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Effect of Previous Posttraumatic Stress in the Perinatal Period

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ABSTRACT

Objective: To review the extant literature on the effect of traumatic experiences that pre-date conception, pregnancy, and the postpartum period (perinatal period) and present a thematic overview of current issues in this relatively new area of inquiry.

Data Sources: Electronic databases CINAHL, PsychINFO, and PubMed were searched. Manual searches of bibliographies supplemented the electronic search. Q1 Q2

Study Selection: Peer-reviewed articles written in English on the role of posttraumatic stress disorder during the perinatal period were included.

Data Extraction: Key findings relevant to perinatal posttraumatic stress that were reported in primary sources and meta-analyses were organized according to themes, including *The Role of Childbirth, Comorbidity With Depression and Anxiety, Risk Factors for Perinatal PTSD, High-Risk Health Behaviors,* and *Association With Adverse Health Outcomes*. Q3

Data Synthesis: Across studies, antenatal posttraumatic stress disorder (PTSD) rates were estimated between 2.3% and 24%, and observed prevalence rates during the postnatal period ranged from 1% to 20%; however, many researchers failed to assess PTSD that existed before or during pregnancy, and when preexisting PTSD is a controlled variable, postpartum rates drop to 2% to 4.7%. In addition to prenatal depression and anxiety and pre-pregnancy history of psychiatric disorders, history of sexual trauma, childhood sexual abuse, intimate partner violence, and psychosocial attributes are risk factors for development or exacerbation of perinatal PTSD.

Conclusion: Women's health care providers should evaluate for PTSD in routine mental health assessments during and after pregnancy, especially with a reported history of trauma or the presence of a mood or anxiety disorder. Such screening will allow women to receive needed treatment and referrals and mitigate the potentially negative sequelae of PTSD. Future investigators must recognize the importance of subsyndromal posttraumatic stress symptoms and individual differences in responses to trauma.

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Women can experience a variety of adverse reproductive-related events during the perinatal period. For some women, achieving and maintaining pregnancy is largely uneventful, while others may confront significant challenges such as infertility, pregnancy loss, and preterm birth. Psychological responses after childbirth or adverse perinatal events and associated medical interventions can vary from no apparent reaction, to grief and mild distress, to psychiatric symptoms and disorders. Although attention has historically been focused on depression, the significance of anxiety, trauma, and anxiety-related diagnoses during the perinatal period has gained increased attention over the last decade (Agius, Xuereb, Carrick-Sen, Sultana, & Rankin, 2016; Blackmore, Gustafsson, Gilchrist, Wyman, & O'Connor, 2016; Grekin & O'Hara, 2014).

According to the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (*DSM-5*), the term *posttraumatic stress disorder* (PTSD) is used to describe the development or worsening of four types of symptoms after a stressful event (American Psychiatric Association, 2013, p. 271). Qualifying events must involve exposure to actual or threatened death, serious injury, or sexual violence to self or others. Symptom clusters involve re-experiencing the event (intrusion symptoms), persistent avoidance of stimuli associated with the event (avoidance symptoms), negative mood alterations, and increased arousal and reactivity (American Psychiatric Association, 2013).

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The effect of trauma on pregnancy and the postpartum period is often underrecognized.

Given the high lifetime prevalence of traumatic exposures and the fact that 4 out of 5 women have children at some point in their lives, it is not surprising that many women enter pregnancy with histories of one or more traumatic events (Craig et al., 2014). Additionally, clinicians have observed that a growing number of life events can lead to posttraumatic stress, including preexisting traumas and events related to the perinatal period. There are many reasons why women may experience pregnancy as stressful (Geller, 2004), and a growing body of research indicates that many women may perceive these events as traumatic (e.g., Grekin & O'Hara, 2014; Verreault et al., 2012).

It is important to differentiate between distress arising from trauma that occurs before pregnancy and incident trauma related to the pregnancy or childbirth itself when considering PTSD during the perinatal period, because they may have different developmental courses and implications for care. In the case of preexisting trauma, PTSD symptoms were present before pregnancy and continued into the perinatal period or resolved until childbirth-related events triggered relapse. When women experience traumatic childbirth and subsequently develop PTSD, it is often because of feelings of loss of control that can involve urgent and unanticipated medical interventions, severe pain, or humiliation (Beck, Driscoll, & Watson, 2013). The occurrence of adverse outcomes, such as perinatal loss or preterm birth that results in admission to the NICU, has also been associated with PTSD responses (Christiansen, Elklit, & Olff, 2013; Daugirdaitė, Van den Akker, & Purewal, 2015; Shaw et al., 2006; Shaw et al., 2009). However, women who experience perinatal loss are typically excluded from research about pregnancy and PTSD because diagnosis of PTSD can be complicated by the significant bereavement component of the loss (Grekin & O'Hara, 2014).

The purpose of the current review was to identify themes and describe the role of trauma and its association with posttraumatic stress reactions, particularly PTSD, during pregnancy and the postpartum period. The effect of preexisting trauma on pregnancy and the postpartum period is often underrecognized. It is important that perinatal nurses and other health care providers be aware of and screen for symptoms of posttraumatic stress, trauma history, and trauma reactions during pregnancy and after childbirth. We identified themes associated with the effect of traumatic experiences that pre-date conception and their effect on the pregnancy and the postpartum period rather than traumatic childbirth or pregnancy complications. Implications for perinatal nurses are provided in Table 1. Additionally, although the effects of perinatal loss are outside the scope of this review, loss of a previous pregnancy or a neonatal death may constitute a preexisting trauma for subsequent pregnancies (Forray, Mayes, Magriples, & Epperson, 2009; Hamama, Rauch, Sperlich, Defever, & Seng, 2010).

We searched Cochrane, PsychINFO, CINAHL, and PubMED electronic databases for

Table 1: Implications for the Perinatal Nurse

Prevalence

- There is a high rate of depression and anxiety comorbidity during the perinatal period.
- Women have high rates of trauma exposure and higher rates of PTSD than men.
- PTSD may be overlooked or misdiagnosed during the perinatal period.

History

- History of preconception trauma and/or prior birth trauma or adverse birth outcomes can have a negative impact on subsequent pregnancies in terms of maternal mental health and health outcomes.

Screening

- In addition to screening for antenatal and postpartum depression, it is critical to include assessment of trauma history and current PTSD symptoms.
- Use of the brief, four-item PC-PTSD is a reasonable option to screen for PTSD symptoms. The PPQ is another PTSD screening measure but is specific to women during the perinatal period.

Interdisciplinary Care

- As with depression screening, positive screening results for PTSD should be followed up with diagnostic assessment.
- Even subclinical levels of PTSD can impair maternal functioning and well-being.
- Referral to mental health professional for full evaluation and/or treatment may be necessary.

Note. PC-PTSD = Primary Care Posttraumatic Stress Disorder screening tool; PPQ = Perinatal Posttraumatic Stress Disorder Questionnaire; PTSD = posttraumatic stress disorder.

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