



POSTPARTUM PTSD: PREVENTION AND TREATMENT

Project ECHO 2017

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Utah Maternal Mental Health Collaborative

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- www.utahmmhc.com
- Resources:
- Support Groups
- Providers
- Sx and Tx brochure/handouts
- Training
- Meets Bi-monthly on second Friday of the month.
- Email Amy-Rose White LCSW-
utahmmhc@gmail.com



Session Objectives

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- Understand primary diagnostic criteria

- Describe impact

- Differentiate between PP PTSD and PPD

- List risk factors

- Describe tx modalities

- Explain how ACES can aid prevention

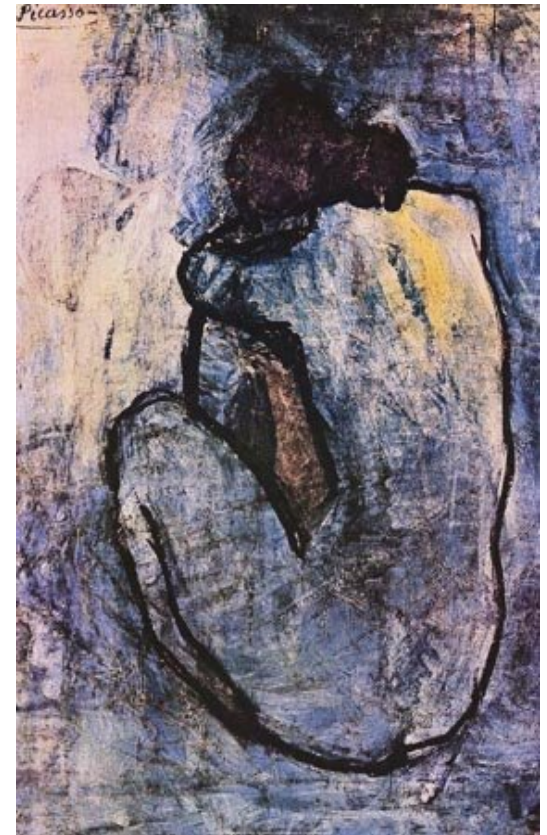
- List five approaches to minimizing risk

- List five resources for patients and professionals

Defining the issue:

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- ❑ What is Reproductive Trauma?
- ❑ Perinatal Mood, Anxiety, Obsessive Compulsive & Trauma Related disorders
- ❑ Postpartum PTSD- An anxiety disorder
- ❑ Why is it relevant to birth professionals?



Thanks for always
thinking about me to
the detriment of your
own mental health.

someecards



Reproductive Trauma in context

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- Reproductive trauma refers to any experience perceived as a threat to physical, psychological, emotional, or spiritual integrity related to reproductive health events.
- This includes the experience of suffering from a perinatal mood or anxiety disorder.
- The experience of maternal mental health complications is itself often a traumatic event for the woman and her entire family.

Common Reproductive Traumas

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- Unplanned pregnancy
- Pregnancy complications
- Difficult, prolonged, or painful labor
- Short intense labor
- Fetal medical complications
- NICU stay
- Infertility
- Abortion
- Miscarriage
- Stillbirth
- Maternal complications during/following delivery

Trauma Informed Birth Practices

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Consider:

PAST

PRESENT

FUTURE

- www.samhsa.gov/nctic/trauma-interventions ~ Trauma informed care federal guidelines
- ACE Study ~ Adverse Childhood Events Study > Development of health and mental health disorders
- <http://www.cestudy.org>
- Research on early stress and trauma now indicates a direct relationship between personal history, breakdown of the immune system, and the formation of hyper- and hypo-cortisolism and inflammation.

