Perinatal Posttraumatic Stress Disorder (PTSD)

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Perinatal PTSD

Common: prevalence 4-6%; higher rates 1-6 months postpartum; 18% if risk factors for PTSD

Risk factors

Subjective experience of childbirth (negative emotions or experience of labor, loss of control, fear of childbirth for self and/or baby)

Maternal mental health (prenatal depression, perinatal anxiety, postpartum depression)

Trauma history and PTSD (previous traumatic events, childhood sexual trauma, prenatal PTSD, previous traumatic birth experience)

Delivery mode and complications (emergency C-section, complications with pregnancy and/or baby)

Screening

PTSD Checklist Civilian (PCL-5): positive screen > 33, self-report, used in the perinatal population but not specifically validated

Perinatal Posttraumatic Stress Disorder Questionnaire (PPSDQ/PPQ): positive screen >19, self-report, specific diagnostic tool for perinatal PTSD but not widely used
Screen for comorbidities: depression (highly comorbid), anxiety, substance use

Assessing DSM-5 criteria for PTSD

Traumatic event/Trauma exposure
Duration >1 month, Distress/Impairment
Symptom criteria
≥1 intrusion (flashbacks, nightmares) *and*
≥ 1 avoidance (trauma reminders*) and*
≥ 2 cognitions/mood (detachment, anhedonia, negative emotions) *and*
≥2 arousal (hypervigilance, sleep difficulties)

Risks of untreated PTSD

Risks to mother: avoidance of prenatal care and postpartum checks, postpartum depression, substance use, preterm labor, fear of childbirth (tokophobia)

Risks to fetus: lower birth weight, preterm birth, negative impact on mother-infant bonding, lower rates of breastfeeding

Guidelines for management of perinatal PTSD (if PCL-5>33 and/or clinical diagnosis of PTSD)

First-line evidence-based therapies: SSRIs, Trauma-focused psychotherapies (TFPT)
Initiate SSRI if TFPT not available, not preferred or not appropriate
Other interventions: education, Imagery rehearsal therapy (IRT), CBT-I, non trauma-focused therapy, social support

Evidence-based trauma-focused psychotherapies:

all effective in reducing PTSD symptoms

- Exposure therapy (ET): effective in postpartum women regardless of whether birth was objectively traumatic
- Trauma-Focused Cognitive Behavioral Therapy (TFCBT): effective for women at risk for experiencing a traumatic birth
- Eye Movement Desensitization and Reprocessing (EMDR): could be especially effective for hyperarousal

Avoid starting prazosin (adjunctive agent for PTSD-related nightmares) **during pregnancy and lactation:**

- few reports from hypertension treatment during pregnancy
- no safety data in pregnancy and lactation
- case report of a patient who had symptoms consistent with hypotension with a dose increase of prazosin in the first trimester. The fetus died and had multiple malformations consistent with hypoxia.
- consider risk/benefit analysis if pregnant while stable on prazosin; lower dose than usual if prescribed during pregnancy; monitor blood pressure carefully for hypotension.

Pharmacological treatment:

- SSRIs (sertraline, fluoxetine)
- Venlafaxine
- See medication table in Perinatal Depression Care Guide for information about SSRIs, venlafaxine

Interventions not effective: debriefing, counseling, trazodone, benzodiazepines