



Review article

The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis



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ARTICLE INFO

Keywords:

Perinatal
Post-traumatic Stress Disorder
Prevalence
Pregnancy
Birth
Postpartum

ABSTRACT

Background: Previous reviews have provided preliminary insights into risk factors and possible prevalence of Post-traumatic Stress Disorder (PTSD) postpartum with no attempt to examine prenatal PTSD. This study aimed to assess the prevalence of PTSD during pregnancy and after birth, and the course of PTSD over this time.

Methods: PsychINFO, PubMed, Scopus and Web of Science were searched using PTSD terms crossed with perinatal terms. Studies were included if they reported the prevalence of PTSD during pregnancy or after birth using a diagnostic measure.

Results: 59 studies ($N = 24267$) met inclusion criteria: 35 studies of prenatal PTSD and 28 studies of postpartum PTSD (where 4 studies provided prevalence of PTSD in pregnancy and postpartum). In community samples the mean prevalence of prenatal PTSD was 3.3% (95%, CI 2.44–4.54). The majority of postpartum studies measured PTSD in relation to childbirth with a mean prevalence of 4.0% (95%, CI 2.77–5.71) in community samples. Women in high-risk groups were at more risk of PTSD with a mean prevalence of 18.95% (95%, CI 10.62–31.43) in pregnancy and 18.5% (95%, CI 10.6–30.38) after birth. Using clinical interviews was associated with lower prevalence rates in pregnancy and higher prevalence rates postpartum.

Limitations: Limitations include use of stringent diagnostic criteria, wide variability of PTSD rates, and inadequacy of studies on prenatal PTSD measured in three trimesters.

Conclusions: PTSD is prevalent during pregnancy and after birth and may increase postpartum if not identified and treated. Assessment and treatment in maternity services is recommended.

1. Introduction

Post-traumatic Stress Disorder (PTSD) may be a significant mental health concern for pregnant and postpartum women. The onset of PTSD can precede pregnancy or occur during the perinatal period (Howard et al., 2014). PTSD can be present in pregnancy as a result of traumatic events such as accidents, interpersonal violence or natural disasters (Anniverno et al., 2013). After birth, PTSD can develop following a difficult or traumatic birth during which women think they or their baby might die or be seriously hurt. If women have a history of PTSD it is also possible this can be re-triggered by events during pregnancy and birth (Halvorsen et al., 2013). A number of studies have shown that PTSD can have a negative impact on women, their relationship and birth outcomes (Nicholls and Ayers, 2007; Onoye et al., 2013; Shaw et al., 2014; Yonkers et al., 2014) and there are indications it may also affect infant emotion regulation and development (Bosquet Enlow et al., 2011; Parfitt et al., 2014).

Most research has assessed perinatal PTSD according to DSM-IV criteria where symptoms of PTSD are grouped into three clusters: (1)

re-experiencing the traumatic event through nightmares, intrusive thoughts or flashbacks; (2) persistent avoidance of reminders of the event and numbing of general responsiveness; and (3) increased arousal such as hypervigilance, irritability, difficulty concentrating and other emotional dysregulation. To be diagnosed with PTSD a person must have at least one re-experiencing symptom, three avoidance symptoms and two symptoms of arousal. Symptoms must cause the person significant distress and impairment in occupational or social functioning (American Psychiatric Association, 2000).

Estimates of the prevalence of PTSD in pregnancy and after birth vary hugely. In pregnancy prevalence estimates range from 0% to 35% (Horsch et al., 2013; Mahenge et al., 2013) and after birth from 0% to 21% (Schwab et al., 2012; Verreault et al., 2012). This is a common problem in the epidemiology of mental health disorders where prevalence often varies widely across studies and countries (Pringsheim et al., 2014). Variation in prevalence can be due to factors such as differences in sampling, measurement and cultural context. In perinatal PTSD research the use of high-risk clinical samples is likely to account for some of the variation because women with complications of

