during pregnancy and after delivery?

Benzodiazepines:

- Physiological dependence, misuse potential, sedation, dizziness, impaired coordination, disinhibition, hypotension, confusion, depression, memory impairment, respiratory depression, rebound anxiety (more likely with shorter-acting benzodiazepines)
- No significant risk of somatic teratogenesis in cases of fetal exposure
 - Previous data suggesting association with oral clefting has not been shown in meta analyses
- Neonatal sequelae of maternal benzodiazepine use:
 - Neonatal withdrawal syndrome: Restlessness, hypertonia, hyperreflexia, tremulousness, apnea, diarrhea, vomiting
 - Floppy infant syndrome reported: hypothermia, lethargy, poor respiratory effort, feeding difficulties
 - Neurobehavioral impact of prenatal exposure is unclear but unlikely to be impacted based on the current data



What are the potential side effects of benzodiazepines and prazosin? What are the potential risks to a developing baby during pregnancy and after delivery? (continued)

Very little data on prazosin in pregnancy

- No increase in teratogenicity based on animal studies
- Reported cases of prazosin use during pregnancy are often in the setting of hypertensive disorders and/or co-administration with other anti-hypertensive agents. This limits ability to distinguish effects of prazosin therapy versus adverse effects of hypertensive disorder itself on gestational outcomes.

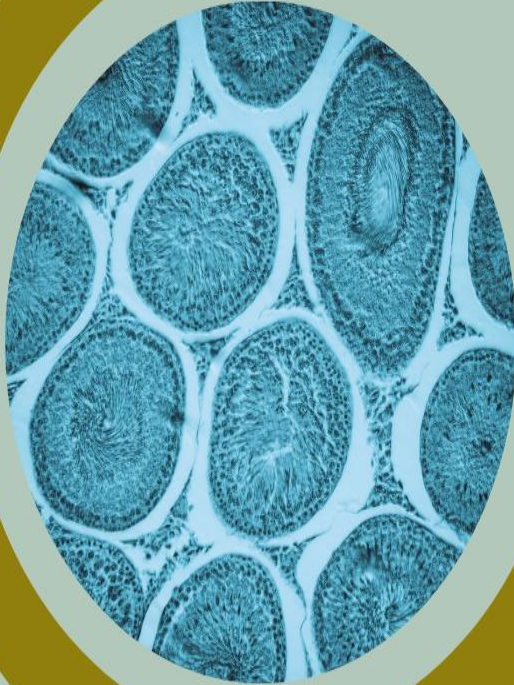


How would you counsel this patient about using benzodiazepines in pregnancy?

- Risk/benefit discussion; discuss side effects and risks as above
- Benzodiazepines are not generally recommended for treatment of PTSD, but are sometimes used in clinical practice for comorbid panic and anxiety symptoms
- If a benzodiazepine is clinically indicated and the patient did well on clonazepam, this is still a valid option



Case Study (continued)



- After risk/benefit discussion of medication versus untreated illness, the patient decides to restart sertraline since she has done well on it before.
- She asks if she can breastfeed on this medication. She did not breastfeed her son and wants to try with her second child.



What is an appropriate starting dose and titration schedule? What is a therapeutic dose?

- May consider starting dose of 25 mg daily x 5-7 days, then increase to 50 mg daily x 5-7 days, then increase to 100 mg daily. May continue for 4 weeks at 100 mg daily, then increase to 150 mg daily or above if still symptomatic
- Therapeutic range for sertraline is 50 mg-200 mg daily (250 mg sometimes used in practice and has provided benefit—mostly anecdotal).



Summary

- A history of trauma is common in reproductive age women, and may arise from prior early life trauma/adversity, sexual assault, intimate partner violence, traumatic childbirth/reproductive loss, or other exposure to other events.
- Screening for trauma and PTSD during routine obstetrical care can be accomplished with a validated screening tool such as the PCL-5.
- Following a positive screening test, patients should undergo a diagnostic assessment, ideally with a psychiatrist.
- Diagnostic criteria for PTSD include a specific constellation of symptoms lasting > 1 month, causing distress or disability, and not explained by a medical condition.
- Peripartum/postpartum PTSD is not a formal condition in the DSM-V, but should be a diagnosis considered in the context of a traumatic delivery.
- There are high rates of both overlapping symptoms as well as co-morbid mood, anxiety, or substance use disorders in patient with PTSD.
- The aim of treatment is to reduce levels of distress and improve function and quality of life with minimal adverse effects. First line treatment includes psychotherapy and SSRIs with a multidisciplinary approach.



Key references

Canfield, Dana MD; Silver, Robert M. MD Detection and Prevention of Postpartum Posttraumatic Stress Disorder, Obstetrics & Gynecology: November 2020 – Volume 136 – Issue 5 – p 1030-1035
doi: 10.1097/AOG.0000000000004093

ACOG Committee Opinion #825: Caring for Patients Who Have Experienced Trauma (April 2021)

ACOG Committee Opinion #547: Health Care for Women in the Military and Women Veterans (December 2012)

ACOG Committee Opinion #498: Adult Manifestations of Childhood Sexual Abuse (August 2011)

Ades, V; Wu, SX; Rabinowitz, E; Chemouni Bach, S; Goddard, B; Pearson A, Savannah; Greene, J . An Integrated, Trauma-Informed Care Model for Female Survivors of Sexual Violence, Obstetrics & Gynecology: 133(4), April 2019 – p 803-809



Resources

Information on how to perform a trauma-informed pelvic exam

- [Dr Lauren Owens: Trauma-Informed Care for the Obstetrician-Gynecologist](#)
- [Tillman, S. \(2020\), Consent in Pelvic Care. Journal of Midwifery & Women's Health, 65: 749-758.](#)

Didactic module: assessing and responding to trauma history in pregnant patients:

- [Stevens NR, Holmgren L, Hobfoll SE, Cvengros JA. Assessing Trauma History in Pregnant Patients: A Didactic Module and Role-Play for Obstetrics and Gynecology Residents. MedEdPORTAL. 2020;16:10925. Published 2020 Jul 20. doi:10.15766/mep_2374-8265.10925](#)

National Center for PTSD: [Sexual Trauma: Information for Women's Medical Providers](#)