Inflammation & Perinatal Depression/Anxiety:

The new paradigm

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- Psychoneuroimmunology (PNI) = new insights
 - Once seen as one risk factor; now seen as THE risk factor underlying all others
 - Depression associated with inflammation manifested by
↑ pro-inflammatory cytokines
 - Cytokines normally increase in third trimester: ↑ vulnerability
 - Explains why stress increases risk
 - Psychosocial, Behavioral & Physical
- (Kendall-Tackett 2007 International Breastfeeding Journal, 2:6)
- Prevention and treatment to ↓ maternal stress & inflammation



Trauma Informed Birth Practices cont.

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Mindful of...

- ❑ Personal trauma history
- ❑ Comorbid health conditions ~ related inflammation
- ❑ Concurrent stressors
- ❑ Woman's perception of pregnancy, birth & early parenting
- ❑ Degree to which inflammatory process can be mediated
- ❑ Providing Psych-ed, concrete resources & follow up care ~ **EMPOWERMENT**



Did you know...

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- Postpartum Depression is the most common complication of childbirth.
- There are as many new cases of mothers suffering from Maternal Depression each year as women diagnosed with breast cancer.
- American Academy of Pediatrics has noted that Maternal Depression is the most under diagnosed obstetric complication in America.
- ***Depression is one of six common perinatal mental health diagnoses.***
- ***Postpartum PTSD is often misdiagnosed as PPD.***

Perinatal Mood, Anxiety, Obsessive, & Trauma related Disorders

Pregnancy and
the First year
Postpartum

- ❑ Psychosis- Thought Disorder or Episode
- ❑ Major Depressive Disorder
- ❑ Bi-Polar Disorder
- ❑ Generalized Anxiety
- ❑ Panic Disorder
- ❑ Obsessive Compulsive Disorder
- ❑ Post Traumatic Stress Disorder

Postpartum Post-Traumatic Stress Disorder (PPTSD) ~ An anxiety disorder

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5.6%-9%

(Creedy, Shochet, & Horsfall, 2000) (Beck, Gable, Sakala & Declercq, 2011).

18-34% of women report that their births were traumatic. (PTSE) A birth is said to be traumatic when the individual (mother, father, or other witness) believes the mother's or her baby's life was in danger, or that a serious threat to the mother's or her baby's ***physical or emotional*** integrity existed.

(Beck, et al. 2011)

(Simkin, 2011)

(Applebaum et. Al 2008)

POSTPARTUM PTSD

Secondary to traumatic labor/ delivery

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- ❑ “In the eye of the beholder”
(Beck, 2004)
- ❑ Full PTSD in 0.2-9% of births
- ❑ Partial symptoms in about 25% -35% of births
- ❑ Often mistaken for PPD
- ❑ Not a separate diagnostic category in the DSM V



POSTPARTUM PTSD

Three primary influences:

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1. Traumatic labor/ delivery
2. Prior traumatic event
3. Neonatal complications

(Beck 2004)



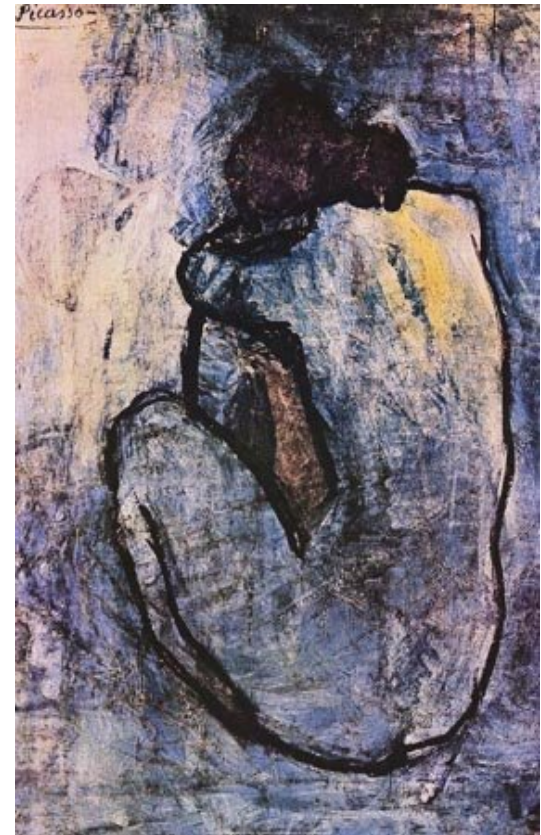
Risk Factors

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Higher risk populations :

