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A review assessing the current treatment strategies for postnatal psychological morbidity with a focus on post-traumatic stress disorder

Susanne Peeler, BSc, MPhil, CSci, FIBMS (Research student)[a,*], Man C. Chung, PdD (Professor)[b], Jacqui Stedmon, PhD (Academic Director of Clinical Psychology)[c], Heather Skirton, RGN, RM, MSc, PhD (Professor)[d]

[a] School of Nursing and Midwifery, Faculty of Health, Education and Society, Plymouth University, Wellington Road, Taunton TA1 5YD, United Kingdom
[b] Zayed University, PO Box 144534, Abu Dhabi, United Arab Emirates
[c] GF15, PAHC, College of St Mark & St John, Plymouth University, Devon, United Kingdom
[d] Applied Health Genetics, School of Nursing and Midwifery, Faculty of Health, Education and Society, Plymouth University, Wellington Road, Taunton TA1 5YD, United Kingdom

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ABSTRACT

Objective: to conduct a systematic review of randomised controlled trials investigating the efficacy of treatments used to manage postnatal psychological morbidity.
Design: a systematic review was conducted of studies in English published from 1995 to 2011. Studies were included in the review if they were randomised controlled trials and had extractable data on symptoms of psychological morbidity after an intervention designed to manage the disorders in postnatal women. Eight studies met the criteria and were included in the review.
Findings: the number of participants ranged from 58 to 1745. The interventions included group and individual counselling, debriefing and expressive writing. Authors of only three studies reported fewer symptoms of PTSD after the intervention. Those that appeared to be helpful were counselling and expressive writing. However most authors did not assess pre-existing PTSD.
Key conclusions and implications for practice: the review revealed that there was no standardised scale used for diagnosis of post-traumatic stress disorder across the studies and no single efficacious treatment. A universal instrument for diagnosis of postnatal post-traumatic stress disorder is required. The intrapartum relationship with midwives appears to be an important contributor to prevention of PTSD and this requires further investigation.

Introduction

Post-traumatic stress disorder (PTSD) is an anxiety disorder with the following symptoms; re-experiencing (e.g. nightmares and flashbacks), persistent avoidance of reminders (e.g. loss of memory of the event) and hyperarousal (e.g. irritability, difficulty concentrating) (APA, 1994). Postnatal PTSD has been acknowledged in the Diagnostic and Statistical Manual of the American Psychiatric Association fourth edition (DSM-IV) since 1994 and may be due to birth trauma related to a woman believing that her life or that of her child has been in danger or her perception of the event is that it was physically or psychologically traumatic. Postnatal PTSD has been reported in the literature since the mid-1990s (Ballard et al., 1995) and could be a concern in terms of public health, since the prevalence ranges from 1.5% to 6% (Ayers, 2001; Beck, 2006; Creedy et al., 2006). However, up to 30.1% of women may be partially symptomatic (Soet et al., 2003). Unlike Postnatal Depression (PND), PTSD levels are not routinely assessed postnatally and some authors suggest that possibly 25% of women, symptomatic with PTSD, remain undetected (Czarnocka and Slade, 2000). Prevalence of PTSD may be increasing due to further medicalisation of childbirth and women's dissatisfaction with the level of care during labour (Fisher et al., 1997; Creedy, 2000). The impact may be serious as women with postnatal PTSD experience impaired quality of life, changes in their physical well-being, mood, behaviour, social interaction, relationship with partner, mother baby bond and desire to have further children (Ayers et al., 2006b; Parfitt and Ayers, 2009).

Current treatments

The current recommended treatment in the UK is Cognitive Behavioral Therapy (CBT) (National Institute for Health and Clinical Excellence, 2005); however Ayers et al. (2008) discuss the often inadequate resources available to treat PTSD postnatally. Eye movement desensitisation and reprocessing (EMDR) is also recommended for non-childbirth related PTSD treatment. (APA, 2004; INSERM, 2004; National Institute for Health and

* Corresponding author.
E-mail address: rutspeeler@plymouth.ac.uk (S. Peeler).

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Clinical Excellence, 2005). Sandstrom et al. (2008) piloted its use with postnatal women and it was found to be effective, but it has not been widely applied and more research is needed. Sandstrom et al. (2008) report that the therapy is straightforward and time-efficient when compared with CBT. Written emotional disclosure has also been found to be effective in treating PTSD. Lange et al. (2000) reported that expressive writing reduced PTSD symptoms, while Sloan et al. (2007) reported improvement in psychological and physical health after therapy. van Emmerik et al. (2008) also found that expressive writing compared well to CBT.

Authors show a lack of agreement about how to treat postnatal PTSD, as traditional counselling approaches do not always work (Gamble, 2004; Gamble et al., 2004a,b). Ayers et al. (2006a) report that 94% of hospitals in the United Kingdom (UK) offer postnatal services for women who have experienced difficult births but many have been set up in response to perceived need, without any strong evidence base regarding efficacy, while the service differs from hospital to hospital. Rose et al. (2009) found that the use of debriefing for PTSD unrelated to childbirth was ineffective and could put people at risk of developing PTSD symptoms. As a consequence the most recent UK and US guidelines recommend against the use of debriefing for the treatment of PTSD (Foa et al., 1999; National Institute for Health and Clinical Excellence, 2005).