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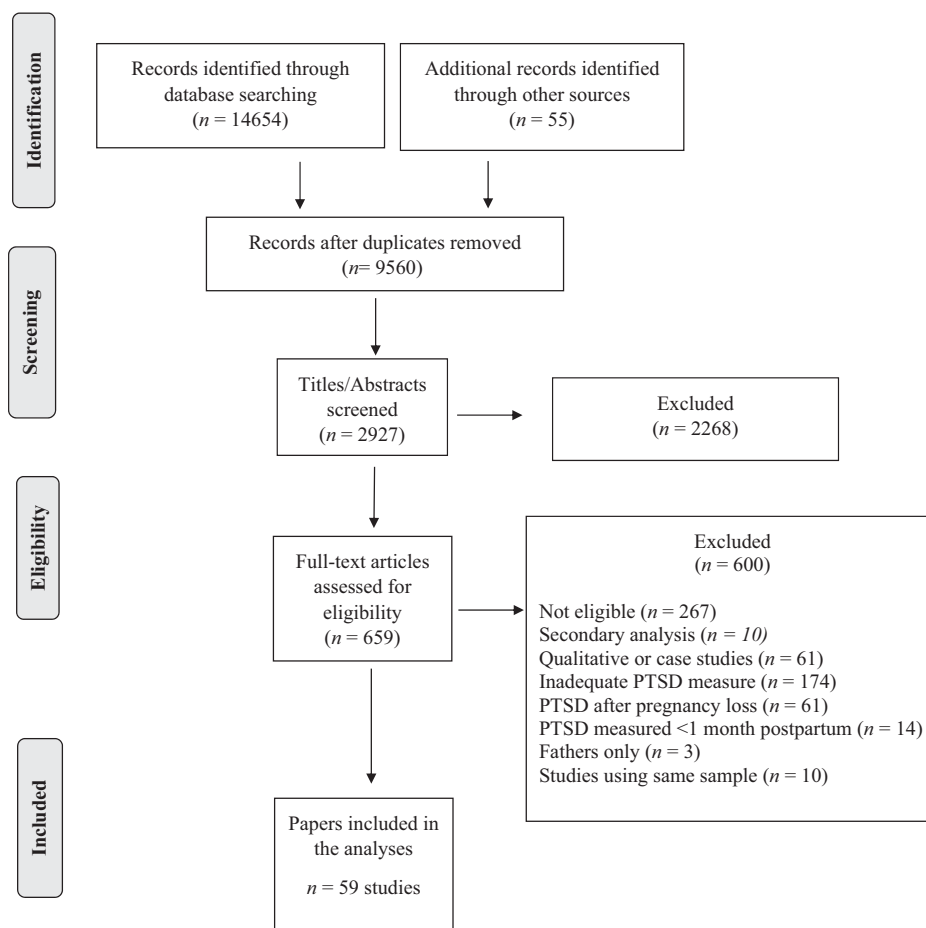


Fig. 1. Flow chart of systematic research.

pregnancy or birth are more likely to report PTSD compared to women in community samples. Differences in measurement are also important, in particular whether studies measure full diagnostic criteria or only symptoms. Self-report measures that do not measure full diagnostic criteria for PTSD might inflate prevalence estimates (Ayers et al., 2015). For example, studies have found that the prevalence of participants meeting the criteria for PTSD measured by a symptom scale decreased from 20% to 3% once stressor criteria and impact on functioning were added (Boals and Hathaway, 2010) and doubled when the criterion A2 (intense emotional response) was removed (Boorman et al., 2014). Similarly, self-report questionnaires may result in higher prevalence rates than clinical diagnostic interviews (Boals and Hathaway, 2010; Ruggiero et al., 2006).

Valid data on the prevalence of birth-related PTSD are important for many reasons. Clinically, it is important to know the true extent of perinatal PTSD to raise awareness and provide appropriate interventions. Economically and politically, accurate estimates of prevalence enable us to balance the cost of prevention and treatment against the public health consequences. Precise estimates of the prevalence of perinatal PTSD are therefore a scientific imperative. To date, three reviews have been published which include some information on postpartum prevalence (Andersen et al., 2012; Grekin and O'Hara, 2014; Olde et al., 2006). Two of these were qualitative reviews with no attempt at meta-analyses (Andersen et al., 2012; Olde et al., 2006). The most recent review included meta-analyses of prevalence and risk factors for postpartum PTSD. This review included 78 studies and the primary focus was on risk factors, however the mean prevalence was reported as 3.17% in community samples and 15.7% in high-risk samples, confirming that prevalence rates are higher in high-risk samples (Grekin and O'Hara, 2014).

These reviews provide a useful overview of risk factors and possible prevalence of postpartum PTSD. However, a number of gaps remain. Firstly, PTSD in pregnancy has not been reviewed despite evidence that it occurs in a significant proportion of women and is associated with poor outcomes such as preterm birth (Shaw et al., 2014; Yonkers et al., 2014). Secondly, all the reviews included studies of prevalence that were based on symptom severity scores rather than full diagnostic criteria which may inflate estimates. Thirdly, the reviews did not distinguish between point prevalence (measured at one time point e.g. 6 weeks after birth) and period prevalence (measured in a time range e.g. 1–6 months after birth). Finally, there has been no attempt to look at changes in the prevalence of PTSD over time despite this being important in informing appropriate timing of screening and intervention. A review of PTSD prevalence in pregnancy and after birth provides an opportunity to examine the course of PTSD longitudinally across pregnancy and the postpartum period.

This review aimed to address these gaps in order to achieve a better understanding of the epidemiology of perinatal PTSD. The objective was to conduct a systematic review of the prevalence rates reported in community and high-risk samples that use full diagnostic measures of PTSD. The course of PTSD over time, comorbidity with depression, and methodological factors that might influence prevalence rates will also be examined. Methodological factors are type of sample (high-risk vs community) and measurement (self-report vs clinical interview). Based on the literature it was expected that: (1) studies recruiting women at high-risk of physical complications or mental health problems will have higher rates compared to those including participants at low-risk or community samples; (2) studies using clinical interviews will have lower rates in comparison with self-report questionnaires; and (3) the prevalence of PTSD will be higher in pregnancy (due to the multiple

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