- African-American women
- Non-private health insurance
- Unplanned pregnancies
- Trauma survivors

Simkin (2011)



Risk: Thinking styles correlated with perinatal anxiety disorders

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- Perfectionistic tendencies
- Rigidity (an intolerance of grey areas & uncertainty)
- An erroneous belief and pervasive feeling that worrying is a way of controlling or preventing events

(Kleiman & Wenzel, 2011)

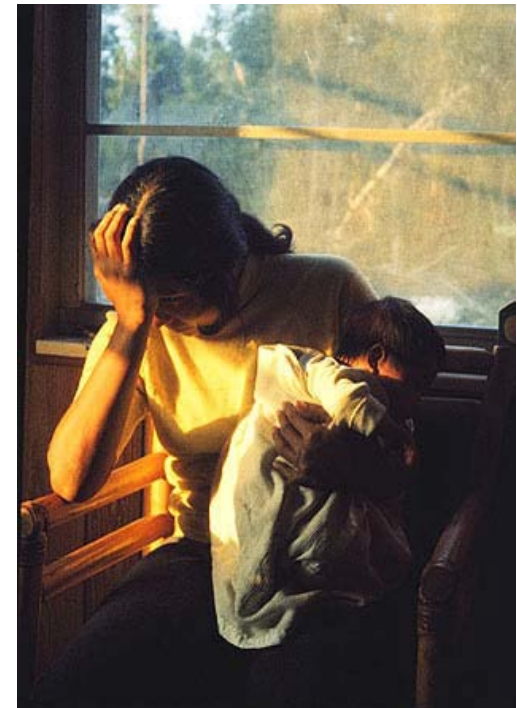
- An erroneous belief that thoughts will truly create reality
- An underlying lack of confidence in one's ability to solve problems
- Intrusive thoughts – such as from post-traumatic stress
- Poor coping skills

POSTPARTUM PTSD

Primary symptoms ~ all three primary influences

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- Intrusive re-experiencing of past traumatic event
 - Visions, flashbacks, nightmares
- Hyperarousal, hypervigilance
- “Emotional numbing”
- Avoidance of reminders of childbirth
- Self-isolation
- Lack of concentration
- Anger, irritability, mood swings
- Insomnia – Night sweats
- Can occur weeks or months post birth
- “Delayed onset”



Additional common sx

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- Feelings of impending doom or imminent danger
- Guilt
- Suicidal thoughts
- Depersonalization - Feeling a sense of unreality and detachment

Intrusion symptoms

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- Repetitive re-experiencing of the birth trauma through flashbacks, nightmares, distressing recollections of the birth experience, and psychological distress following birth.

Avoidance symptoms

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- Attempts to avoid reminders of the birth experience such as doctors offices as hospitals, people associated with birth experience (sometimes including the baby), thoughts about the birth experience.

Increased arousal symptoms

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- Difficulty sleeping, heightened anxiety, irritability, and concentration challenges.

(Beck et al. 2011)

POSTPARTUM PTSD

Secondary to traumatic labor/ delivery

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Five essential themes:

1. “Going to the movies”
2. “A shadow of myself”
3. Seeking to have questions answered and needing to “talk, talk, talk”.
4. Dangerous trio of anger, anxiety, & depression: spiraling downward
5. Isolation from world of motherhood: “Dreams shattered”

(Beck, 2004)

Trapped in flight, flight or freeze...

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Lizard Brain

- Limbic system over-activated.
- Difficulty accessing self-soothing strategies



Amy-Rose White LC

Wizard Brain

- Prefrontal cortex engaged. Central nervous system soothed.



