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Postpartum Post Traumatic Stress Disorder

Misty M. Ginicola, Ph.D., LPC, Southern Connecticut State University
Melissa Kish, BS, MA, Southern Connecticut State University

DESCRIPTION OF POSTPARTUM PTSD

Over 40% of women report that their labor was traumatic; however, a small percentage experience trauma that leads to the development of Post Traumatic Stress Disorder (PTSD) symptoms following the labor and delivery experience. The exact prevalence of Postpartum PTSD depends on the presence of significant risk factors, such as experience of prenatal depression or anxiety symptoms, a high-risk pregnancy, a history of other mental health diagnoses, childhood sexual abuse, and other traumatic experiences (Beck et al., 2013; Shlomi, Dulitzky, Margolis-Dorfman, & Simchen, 2016). For women without many risk factors, postpartum PTSD rates are approximately 3% of the population; however, for those who carry significant risk factors, prevalence rates are over 15% (Grekin & O'Hara, 2014).

In terms of prevention, diagnosis and treatment, it is important to identify pertinent risk factors, with the caveat that not all risk factors are equal. For example, a significant risk factor is a history of trauma, which can trigger emotions and subsequent traumatic reactions during pregnancy, labor, and birth; it can also specifically trigger the PTSD symptoms associated with previous trauma (Wosu, Gelaye, & Williams, 2015). In terms of trauma associated with the labor and delivery experience itself, two factors seem to play a significant role in the development of Postpartum PTSD – experiencing a real, or perceived life-threatening event, and experiencing negative interactions with health providers. These risk factors are discussed in more detail below, with a common thread being that the mothers experienced high states of anxiety, fear, lack of control, and helplessness during these encounters (Beck, 2004; Polachek et al., 2012).

First, experiencing a life-threatening experience during labor and delivery, such as Preeclampsia/HELLP, emergency c-section, preterm birth, and infant loss strongly predicts Postpartum PTSD (Andersen et al., 2012). It is noteworthy that in cases of infant loss, lack of good levels of social support is most related to intense and prolonged grief and traumatic reactions (Badenhorst & Hughes, 2007). Similarly, lack of support and control during delivery also strongly predicts postpartum PTSD symptoms (Andersen et al., 2012). Experiencing previous painful births and experiencing a long or arduous labor are both identified as a smaller risk factors for postpartum PTSD (Andersen, Melvaer, Videbech, Lamont, & Joergensen, 2012; Polachek et al., 2012).

Second, the perceived quality of interactions with health care providers, specifically negative, demeaning or abusive relations, strongly predicts the onset of postpartum PTSD (Andersen et al., 2012; Polachek, Harari, Baum, & Strous, 2012; Grekin & O'Hara, 2014). Women who experienced abuse at the hands of their health care providers reported feeling silenced, ignored, unimportant, violated, and betrayed (Beck, 2004). These experiences usually include a provider or providers

treating the laboring mother with dehumanizing and demeaning treatment that may include verbal threats such as threatening medical interventions if the mother does not comply with instructions or her labor does not progress (Beck, Driscoll, & Watson, 2013). Other common experiences include providing medical interventions without consent (e.g., an episiotomy, breaking the woman's amniotic sac, inserting a catheter) and not taking the woman's input seriously (e.g., experiencing severe pain indicating something is wrong and being ignored; Beck et al., 2013). Many experiences include a provider invading a woman's privacy (e.g., removing clothing and performing vaginal exams without asking) and other unethical medical practices (e.g., coercing or preventing women from receiving medical interventions such as an epidural or a C-section; Beck et al., 2013).

Postpartum PTSD is diagnostically the same as PTSD, as identified by the DSM-5 (American Psychiatric Association, 2013); however, postpartum PTSD differs from other forms of PTSD in significant ways (Ayers, Joseph, McKenzie-McHarg, Slade, & Wijma, 2008). For example, traumatic symptoms can be worsened by the physiological changes and hormonal shifts a postpartum mother experiences. Additionally, triggers for individuals with PTSD can be typically viewed as joyous occasions for others (e.g., reminders of the birth, or the child's birthday; Ayers et al., 2008). The mother may also experience reminders of the trauma when she interacts with her partner, her baby and health care staff (Ayers et al., 2008). In addition, physically healing from the labor experience, receiving congratulatory messages surrounding the birth of the baby, and going to doctor's appointments may serve as additional triggers (Ayers, et al., 2008). These negative feelings can cause the mother to experience additional guilt and shame because although she loves her baby, the baby is a simultaneous reminder of the trauma (Ayers et al., 2008).

