Perinatal Posttraumatic Stress Disorder (PTSD)

Carmen Croicu, MD

Perinatal PTSD

Common: prevalence 4-6%; higher rates 1-6 months postpartum; 18% if risk factors for PTSD; rates of PTSD are as high as 24 % for women from racial minority groups, teens, and those of lower socioeconomic status

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): 20-item self-report checklist of PTSD symptoms (based closely on the DSM-5 criteria), cutoff score between 31-33 indicative of probable PTSD, used in the perinatal population but not specifically validated

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), pregnancy complications (preeclampsia, gestational diabetes)

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 symptoms and postpartum PTSD following traumatic childbirth experience

Perinatal PTSD (Continued)

Avoid starting prazosin (adjunctive agent for PTSD-related nightmares) **during pregnancy and lactation:** limited data and no adequate studies in pregnant women, concerns about how maternal hypotension could affect fetal growth

- Data from reports of its use in the treatment of HTN during pregnancy (n=268, usually in conjunction with other antihypertensives): no increased risk for birth defects
- Experimental animal studies: not expected to increase the risk of congenital malformations
- Case report of a fetal demise attributable to maternal hypotension and caused by an increased dose of prazosin
- Small study (n=11): no pattern of congenital anomalies or specific prazosin related fetal toxicity
- No reports examining effects of prazosin during lactation; the manufacturer has reported that "one mother excreted at most 3% of the dose into her breastmilk."
- If prazosin is essential to maintain psychiatric stability it is very important to inform the woman about the risks and benefits of this medication; greater bioavailability and slower elimination in pregnant women; lower dose than usual if prescribed during pregnancy;

Pharmacological treatment:

Recommended:

- SSRIs (sertraline, fluoxetine)
- Venlafaxine (if lack of response to SSRIs, hx of robust response to venlafaxine)
- See medication table in Perinatal Depression Care Guide for information about SSRIs, venlafaxine

Not recommended:

- Clonidine:
  - Use in pregnancy: associated with fetal growth retardation
  - Use during lactation: high serum levels, infant hypotonia, drowsiness, apnea, seizures
- Benzodiazepines: worsening treatment outcomes
- Propranolol: lack of evidence for PTSD, limited data in pregnancy and lactation

Interventions not effective:

Debriefing, counseling, trazodone, benzodiazepines

Perinatal PTSD Resources

Review Articles:

Cirino NH, Knapp JM. Perinatal Posttraumatic Stress Disorder: A Review of Risk Factors, Diagnosis, and Treatment. Obstet Gynecol Surv. 2019 Jun;74(6):369-376.

Davidson AD, Bhat A, Chu F, Rice JN, Nduom NA, Cowley DS. A systematic review of the use of prazosin in pregnancy and lactation. Gen Hosp Psychiatry. 2021 Jul-Aug;71:134-136.

Thomson M, Sharma V. Pharmacotherapeutic considerations for the treatment of posttraumatic stress disorder during and after pregnancy. Expert Opin Pharmacother. 2021 Apr;22(6):705-714.

Oher references:

Zitoun N, Campbell MK, Matsui D, Garcia-Bournissen F. Prospective evaluation of pregnancy outcomes after gestational exposure to prazosin. Br J Clin Pharmacol. 2023 Nov;89(11):3324-3329. doi: 10.1111/bcp.15829. Epub 2023 Jul 10. PMID: 37323115.

Resources:

PTSD Checklist for DSM-5 (PCL-5):
https://istss.org/clinical-resources/assessing-trauma/ptsd-checklist-dsm-5

Internal Society for Traumatic Stress Studies:
www.istss.org

National Centers for PTSD:
http://www.ptsd.org