Risk factors related to delivery

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- ❑ Major hemorrhage
- ❑ Severe hypertensive disorders (preeclampsia/eclampsia)
- ❑ Intensive care unit admission
- ❑ NICU stay
- ❑ Unplanned Cesarean

Jukelevics, N. (2008)



Contributing risk factors cont.

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- Unexpected hysterectomy
- Perineal trauma (3rd or 4th degree tear)
- Cardiac disease.
- Prolapsed cord
- Use of vacuum extractor or forceps

Jukelevics, N. (2008)

POSTPARTUM PTSD

Risk cont.

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- ❑ Feeling out of control during labor
- ❑ Blaming self or others for difficulties of labor
- ❑ Fearing for self during labor
- ❑ Physically difficult labor
- ❑ Extreme pain
- ❑ Fear for baby's well-being
- ❑ High degree of obstetrical intervention



(Furuta, Sandall, Cooper, & Bick (2014)

Primary psychological themes

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- Fear of unsafe care
- Lack of choice regarding routine medical procedures
- Lack of continuity of care providers
- Care being based solely on delivery outcome

(Beck, 2004).

POSTPARTUM PTSD

Risk factors secondary to prior trauma

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- ❑ Sx related to past trauma triggered by childbirth
- ❑ Hx of emotional, physical abuse or neglect
- ❑ Hx of sexual abuse
- ❑ Hx of rape
- ❑ Hx of PTSD
- ❑ ACEs score significant

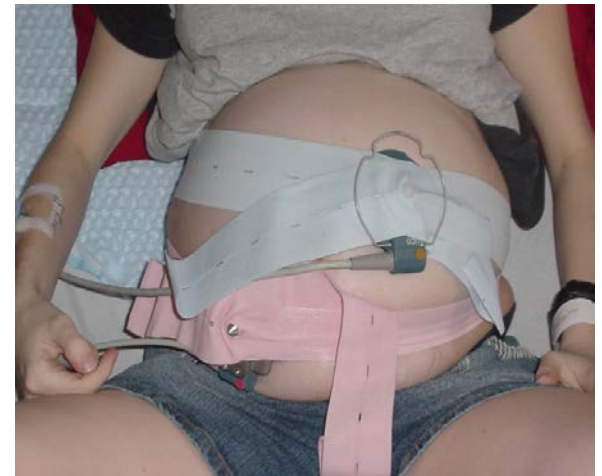


POSTPARTUM PTSD

Risk factors secondary to neonatal complications:

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- Greater severity of neonatal complications ↑
- Lower gestational age
- Greater length of stay in NICU
- Stillbirth
- Significant in fathers as well



NICU Families at risk

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- PTSD preterm delivery 7.4%
- PTSD and major depressive disorder is 4 fold increase in prematurity 2654 women
- Mothers- 15%-53%
- Fathers- 8%-33%
- <http://www.preemiebabies101.com>

PTSD or Depression? Or both?

PTSD or Depression?

Symptoms for post-traumatic-stress disorder, or PTSD, differ from post-partum depression, and can be severe.

PTSD

- The person persistently re-experiences the traumatic event (in this case childbirth) in one or more of the following ways: recurrent and intrusive distressing recollections of the event; recurrent distressing dreams and nightmares; flashbacks; intense psychological distress and/or physiological reactivity on exposure to cues that resemble the traumatic event.
- Persistent avoidance of stimuli associated with the traumatic event and numbing of general responsiveness as indicated by efforts to avoid thoughts/activities/places or people that arouse recollections of the trauma; feelings of detachment.
- Persistent symptoms of increased arousal, including difficulty falling or staying asleep; irritability or outbursts of anger; difficulty concentrating; hypervigilance; exaggerated startle response.