The prognosis of postpartum PTSD is predicted by the severity of symptoms at onset, lack of social support, high levels of neuroticism, insomnia, history of sexual assault and the presence of multiple negative life events (Garthus-Niegel, Ayers, von Soest, Torgersen, & Eberhard-Gran, 2015). Mothers with a child abuse or neglect history are also more likely to experience impaired bonding with their infant after being diagnosed with postpartum PTSD.

Resources for Postpartum PTSD:

http://www.midwiferytoday.com/articles/healing_trauma.asp
http://www.postpartum.net/learn-more/postpartum-post-traumatic-stress-disorder/
http://www.birthtraumaassociation.org.uk

IDENTIFICATION/ASSESSMENT STRATEGIES

Postpartum PTSD can be assessed clinically with DSM-5 symptom criteria (APA, 2013) and other traditional PTSD measures. There is only one formal assessment tool created to assess postpartum PTSD in research: the Perinatal PTSD Questionnaire (PPQ; Quinnell & Hynan, 1999). The PPQ has been used in several studies of postpartum PTSD, as its questions are directly related to birth trauma (Ayers & Pickering, 2001). The PPQ has 14 yes or no questions, directly assessing intrusive thoughts of the trauma surrounding the birth, avoidance of reminders of the trauma, and increases in arousal (Quinnell & Hynan, 1999). The PPQ has excellent test-retest reliability ($r = 0.92$) and good internal consistency ($\alpha = 0.85$), with significant convergent validity demonstrated with the Impact of Events Scale; DeMier, et al., 1996). It should be noted that this original measure was not

meant to provide a diagnosis on its own; rather it is a tool that researchers utilized to help predict outcomes involved with peripartum PTSD symptoms.

Fortunately, this scale was later modified into a 5-point Likert scale (scored 0 to 4), with items assessing the experience of PTSD symptoms related to childbirth during a time frame of 4 to 18 months postpartum (Callahan, Borja & Hynan, 2006). The modified PPQ scores range from 0-56, assessing for symptoms across three diagnostic components of PTSD, including intrusion, avoidance, and hyperarousal symptoms. Callahan and colleagues proposed that the modified PPQ can serve as a screening tool for referral to mental health services by doctors, with a cutoff score of 19 correctly identifying mothers that need to be referred for therapy. This scale can also be used as a discussion-starter in a counseling session. The modified assessment has both significant convergent and divergent validity.

Resources for Assessment of Postpartum PTSD:

Perinatal PTSD Questionnaire: http://www.neonatenurses.com/includes/perinatal_posttraumatic_stress_disorder_questionnaire.pdf

INTERVENTION STRATEGIES

The literature is limited in terms of intervention research on this population. The literature indicates several potential treatment strategies, many which overlap with treatment of non-postpartum PTSD. However, these strategies are focused particularly on the birth experience and postpartum concerns.

Birth Trauma Counseling

Birth trauma counseling, involves working with a provider to discuss the birth experience, validate feelings, and help understand what happened and why it occurred (Gamble & Creedy, 2009). Processing what happened and what could have been managed differently may give the client a sense of control (Gamble & Creedy, 2009). It is noteworthy that if the provider was the source of the trauma, processing the medical details with the counselor may not be particularly helpful. Instead, the counselor may wish to have the client consult with a trained and certified doula (trained labor and delivery assistant who focuses on taking care of the physical and emotional needs of the mother) or childbirth educator may be a better approach (Ahlemeyer & Mahon, 2015; Philips & Kelly, 2014).