Olde et al. (2006) suggested a multistep psychosocial approach for treatment involving crisis management for those traumatised by their birth experience. This involves identification by screening immediately after birth, provision of a supportive environment where the woman can talk to health professionals and referral for CBT if necessary.

Steele and Beadle (2003) reported inconsistency in management of perinatal mental health between 46 maternity units surveyed in two regions of England. This inconsistency was again highlighted by Rowan et al. (2007), who reported the disparity between current practice and postnatal mental health policy. They stressed the importance of offering a service for both those who perceive their birth experience as traumatic (but may not subsequently develop a mental health problem) and for those who develop symptoms of PTSD requiring a specific treatment. A generalised approach in terms of a 'birth afterthoughts' service may not be appropriate for all women but a co-ordinated approach to the management of perinatal mental health services is necessary.

In view of this lack of consistency in management of postnatal PTSD, a systematic review of the current treatments available is required. The aim of the systematic review reported in this paper was to assess the efficacy of current treatments for postnatal PTSD.

Methods

The review process was based on the Potsdam guidelines for systematic reviews (Cook et al., 1995, p. 167) which defines a systematic review as

> The application of scientific strategies that limit bias to the systematic assembly, critical appraisal and synthesis of all relevant studies on a specific topic.

The guidance published was adhered to regarding the following; posing a relevant hypothesis, searching for eligible studies, using robust scoring systems to ascertain the quality of studies and extracting analysing and interpreting the data obtained from the primary studies.

Search strategy

The following databases were searched, Medline, Ebsco, BNI, Cochrane, PILOTS and Psychinfo for papers published between 1995 and 2011. The start date (1995) was influenced by the literature first reporting postnatal PTSD (Ballard et al., 1995). The key search terms used were 'PTSD' or 'traumatic stress' and 'post natal' or 'postnatal' or 'childbirth' or 'child birth' or 'post partum' or 'mother' or 'matern*. The search revealed 102 papers, subsequently 29 were retrieved and the abstracts or full texts were read. Two additional studies were retrieved by ancestral searching of two previous review papers (Gamble and Creedy, 2004; Mangaoang, 2009).

Eligibility for inclusion in review

The inclusion criteria were research studies in which the method was a randomised controlled trial (RCT) investigating treatment interventions for psychological morbidity and in particular postnatal post-traumatic stress disorder, studies written in English, studies conducted in any population from any country. In some papers the authors of studies on PTSD also referred to psychological morbidities other than PTSD and for completeness we have reported those data in our analysis. However we excluded those studies where morbidity was not directly linked by the authors to PTSD. The following studies were also excluded: those focussing on women in pregnancy, studies in which the women did not have evidence of psychological morbidity and where the treatment intervention was unassessed.

Of the 29 papers found, six were reviews of the topic (Bailham and Joseph, 2003; Gamble and Creedy, 2004; Olde et al., 2006; Bastos et al., 2009; Mangaoang, 2009; Lapp et al., 2010) eight were randomised controlled trials; (Lavender and Walkinshaw, 1998; Di Blasio and Ionio, 2002; Priest et al., 2003; Tam et al., 2003; Ryding et al., 2004; Gamble et al., 2005; Kershaw et al., 2005; Selkirk et al., 2006). Ten were reports of current practice (Allott, 1996; Smith and Mitchell, 1996; Allan (1998); McKenzie-McHarg, 2004; Stowe and Newport, 2005; Alder et al., 2006; Ayers et al., 2006a; Kitzinger and Kitzinger, 2007; Rowan et al., 2007; Buck, 2009). Two were qualitative in nature (Beck 2005; Beck, 2006) one reported a case study (Ayers et al., 2006b) and two others (Sorenson, 2003; Sandstrom et al., 2008) were excluded as no control group had been used in the studies (see the flow chart in Fig. 1). In order to assess efficacy of treatment for PTSD and other psychological disorders in a scientifically robust manner, only the eight RCTs were selected for detailed analysis.

Of the eight studies included in the review, one was conducted in Italy, three in Australia, two in the UK, one in Sweden and one in Hong Kong.

Quality assessment of papers reviewed

The quality assessment tool used in this study was that proposed by Kmet et al. (2004). A quality rating was given to important components of the study such as randomisation and blinding, study design, variance, analysis and confounding variables. Each paper was scored by two researchers independently and their scores were averaged. The quality ranged between 96% and 65%. All eight RCTs were deemed of sufficient quality to be included in the review. Please see Table 1 for a comparison of the studies.

Data extraction and management

Data were extracted according to the Cochrane review protocol (Bastos et al., 2009) which involved comparison of type of participants, sample size, diagnostic criteria used, nature, timing and duration of debriefing intervention, number and frequency of sessions, type of professional delivering the intervention, intervention components, control components, outcomes (primary