Post-partum depression:

- Depressed mood
- Diminished interest or pleasure in activities
- Sleeping/eating disturbances
- Anxiety/insecurity
- Emotions on a roller coaster
- Fatigue or loss of energy
- Guilt
- Diminished ability to concentrate
- Loss of self (not normal self, don't feel real)
- Recurrent thoughts of death, suicidal ideation

Sources: DSM IV-Text Revision (2000); American Psychiatric Association; Cheryl Beck of University of Connecticut School of Nursing.

POSTPARTUM PTSD

Impact

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- ❑ Avoidance of aftercare and related trigger
- ❑ Primary reminder of the birth?? The infant
- ❑ Impaired mother-infant bonding
- ❑ Sexual dysfunction
- ❑ Avoidance of further pregnancies
- ❑ Symptom exacerbation in future pregnancies
- ❑ Elective C-sections in future pregnancies

Gardner, P (2003)

POSTPARTUM PTSD

Subsequent Pregnancy

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- ❑ Different care providers
- ❑ Different birthing location
- ❑ Emphasis on relationship development with providers
- ❑ Comprehensive birth planning around unique needs

(Beck & Driscoll, 2006)



Potential impact of nursing on mothers with PTSD and/or depression

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- PNI research suggests that the natural inflammatory response on pregnancy, combined with inflammatory process such as stress and pain, i.e.: nipple pain, can increase risk and severity of symptoms.
- When nursing is going well = protective.
- When nursing is very stressful and/or painful = increased risk.
- For trauma survivors: “One more thing to be violated”.
- Dangerous mix: birth trauma and insufficient milk supply

Kendall-Tackett (2015)

Postpartum Hemorrhage:

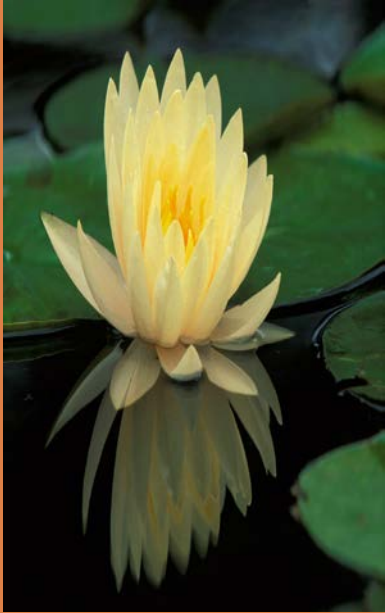
A physician/pt's story:

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- “In the months after my son’s delivery, it was as if a curtain had descended over my life. In addition to a terrible feeling of numbness, I was haunted by flashbacks and nightmares about what had happened. Billboards for the hospital where I’d delivered, people dressed in scrubs, pregnant women, a favorite red velvet cake that now resembled to me a large blood clot and, worst of all, my own baby—the sight of any of these could trigger flashbacks and bouts of heart-stopping, sweat-drenched panic.”
- For my postpartum checkup, I saw a new obstetrician, who listened uncomfortably to my tearful story and ultimately dismissed my symptoms as hormone-induced baby blues, “Mother Nature’s way of kicking women when they’re down.”

Screening Instruments

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- TES-B
- PSS-SR - Post-Traumatic Stress Disorder Symptom Scale
- Few birth trauma specific
- **Self-Assessment of Maternal Distress After a Difficult Birth** ~ Penny Simkin and Phyllis Klaus
- Edinburgh Postnatal Depression Screen

Evidenced based treatment modalities

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- EMDR
- MBCBT
- Supportive Psychotherapy
- Trauma Focused Psychotherapy
- Medication
- Social Support



Note:

- Exposure therapy may be re-traumatizing for perinatal women and contraindicated (Bennett 2007)

Psychotropics - Helpful adjunct to ameliorate hypervigilance, insomnia, hyperarousal

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- SSRIs –

(Zoloft, Lexapro, Prozac)

Multiple sx reduction & comorbid depression

- Adrenergic agents

(Clonidine, Propranolol)

Blocks norepinephrine, lowers nightmares and intrusive thoughts

(Kendall-Tackett 2007)

- Anticonvulsants

(Valproic acid)

Decreases hyper-arousal, intrusive images, numbing, hyperarousal

- Anti-psychotics

(Quetiapine, Risperidone)

Appropriate for psychotic sx and/or co-morbid psychosis.

