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A systematic review of midwife-led interventions to address post partum post-traumatic stress

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ABSTRACT

Objective: to systematically identify interventions that midwives could introduce to address post-traumatic stress in women following childbirth.
Methods: a search strategy was developed and relevant papers were identified from databases including Cinahl, Cochrane Library, EMBASE, Maternity and Infant Care, MEDLINE, PsycINFO, and Web of Science. Key search terms used were post-traumatic stress, post partum, intervention, controlled trial and review. Papers eligible for inclusion were primary studies and reviews of research published from 2002–2012, focusing on interventions which could be implemented by midwives for the prevention and/or management of PTSD. For primary studies, RCTs, controlled clinical trials, and cohort studies with a control group were eligible. Eligible reviews were those with a specified search strategy and inclusion/exclusion criteria. Methodological quality was assessed using recognised frameworks.
Findings: six primary studies and eight reviews were eligible for inclusion. The majority of included studies or reviews focused on debriefing and/or counselling interventions; however the results were not consistent due to significant variation in methodological quality and use of dissimilar interventions. Two of the reviews considered the general management of post partum PTSD and one broadly covered anxiety during pregnancy and the post partum, incorporating a section on PTSD. The majority of women reported that the opportunity to discuss their childbirth experience was subjectively beneficial.
Conclusions and implications for practice: no evidence-based midwifery interventions were identified from this systematic review that can be recommended for introduction into practice to address PTSD. It is recommended that future research in this area should incorporate standardised interventions with similar outcome measures to facilitate synthesis of results. Further research on interventions used in non-maternity populations is needed in order to confirm their usefulness in addressing post partum PTSD.

Contents

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Introduction

Childbirth is generally viewed as a positive, life-changing event for women and their families. However, it is now acknowledged that this period of time may be one of critical psychological adjustment for women (National Institute for Health and Clinical Excellence (NICE), 2007) and as such precipitate the development of mental health problems. This can have severe consequences not only for the woman herself, but may also impact on the relationship with her partner (Nicholls and Ayers, 2007), and their infant, potentially resulting in a dysfunctional mother–infant bond (Murray and Cooper, 1997).

Midwives have a responsibility and public health role to recognise and address mental health problems throughout the perinatal period; the Centre for Maternal and Child Enquiries (CMACE) (2011) advised that women who are at risk of developing a serious mental illness after childbirth should be managed proactively. Post partum psychological morbidity is usually strongly affiliated with depression, but there is growing recognition of other conditions, such as post-traumatic stress disorder (PTSD). PTSD can occur as the result of a birth perceived as traumatic and may impact on women's ability to cope and parent effectively in the postnatal period.

PTSD is a psychiatric anxiety disorder that is triggered by exposure to a psychologically traumatic event. Examples of precipitates for the disorder include involvement in combat (Richardson et al., 2010), exposure to a natural disaster (Neria et al., 2008), subjection to sexual assault (Chen et al., 2010), and involvement in a road traffic accident (Chossegros et al., 2011). Furthermore, as well as those directly affected by the traumatic occurrence, witnesses of a distressing event are also at risk of developing PTSD (National Institute for Health and Clinical Excellence (NICE), 2005). This can be observed in situations such as in parents caring for a child with a life-threatening illness (Manne et al., 1998). The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (American Psychiatric Association (APA), 2000), classifies symptoms of PTSD into three clusters for clinical diagnosis: those related to the re-living or re-experiencing the event such as distressing dreams of the event, those related to arousal and avoidance such as the evasion of thoughts associated with the trauma, and lastly hyper-arousal symptoms such as disturbed sleep patterns. For clinical diagnosis symptoms from each cluster must be present for more than a month, with the disorder being described as chronic if symptoms are present for more than three months. Also, the effects of the disorder must cause significant distress and disturbance to personal functioning in areas such as social or occupational realms (American Psychiatric Association (APA), 2000).