Cognitive Behavioral Therapy

As with non-postpartum cases of PTSD, CBT is likely an effective approach for treatment. Case studies indicate that Cognitive Behavioral Therapy has been effective in the treatment of Postpartum PTSD (Ayers, McKenzie-McHarg, & Eagle, 2007; Institute of Medicine, 2012). Because most experiences of Postpartum PTSD involve shame, guilt and negative thoughts about the birth experience, addressing these thoughts can be beneficial. Examples of some irrational beliefs experienced by the mother are that her body has failed, that "good" mothers are able to deliver vaginally and breastfeed immediately, or that the mother is responsible for violations that occurred by providers.

Eye Movement Desensitization & Reprocessing

Eye Movement Desensitization and Reprocessing (EMDR) has some preliminary support as an effective treatment (Beck et al., 2013; Sandstrom, Wiberg, Wikman, Willman, & Hogberg, 2008; Wijma, Soderquist, & Wijma, 1997). Processing the delivery experience is the main focus using EMDR. However, including relevant experiences after the delivery that may contribute to the overall postpartum trauma, such as not being able to bring an infant home from the hospital and struggling with breastfeeding or attachment, may also be beneficial.

Self Care

Clinically, Beck and colleagues (2013) report using the NURSE plan with clients, which is a detailed self care plan model. This model guides counselors in their discussion with and support of clients to treat their PTSD symptoms. The Nurse plan incorporated the client's Nourishment and Needs (meals, medications, fluid intake, and vitamins), Understanding (therapy sessions where it was a safe place to share thoughts and feelings), Rest and relaxation (getting support with the children to get enough sleep and rest), Spirituality (incorporating the client's religion or spiritual beliefs), and Exercise (remaining physically active). Although this response seems promising, beyond clinical reports, there is no empirical studies of this approach. However, many new mothers may overlook caring for themselves, which is a crucial component of their maternal wellbeing (Fahey & Shenassa, 2013).

Interpersonal Therapy

Interpersonal Psychotherapy (IPT) is an effective therapeutic intervention with other postpartum mental health diagnoses (Claridge, 2014) and is successful in treating PTSD from other trauma etiologies (Stuart & Robertson, 2012). IPT also appears that it would be helpful with Postpartum PTSD, as research indicates that building a client's resiliency can serve as a buffer to their PTSD symptoms (Sexton, Hamilton, McGinnis, Rosenblum, & Muzik, 2015). Following the creation of a therapeutic alliance, the counselor should begin with helping the client identify interpersonal difficulties and communication problem areas that are adding to the client's distress (Stuart & Robertson, 2012). The counselor utilizing IPT assists the client to identify and express emotions and process past history and emotional difficulties (Stuart & Robertson, 2012). IPT involves psychoeducation and facilitation of plans to increase level of social support and self-care (Stuart & Robertson, 2012). Exploring the themes that are involved in postpartum distress may also be helpful. These postpartum themes may include conflicted feelings towards the infant, identity change, quality of relationship with partner, self-confidence, and changing relationships with family and friends (Miniati et al., 2014).

Resources:

Traumatic Childbirth: http://www.amazon.com/Traumatic-Childbirth-Cheryl-Tatano-Beck/dp/0415678102/ref=sr_1_1?ie=UTF8&qid=1447729651&sr=8-1&keywords=traumatic+childbirth

EMDR: http://www.emdr.com/

Interpersonal Psychotherapy Clinician's Guide: http://www.amazon.com/Interpersonal-Psychotherapy-2E-Clinicians-Guide/dp/1444137549/ref=sr_1_2?s=books&ie=UTF8&qid=1447818181&sr=1-2&keywords=interpersonal+psychotherapy

Resources for Clients

Trauma and Birth Stress Resources: http://www.tabs.org.nz/
Solace for Mothers: http://www.solaceformothers.org
Online Support Groups: http://www.postpartum.net/psi-online-support-meetings/
Heal Your Birth Story: http://www.amazon.com/Heal-Your-Birth-Story-unexpected-ebook/dp/B0108GGHTI/ref=sr_1_2?ie=UTF8&qid=1447728053&sr=8-2&keywords=postpartum+PTSD
Birth Trauma: http://www.amazon.com/Birth-Trauma-Post-Traumatic-Disorder-Following/dp/0956702473/ref=sr_1_3?ie=UTF8&qid=1447729685&sr=8-3&keywords=traumatic+childbirth

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