- SARIs

(Trazadone)

Decreases nightmares

Somatic Treatments

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- ❑ Adequate sleep
- ❑ Exercise, yoga
- ❑ Support groups
- ❑ Body work/massage
- ❑ Craniosacral therapy
- ❑ Journaling
- ❑ Art therapy





Trauma Informed Birth Practices

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SAMSA Trauma Informed Care Guidelines

- Realizing
- Recognizing
- Responding
- Re-traumatization minimization



Trauma Informed Birth Practices

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Mindful of...

- ❑ Personal trauma history
- ❑ Comorbid health conditions ~ related inflammation
- ❑ Concurrent stressors
- ❑ Woman's perception of pregnancy, birth & early parenting
- ❑ Degree to which inflammatory process can be mediated
- ❑ Providing Psych-ed, concrete resources & follow up care ~ **EMPOWERMENT**

PTSD Prevention

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Talk about it!

- Goal is to educate, empower, plan and acknowledge the enormity of pregnancy, birth, and early parenting without frightening women.
- Primary emphasis on this time as an emotional one and staying mindful of contributing influences

Prevention and Treatment: Wellness Planning

45

- **S**leep
- **N**utrition
- **O**mega-3
- **W**alk
- **B**aby breaks
- **A**dult time
- **L**iquids
- **L**aughter



See www.utahmmhc.org

Let's put the kids to
bed early tonight, turn
on some music, and
sleep like crazy.



somee cards

the mom . com

+ Concrete interventions: Screen

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- Hx of trauma ~ ACE questionnaire
- Co-morbid medical conditions
- Con-current or recent stressors
- Recognize that new medical conditions amplify risk
- (Gestational diabetes, Group B Strep, etc.)

Even paper tigers bite!

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- Patients with a positive ACE score may be more likely to scan the environment for danger.
- Supporting women struggling with past PTSD in recognizing when their brain “over-estimates” a threat.



Understand & Educate prenatally cont.

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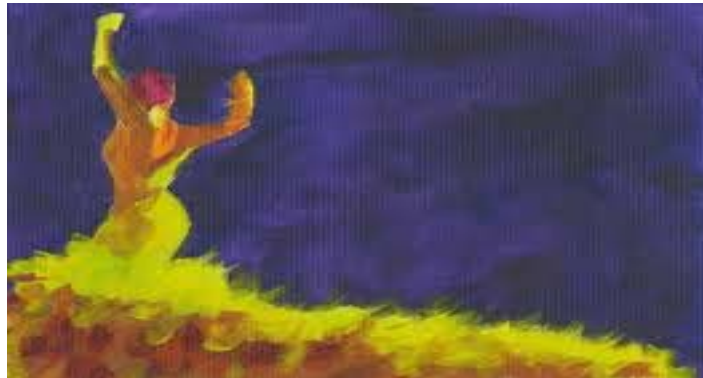
- What are her expectations?
- What are hospital practices?
- Plan B?
- Options and their pros and cons
- Explore her comfort when routines change?

- Explore fears & doubts
- Herself, team
- Her degree of desire for control
- Beliefs about pain
- Her planned coping strategies

Empower prenatally

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- Identify mantras to make adapting easier
- “Follow my baby where she takes me”
- “The sensation is strong and I am stronger”
- Answer questions
- EXPLAIN why & when medical decisions are usually made.
- Remind her of what choices she does have



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PP PTSD Prevention: Implications for Clinical Practice During Birth

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- Studies highlight the importance of the *mother's perception* of her childbirth.
- The number of hours in labor is less important than whether or not the mother felt that her labor was prolonged.
- Similarly, the mother's experience of whether or not complications occurred carries more weight than the obstetrician's perceptions of whether or not complications occurred.
- Higher ratings of reported sense of control during labor and delivery appeared to partially mediate the risk of PTSD symptoms.
- Thus researchers call for individually tailored obstetric care, hypothesizing that by increasing women's sense of control during labor and delivery, we may help to protect them from PTSD symptoms later on.

