Postpartum PTSD

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Introduction

The experience of childbirth can be both amazing and traumatic for many individuals. Even without any abnormal occurrences, a birthing experience can be traumatic, leading to the development of Posttraumatic Stress Disorder (PTSD) (Hendrix et al., 2021). The prevalence of PTSD for postpartum women range from 3-15% (Miller et al., 2021). Also, many postpartum women report many symptoms of PTSD but do not meet the full criteria for diagnosis, which is estimated to be around 33% (Hendrix et al., 2021). It is important for providers to understand the implications of traumatic birthing experiences and risk of subsequent development of PTSD as it could assist in providing appropriate interventions needed to address symptoms. This literature review aims to discuss various treatment interventions for traumatic births and the prevention of PTSD. PICO question as is follows: In women who experienced a traumatic birth (P), does psychological interventions (I) prevent or reduce PTSD symptoms (O) compared to treatment as usual (C).

Background

Approximately 4-6% of women develop PTSD following giving birth (Ayers, 2017; Baptie et al., 2020). Symptoms can include intrusive memories and flashbacks of the birth, avoidance of hospitals, avoidance of getting pregnant again, and feelings of guilt, shame, fear, irritability, poor mother infant bonding, and increased risks of anxiety and cognitive and behavioral issues in the child (Baptie et al., 2020; Hendrix et al., 2021). Recognizing possible risk factors associated with birth trauma and PTSD can be helpful in understanding the origin and developing an effective treatment plan.

The highest correlated risk factors to developing PTSD included the woman perception of her birthing experience as negative, having surgical interventions, lack of support during the birthing experience, and dissociation (Ayers, 2017). Also, women who have a history of PTSD

prior to the traumatic birth are also at an increased risk (Martini et al., 2022). It should also be noted that even births without complications can result in postpartum PTSD, especially in the case where a mother views her birthing experience as poor or negative (Baptie et al., 2020; Hendrix et al., 2021). In postpartum PTSD, the ability to cope with stress is significantly impaired and there is a high level of comorbid depression.

Unlike many other postpartum complications, the ability exists to prevent postpartum PTSD (Ayers, 2017). Hence, it is understandable why preventative measures are needed to address the development of postpartum PTSD. Women who are at higher risk of developing postpartum PTSD warrants early interventions for the best outcomes.

Interventions

There are numerous clinical interventions to address PTSD following childbirth including psychotherapy, grief counseling, expressive writing, debriefing, and midwifery counseling (Miller et al., 2021). Resilience, meaning having the capacity to overcome adverse events, and post-traumatic growth, which refers to experiencing positive changes in beliefs or functional capacity as a result of overcoming a challenging life event, are both associated with more positive outcomes for women at risk for postpartum PTSD (Ayers, 2017). Providing support during labor and birth has been shown to reduce the risk of developing postpartum PTSD and increasing the capacity for resilience. It has also been shown that having a supportive environment, including support from the mother's healthcare providers during the birthing experience, has been identified as a protective barrier against potentially negative outcomes, including postpartum PTSD.

Timing of interventions targeting the prevention of PTSD symptoms following traumatic births is imperative to treatment outcomes (Miller et al., 2021). Early interventions should be administered in the days, weeks, and within the first three months following a traumatic birth to

prevent the accumulation of unprocessed traumatic memories. Treatment guidelines for postpartum PTSD include the use of eye movement desensitization and reprocessing (EMDR) as a first line treatment (Hendrix et al., 2021). The timing of providing EMDR in the postpartum period to prevent PTSD has been suggested to take place between four weeks and three months following the traumatic birth, which is considered to be an early intervention (Hendrix et al., 2021; Miller et al., 2021).

It is recommended that Trauma Focused CBT and prolonged exposure therapies can be administered up to four weeks after the traumatic birth and EMDR can be administered after four weeks from the date of the traumatic birth to be an effective intervention. Other findings have demonstrated that midwifery or clinician led interventions delivered within 72 hours of a traumatic birth is more effective at treating and reducing the symptoms of PTSD compared to care as usual (Miller et al., 2021). There is insufficient data to support the idea of providing high intensity early psychological treatment interventions. Interestingly, there is not sufficient evidence supporting the concept of providing universal multiple session interventions to any individual exposed to traumatic events, regardless of their symptomology, in an effort to prevent PTSD.

Conclusion

It is imperative that clinicians have an understanding of birth trauma and postpartum PTSD so a mother can be provided with the most clinically appropriate interventions available. This literature review was helpful in identifying the etiology, risk factors, possible signs and symptoms, and treatment interventions for postpartum PTSD. While this review did help to answer the PICO question, there were mixed reviews as to the recommended therapies and timing of these interventions, but it is noteworthy that most early interventions had positive outcomes for reducing the risk of developing postpartum PTSD following a traumatic birth.

Based on this literature review's initial findings, some points of interest for further research would include what types of interventions could be provided during the labor experience to prevent a traumatic birthing experience. Being that so many births, which are classified as routine, uncomplicated deliveries, are still reported as being traumatic, this warrants further attention and action to address these issues. If perception has such a significant impact on classifying a birth as being traumatic, providers need to be better equipped and educated to provide a healthy birthing environment for a more satisfying birthing experience. This could take the form as cultural sensitivity training, implicit bias training, general education for improved patient and family education initiatives, the list could go on. The hope is that with more knowledge, there will be better outcomes.

References

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