The onset of PTSD following childbirth has been a somewhat controversial topic as childbirth is usually thought of as a positive and natural life event for the majority of women. This has raised questions about whether childbirth can really precipitate PTSD that fully meets diagnostic criteria (Laing, 2001), particulary if considered in light of the original DSM definition of the constituents of a traumatic event that could precipitate PTSD (something out of the range of usual human experience) (American Psychiatric Association (APA), 1980). However it is accepted that childbirth is, at least in some instances, a complex event that may lead to a variety of psychological responses. Women may perceive their birthing experience as traumatic as a result of the mode of birth, intervention during the process, and the way they are treated by health care professionals (Allen, 1998). The DSM definition of stressors for the development of PTSD was revised in 1994 (DSM-IV) to include 'stressful situations in which a person had experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others' (American Psychiatric Association (APA), 2000, p. 467). Thus this definition can clearly be applied to certain experiences of childbirth, whether the perceived threat is subjective or objective.

Research has identified significant prevalence of PTSD following adverse experiences of obstetric related events such as perinatal loss, stillbirth, and premature births (Turton et al., 2001; Holditch-Davis et al., 2003; Engelhard et al., 2006). After early pregnancy loss, for example, prevalence rates of PTSD were found to be 25% ($n=28/113$) at one month after the event, decreasing to 7% ($n=7/101$) after four months (Engelhard et al., 2001). In a sample of parents whose infant was admitted to the neonatal intensive care unit ($n=127$), Lefkowitz et al. (2010) found that 35% of mothers met diagnostic criteria for Acute Stress Disorder at 3–5 days after their infant's admission, and 15% of mothers met PTSD diagnostic criteria 30 days later. Also, in a small sample of mothers who had a premature infant ($n=30$), Holditch-Davis et al. (2003) found that all participants had at least one post-traumatic symptom, whereas over half had all three main symptoms of re-experiencing the event, avoidance of reminders or numbing, and increased arousal at six months after their infant's expected date of childbirth. Furthermore, post-traumatic stress reactions have also been identified after childbirth in which the pregnancy is full term and the infant healthy. Olde et al. (2006) suggests that what may seem the norm for health care providers may be perceived as traumatic for the woman who is ill prepared for the experience. Olde et al. (2006) reported from a review that the prevalence figures of those that fit the 'PTSD-profile' (that is fulfil DSM-IV criteria B, C, and D) after live childbirth is between 2.8% and 5.6% at around six weeks post partum but decreases over time to approximately 1.5% by six months post partum.

Manifestations of PTSD exhibited in the wake of traumatic childbirth are thought to be similar to those shown after PTSD in the general population. Thus they may include intrusive symptoms such as flashbacks and nightmares, avoidance symptoms such as avoiding talking or reading about birth, and symptoms of increased arousal such as general distress, amnesia, sleep disturbances, dissociation, and negative evaluation of self-worth (Allen, 1998; Creedy et al., 2000). More unique manifestations such as hindrance of breast feeding because of fear of further violation of the woman's body have also been identified (Beck and Watson, 2008). Although mostly based on results from small-scale qualitative studies, long-term consequences of PTSD following childbirth are thought to be far-reaching with personal, relational and societal implications for women and their families. Research has suggested that a possible effect of the disorder is the development of dysfunctional mother–infant attachment that may result in a relationship that is either avoidant/rejecting or over-anxious/protective (Allen, 1998; Parfitt and Ayers, 2009). Other effects may include strain on the mother–partner relationship (Nicholls and Ayers, 2007), sexual avoidance (Ayers et al., 2006b), and fear of future childbirth, known as secondary tokophobia (Hofberg and Brockington, 2000). This in turn may dissuade against further pregnancies or result in request for elective caesarean sections for subsequent childbirth (Beck, 2004).

Limited research has explored what can be implemented in the antenatal or intrapartum period for the primary prevention of