-Ruta Nonacs, MD PhD MGH Center for Women's Mental Health 2014

PP PTSD Prevention: General guidelines

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- Note potential predictors of PTSD: high level of intervention during labor ~ All NICU families!
- Screen for and recognize symptoms of trauma or history of PTSD and/or abuse
- Labor can be re-traumatizing- Guard and protect for this
- Provide de-briefing sessions
- Treat each woman as if she were a survivor of trauma
- Tease out what may look like Postpartum Depression/ Anxiety but is actually PTSD

(Beck & Driscoll 2006)

PTSD Prevention in summary

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Talk about it!

- Goal is to educate, empower, plan and acknowledge the enormity of pregnancy, birth, and early parenting without frightening women.
- Primary emphasis on this time as an emotional one and staying mindful of how she is feeling.
- Reach out for support!

Prevention

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During the Birth

- Explain changes, offer information, CHOICE
- Involve pt in decision making as much as possible
- Acknowledge challenges as real
- Offer praise for flexibility

Postpartum

- Review birth and why things went the way they did
- Answer questions
- Reframe feelings of failure

Treatment:

Recognizing sx and referring

- Important regardless of role (MD, Doula, CPW, RN, etc.)
- Key messages;
- While well-“I want you to tell me if you don’t feel like yourself”
- When symptomatic- “I know what this is & I know how to help you get better”
- Holding environment
- Solution focused
- Practical
- Establish presence of “expert”
- “You are not alone”, “You are not to blame”, “You will recover”
- Your well-being is as important as baby’s

Key Message:

“You are not alone”

“You are not to blame”

“You will get better”

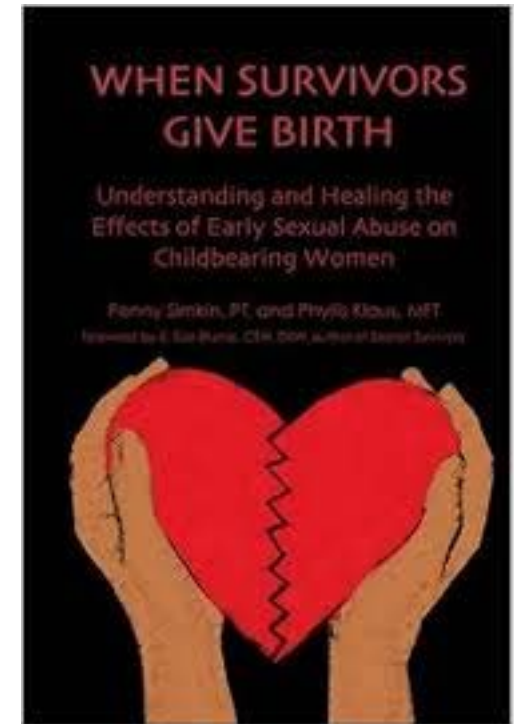
PP PTSD prevention in sexual abuse survivors

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Birth Counseling

- Avoiding re-traumatization
- Opportunity for birth as healing
- Doula Care

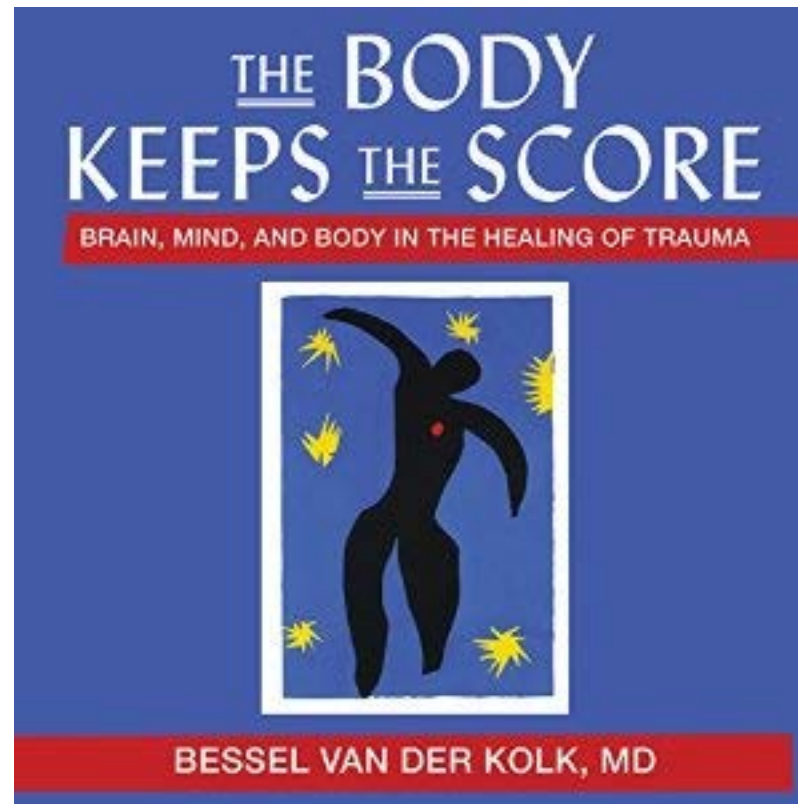
**“When survivors give birth:
Understanding & healing the effects
of early sexual abuse on
childbearing women” Penny Simkin,
PT & Phyllis Klaus, CSW, MFT (2004)**



“The Body Keeps the Score”

Bessel Van Der Kolk (2014)

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Utah Maternal Mental Health Collaborative

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PP PTSD Resources:

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- <http://pattch.org> ~ Prevention and Treatment of Traumatic Birth – PATTCh
- www.tabs.org.nz ~ Trauma and Birth Stress New Zealand
- www.solaceformothers.org ~ Support groups, stories, referrals etc.
- www.postpartum.net ~ Postpartum Support International
- www.womensmentalhealth.org ~ MGH Center for Women's Health

PMAD resources

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- www.utahmmhc.com - Utah Maternal Mental Health Collaborative. Interagency networking, resource and policy development. See website for many resources, free support groups, etc.
- www.postpartum.net - Postpartum Support International. 2020mom partner and largest perinatal support organization. Resources and training for providers and families. Free support groups, phone, and email support in every state and most countries.
- <http://www.mmhcoalition.com> -National Coalition for Maternal Mental Health- Social Media Awareness Campaign, ACOG, private & non-profit.

Provider Resources

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- ❑ www.samhsa.gov/nctic/trauma-interventions ~ Trauma informed care federal guidelines
- ❑ <http://pattch.org> ~ Prevention and Treatment of Traumatic Birth
- ❑ <https://blogs.city.ac.uk/birthptsd/> ~ International network for perinatal PTSD research
- ❑ http://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth/en/ ~ Prevention and elimination of disrespect and abuse during childbirth: WHO position statement
- ❑ www.2020momproject.org -California Maternal Mental Health Collaborative.
- ❑ www.mededppd.com - CDC sponsored site with a care algorithm and online CEUs for providers as well as a portal for families.
- ❑ <http://www.mmhcoalition.com> -National Coalition for Maternal Mental Health- Social Media Awareness Campaign, ACOG, private & non-profit.
- ❑ www.womensmentalhealth.org MGH Center for Women's Mental Health: Reproductive Psychiatry Resource and Information Center. Harvard Medical School.
- ❑ www.motherisk.org Medication safety and resources.



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